NHS
Derbyshire Healthcare
NHS Foundation Trust

Meeting of the Board of Directors 28 June 2017

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Derbyshire Healthcare NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING - WEDNESDAY 28 JUNE 2017
TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B
CENTRE FOR RESEARCH & DEVELOPMENT, FIRST FLOOR,

	TIME	AGENDA	ENC	LED BY
1.	1:00	Chair's welcome, opening remarks, apologies for absence and Declarations of Interest Register	**A**	Caroline Maley
2.	1:05	Service Receiver Story	**-**	Carolyn Green
3.	1:30	Minutes of Board of Directors meeting held on 24 May 2017	**B**	Caroline Maley
4.	1:35	Matters arising – Actions Matrix	**C**	Caroline Maley
5.	1:40	Questions from governors or members of the public	**-**	Caroline Maley
6.	1:45	Acting Chair's Update	**-**	Caroline Maley
7.	1:50	Acting Chief Executive's Update	**D**	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY				
8.	2:00	Integrated Performance and Activity Report	**E**	Mark Powell/Claire Wright/Amanda Rawlings/Carolyn Green
9.	2:30	Cyber-attack and Lessons Learned Report	**F**	Mark Powell
10.	2:40	Position Statement on Quality	**G**	Carolyn Green
11.	2:50	Board Committee Assurance Summaries and Escalations: Audit & Risk Committee 25 May, Mental Health Act Committee 9 June, *(minutes of these meetings are available upon request)*	**H**	Committee Chairs
3:00 B R E A K				
12.	3:15	Deep Dive – Substance Misuse	**I**	Mark Powell
13.	3:40	Equality, Diversity and Inclusion Update	**J**	Amanda Rawlings
14.	3:50	Workforce Plan ***(paper to follow)***	**K**	Amanda Rawlings
15.	4:00	Progress on the Staff Survey	**L**	Amanda Rawlings
CLOSING MATTERS				
16.	4:10	Any Other Business	**-**	Caroline Maley
17.	4:15	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	**M**	Caroline Maley
FOR INFORMATION				
Report from confidential Council of Governors meeting 2017/18 Board Forward Plan			**N O**	-

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.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 27 July 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 Chair'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 Kate Majid (spouse) Assistant Chief Commissioning Officer, NHS North Derbyshire CCG	(a, d)
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 Julia Tabreham Deputy Trust Chair and Non-Executive Director	Non-Executive Director, Parliamentary and Health Service Ombudsman Director of Research and Ambassador Carers Federation Leads the Parliamentary and Health Service Ombudsman's contribution to establishing NHS complaints advocacy support in Ireland	(a, d)
Lynn Wilmott-Shepherd Interim Director of Strategic Development	Substantive post – Director of Commissioning and Delivery, NHS Erewash CCG	(d)
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, d)

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

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling 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 Training Rooms 1 and 2
Research and Development Centre, Kingsway, Derby DE22 3LZ

Wednesday 24 May 2017

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4.35pm

PRESENT:	Caroline Maley	Acting Trust Chair
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Barry Mellor	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance & Deputy Chief Executive
	Carolyn Green	Executive Director of Nursing & Patient Experience
	Dr John Sykes	Executive Medical Director
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
	Mark Powell	Acting Chief Operating Officer
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Lynn Wilmott-Shepherd	Interim Director of Strategic Development
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary (Minutes)
For DHCFT 2017/073	Peter	Service User
For DHCFT 2017/073	Velmer Boreland	Occupational Therapist
For DHCFT 2017/083	David Tucker	General Manager, Children & Young Peoples Services
For DHCFT 2017/083	Scott Lunn	CAMHS & IAPT Operational Lead
For DHCFT 2017/083	Aislinn Choke	Consultant Psychiatrist/Associate Medical Director
For DHCFT 2017/083	Beth Howman	Consultant Paediatrician
APOLOGIES:	Margaret Gildea	Senior Independent Director
	Dr Anne Wright	Non-Executive Director
VISITORS:	John Morrissey	Lead Governor, Public Governor, Amber Valley South
	Gillian Hough	Public Governor, Derby City East
	Carole Riley	Public Governor, Derby City East
	Rosemary Farkas	Public Governor, Surrounding Areas
	Melissa Castledine	Derbyshire Mental Health Alliance

DHCFT 2017/072	**ACTING CHAIR'S WELCOME, OPENING REMARKS AND APOLOGIES** Acting Trust Chair, Caroline Maley, opened the meeting and welcomed everyone. Apologies were noted from Margaret Gildea and Dr Anne Wright.
DHCFT 2017/073	**SERVICE RECEIVER STORY** Nicola Fletcher introduced service receiver Peter who gave an account of his experience of secure services and his time spent at the Kedleston Unit. He also talked about how he studied for a degree whilst undergoing his recovery and described his eventual progress into employment. Occupational Therapist, Velmer Boreland accompanied Peter and

	talked about how the use of community resources and peer support programmes had played a part in aiding Peter's recovery. Peter talked about how he was encouraged to take up new interests and enrolled on courses specialising in resilience training and understanding relationships which helped build his confidence. He was also encouraged to study for a teacher training qualification that he is due to complete in July which will enable him to be qualified to teach six-form students and above. The Board heard how Peter had been involved with the CQC inspection team and how this had led to him being employed by the CQC occupational therapy and clinical team. Peter is pleased that during his time with the Trust he has grown in confidence and has become more independent. He has learnt how to stay well and to spot his strengths. He has also learnt how to cope with disappointment and how to utilise his support networks. He spoke of his aspirations for the future and is currently applying for jobs. He is coming to end of his time at the Kedleston Unit and now spends five nights a week at a transition house. He hopes to secure his own flat in the near future. When asked by the Board if there was any part of the Trust's service that should change Peter described how difficult it had been accessing clarity of which advocacy service to use, and then keeping in contact with the same branch of the advocacy service. Instead he utilised the support of the clinicians on the ward and the Occupational Therapists. The Board discussed the issues raised and undertook to improve the advertising of the local authority commissioned independent advocacy service. Carolyn Green undertook to explore the service offered by the Derby city and Derbyshire services, and include this in ward information booklets and posters. Discussion also centred around how the Trust could enable Peter and others in his situation move forward in life. The Board heard of plans to develop a recovery college within the Kedleston Unit that would inspire a sense of hope and recovery for people. Although this resource is still in its infancy Peter has kindly agreed to support staff in setting up this facility which would be an important resource to have within patient centred care planning. The Board supported this initiative and it was agreed that Carolyn Green would develop a recovery and enablement strategy that will be submitted to the Quality Committee, the results of which would be reported to the through to the Board. The Board was impressed with Peter's local insight and his understanding of the choices he made and in developing his recovery. This was a truly inspirational story and the Board wished him well for the future. **ACTION: Carolyn Green will work with the Nursing and Quality team, specifically Allied Health Professionals to develop a recovery and enablement strategy that will be submitted to the Quality Committee to focus upon employment and a positive approach to recovery.** **RESOLVED: The Board of Directors expressed thanks to Peter for sharing his inspiring story and appreciated the opportunity to hear at first hand the service the Trust had provided.**
DHCFT 2017/074	**MINUTES OF THE MEETING DATED 26 APRIL 2017** The minutes of the previous meeting, held on 26 April were agreed and accepted subject to Claire Wright's title being corrected to Executive Director of Finance and Deputy Chief Executive.
DHCFT 2017/075	**MATTERS ARISING AND ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted on the actions matrix.

	Carolyn Green updated the Board on the outcome from last month's Service User Story and was pleased to report that immediate financial support would be given to the carers' support group
DHCFT 2017/076	**QUESTIONS FROM PUBLIC GOVERNORS** Two questions were received from public governors. The first was from Gillian Hough Public Governor, Derby City East who asked what steps the Board would be taking to manage the potential risk to the quality of service delivery as the Trust moves towards the transaction with DCHS. The Chair responded that the Board has looked at clinical services and discussed the opportunity to work with DCHS to address and improve the health of our population. As regards to the quality of individual services the Board considers that integration will provide opportunities to improve quality and efficiencies and may improve the Trust's financial outlook. The Board will ensure that the CQC action plan is delivered and focus on obtaining the best clinical and effectiveness standards will continue. There were ten parts to a question received from Ruth Greaves, public governor for Derbyshire Dales. A written statement by Amanda Rawlings responding to these questions was circulated at the meeting and would be included in the supporting papers for the next Board meeting in June. **RESOLVED: The Board of Directors noted and responded to questions raised by the public governor for Derbyshire Dales and the public governor for Derby City East.**
DHCFT 2017/077	**ACTING CHAIR'S VERBAL REPORT** Caroline Maley firstly expressed her thanks to everyone involved in making sure safety was paramount during last week's cyber-attack. Throughout this period she was kept updated with progress and felt assured by the work being undertaken by the IT support teams who performed a sterling job under extremely difficult circumstances. During the last month Caroline Maley continued to meet with chairs of other organisations and commissioners from Erewash and Hardwick Commissioning Groups. She also met with the chair of Leicestershire Partnership Trust when they discussed the care services being offered through a pilot scheme in social care. The Council of Governors met on 2 May in public session and this meeting was observed by a number of governors from DCHS. An effective Governance Committee was held on 17 May and she also met with the Lead Governor, John Morrissey. The Non-Executive Directors met in May for their quarterly meeting and this allowed the chairs of the different Board committees to discuss how their work was progressing. Caroline Maley also attended the Audit & Risk Committee on 27 April to review the Annual Report and Accounts for 2016/17 prior to formal sign off by the Committee later in May. The Joint Integration Programme Committee (JIPC) took place on 3 May and a report of this meeting is included as part of the Acting Chief Executive's report. Cultural Assessments were held with a number of Executive Directors and Non-Executive Directors on 23 May. Caroline Maley explained that this is part of the due diligence activity being conducted by Ernst & Young in preparation for the Outline Business Case and will enable the Trust to get a deeper insight into the challenges that might be faced through integration.

	Caroline Maley attended the DAFT Conference (Derbyshire's Association for Family Therapy) and said that it was of great interest to see the work that is being carried out with families. **RESOLVED: The Board of Directors noted the activities of the Acting Chair throughout the month of May.**
DHCFT 2017/078	**ACTING CHIEF EXECUTIVE'S REPORT** The Acting Chief Executive's report provided the Board of Directors with feedback and an update on developments occurring within the local Derbyshire health and social care community. Ifti Majid referred to discussions held at the last Board meeting concerning public protection with regard to the number of people being released from prison. The Trust is unfortunately one of the few trusts not commissioned to provide a community forensic mental health care service. He informed the Board that he has written to commissioners and the STP expressing the Trust's serious concern regarding the risks associated with the release to Derbyshire of IPP (Indeterminate Imprisonment for Public Protection) prisoners and asked commissioners for a specific forensic stream that will help the Trust to manage the complex needs of these individuals. This risk has also been added to the Board Assurance Framework as one of our highest risks. Following on from the last meeting when the Board heard of the issues junior doctors are experiencing, Ifti Majid invited junior doctors to take part in a two-way shadowing exercise with the Board so they can understand more about the challenges junior doctors face when placed in our organisation and he urged Board members to put themselves forward to take part in this programme. Ifti Majid's report included an overview of the Trust's experiences during the recent cyber-attack and he thanked all staff who worked hard to ensure that the quality of the Trust's services was not compromised in any way. Mark Powell responded that the IT team had taken precautionary action during this period and was pleased to report that none of the Trust's systems were affected by the virus. The Trust's priorities were to make sure clinical systems were operating as quickly as possible. He was pleased to report that the Trust's PARIS disaster recovery process meant that there were no patient safety issues arising. Debriefing and lessons learnt sessions are being undertaken and will form part of a report that will be received by the Board at the next meeting in June. Mark Powell assured the Board that work had taken place to ensure that paper records that were kept during this period have been transferred to the electronic system and that wards were provided with extra staff to enable this to be carried out without staff being pulled away from clinical duties. Ifti Majid referred to the outcome of the CQC visit in February 2016 and the Deloitte Well Led exercise carried out in January 2016 which resulted in the Trust being in breach of its provider licence. He informed the Board that he had positive feedback from NHS Improvement about the Trust's progress to comply with conditions placed on the Trust with respect to its NHS provider licence. He hoped that formal notification that the Trust is free of all former licence breaches may be forthcoming shortly. Appended to this paper was a summary report from the Joint Integration Programme Committee. Ifti Majid pointed out that this did not contain the full detail of discussions that took place during the meeting and he intended to discuss with the Joint Integration Programme Director how these reports could be more detailed. **ACTION: Report on recent cyber-attack to be received at the June meeting.** **RESOLVED: The Board of Directors noted the Acting Chief Executive's update**

DHCFT 2017/079	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)** The report showed that the Trust continued to perform well against many of its key indicators during April. Owing to the IT downtime during week commencing 15 May, reporting of data was delayed which affected the level of narrative that has been able to be provided within the report. As a result, quality, workforce and operational sections were scrutinised by Board members to establish key performance issues and to gain assurance on mitigating actions being undertaken in these areas. The Board recognised that positive improvements have been made with regard to the stability around workforce metrics which showed a good start to the year. In terms of challenges, the report drew attention to a lack of staff capacity across the organisation resulting in poor performance in staff supervision and appraisals and Executive Directors were urged to place an internal focus on these key areas. In response, Mark Powell undertook to refocus the teams on all internal performance issues, the results of which would be seen in future IPR reports. With regards to financial performance, Claire Wright reported that at month one the Trust is ahead of plan and plans are in place to achieve the Trust's CIP of £3.85m. She is forecasting that the Trust will achieve its control total at the end of the year despite there currently being an overspend on pay and employee expenses. The report showed that the sickness absence rate is still high and the underlying causes of stress and anxiety are one of the Trust's biggest challenges. Amanda Rawlings reported on the Trust's vacancy situation and explained that with the TRAC electronic recruitment management tool now operational the Trust's vacancy rate should improve. She was working on innovative ideas to attract staff and establishing systems that will anticipate vacancies that will arise through retirement or staff movement in order to predict immediate needs. Individuals will be recruited and retained through development opportunities. Richard Wright referred to the recent recruitment visit made to India. Mark Powell responded that he would provide the Board with a full report on his trip to India at the next meeting in June that will set out the progress made and the development of a clear partnership with India's National Institute of Mental Health which will play a significant role in improving recruitment in the longer term. The Trust is also exploring recruitment opportunities for doctors in Egypt. Concern was raised with regard to safe staffing levels in the Hartington and Radbourne Unit. Carolyn Green assured the Board that emergency planning measures were not required as occupancy is currently quite low in these units and some staff have been transferred to other areas. The Board requested that future IPR reports include a short summary on safer staffing, and that a report be received by the Quality Committee on safer staffing mitigation plans. **ACTION: Summary report on Safer Staffing to be regularly included in the IPR** **ACTION: Report on safer staffing mitigation plans to be received by the Quality Committee.** **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 2017/080	**CONTROL OF INFECTION REPORT** The Control of Infection Report summarised the activity in the safe management of Infection Prevention and Control over the preceding 12 months. The Board noted that this annual report was scrutinised by the Quality Committee and

	significant assurance was established. **RESOLVED: The Board of Directors accepted the Annual Control of Infection Report and received significant assurance on standards of cleanliness of clinical areas and food preparation areas**
DHCFT 2017/081	**<u>QUALITY POSITION STATEMENT</u>** Carolyn Green provided the Board of Directors with an update on the organisation's continuing work to improve the quality of services that are provided in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives. Reference was made to the increase in drug related deaths in substance misuse. Carolyn Green assured the Board that the Quality Committee will continue to monitor the substance misuse integrated services and will maintain a monitoring brief on this national trend and challenged John Sykes and Lynn Wilmott-Shepherd to establish the learning to be had from effective governance of clinical consortium arrangements. In her support, Julia Tabreham as Chair of the Quality Committee referred to the level of intervention that the Trust's integrated service model has had across the wards and third sector organisations which had made an impression on A&E admissions and asked John Sykes and Lynn Wilmott-Shepherd to look at this clinical consortium's success criteria. John Sykes responded that this has resulted in a significant alignment of organisations within a lead provider model and he believed that an aligned strategy would be of great benefit to staff. Carolyn Green drew attention to Improving Access to Psychological Therapies services (IAPT) and informed the Board that she proposed to explore extending IAPT into walk-in centres to cope with primary care demands which would be beneficial to neighbourhoods and would also avoid activity from Accident and Emergency services. The report also included the notification of a visit by the CQC on 12 July to check compliance with the Mental Health Act and Code of Practice which was formally noted by the Board. **RESOLVED: The Board of Directors received and noted the Quality Position Statement**
DHCFT 2017/082	**<u>BOARD ASSURANCE SUMMARIES & ESCALATIONS</u>** Assurance summaries were received from the Board Committees that took place during April and May 2017. Committee Chairs summarised the escalations that had been raised and these were noted by the Board. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries and Escalations.**
DHCFT 2017/083	**<u>DEEP DIVE – PAEDIATRICIAN CAMHS WAIT TIMES</u>** The Paediatrician and CAMHS services team joined the meeting and provided the Board with an insight into some of the key challenges and achievements for their services. The Board heard from David Tucker, Beth Howman, Aislinn Choke and Scott Lunn about a number of initiatives they have used to help manage the referral pressures and long waiting lists in CAMHS and Paediatrics. These initiatives included assessing job plans for each role to ensure the team had the correct processes in place for work priorities. They also held a recruitment campaign and recruited three new doctors and managed to secure some locum cover that provided extra capacity. The team have also made use of funding identified for consultant paediatricians and utilised nurses to carry out work previously carried out by

	paediatricians. This has enabled the team to recruit a psychologist to help with additional demand. The team also entered joint recruitment with Derby Teaching Hospital to make posts more attractive to applicants. Despite this effort, there is an ongoing strain on services. The trajectory for paediatrics patients waiting over 52 weeks showed significant demand. The Board was informed that 'waiting well' checks take place during this wait time and this process is working effectively. The team considered that the recent addition of a waiting list care co-ordinator will help with the flow of appointments. One of the key challenges for the team is that appointments are not kept. Families are reminded of the importance of notifying the team when cancelling appointments and the Board heard how DNAs (Did Not Attend) were checked on a case by case basis for issues relating to safeguarding or neglect. Support services also work with families to help them attend. The Board was concerned to hear that the number of appointments lost each week equates to three whole time staff. A great deal of work has taken place within the team to improve waiting times. The team gave an overview of their plans for future improvement. A speciality doctor is due to start in June. The Board was informed that consultant paediatricians are in great demand and is also a very difficult post to recruit to. The team is trying to be as flexible as possible with the work plans to attract consultant paediatricians. The current CAMHS service performance shows a resource gap. The Trust receives a certain amount of funding but not enough funding to provide the right scale of services for the population of children. Community paediatricians are commissioned to work with young people up to the age of 16 years unless in they are in attendance at special schools or subject to child protection. This is a known commissioning gap and the Board heard that Lynn Wilmott-Shepherd is working towards addressing this issue. The Board understood that there is an increasing complexity of cases and consistent demand on resources. The current wait list assessment showed a number of reasons for the longest wait times. CAMHS and Learning Disabilities see three times their commissioned referral rate. The service is operating at two thirds capacity for paediatric consultants. Plans for future improvement involve implementing a new service model with a pathway that is clinically led with assessment function consultants who will work on getting people referred to the correct treatment pathway to help with flow. The implementation of an assessment intervention team has improved access and has decreased both the internal and external waits by 16%. The team described how CAMHS has seen a huge increase in referrals from A&E which was considered to be a good indication that young people are accessing the service. The Board considered this to be a useful summary of the intervention by the CAMHS and Paediatric Team and they were commended for their positive and creative thinking. Despite all their good work too many children have to wait a considerable amount of time. The Board was assured that the team was doing everything possible to improve the waiting time. There is a need to reinforce the decision making across the Trust and balance the clinical services needs with the financial position and work with Commissioners to ensure appropriately contracted services. **RESOLVED: The Board of Directors considered and noted the presentation made by the Paediatrician and CAMHS services team**
DHCFT 2017/084	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)</u>** Sam Harrison presented the Board with the final Governance Improvement Action Plan (GIAP) report. This report provided Board members with an update on progress on the delivery of the two remaining recommendations from the GIAP. ***M1 - The Trust will deliver a Governance Improvement Action Plan (GIAP) to address the findings and recommendations from the Employment Tribunal***

	Investigation, Deloitte report, and the CQC focused inspection: The Board acknowledged that Deloitte carried out a review of the implementation of the GIAP, which took place between February 2017 and April 2017. A final report received from Deloitte on (24 April) provided assurance that the all findings from the GIAP have been completed and that the Trust now meets the benchmark Deloitte would associate with organisations rated amber-green against NHS Improvement's well-led framework. ***M3 - The Trust will undertake to gain external assurance that the Governance improvement action plan has been implemented in full or that it can be implemented in full:*** This recommendation relates to external assurance received from Deloitte and enabled the Board to be satisfied that the GIAP has been implemented in full. The Board passed and approved both recommendations M1 and M3. The outcome of the Deloitte report will now be submitted to NHS Improvement. In terms of reporting and embeddedness Sam Harrison informed the Board that she is waiting for feedback from NHSI on the Deloitte report. This will be monitored through the Executive Leadership Team to ensure embeddedness and continuation of governance evidence,working towards an anticipated full well-led review during 2017/18. **RESOLVED: The Board of Directors:** **1) Noted the completion of all actions addressing GIAP recommendations** **2) Formally approved the two blue forms as presented and confirm that this is provides assurance of completion, namely M1 and M3** **3) Noted the full completion of the Governance Improvement Action Plan.**
DHCFT 2017/085	**<u>INFORMATION GOVERNANCE UPDATE</u>** This report provided the Board with a performance update on the Trust's Quarter 4 progress towards meeting the requirements of the 2016-17 Version 14 Information Governance Toolkit as well as the work of the Information Governance Committee and Information Governance breach monitoring. The report assured the Board of the successful completion of Information Governance monitoring. The Board noted the good governance around IG training compliance that will be reinforced throughout this year. Sam Harrison highlighted the IG bulletin that had been published several times during the year which served to ensure organisational learning and implementation of best IG practice across the organisation. **RESOLVED: The Board of Directors:** **1) Acknowledged the successful completion of the IG Toolkit** **2) Acknowledged the progress made with the IG work plan and** **3) Acknowledged the risk to the organisation of failing to meet the requirements of the IG Toolkit particularly with regards to the mandatory IG Training requirement.**
DHCFT 2017/086	**<u>FIT AND PROPER PERSON DECLARATION</u>** The purpose of the paper was to support the Chair's responsibility to declare that all Trust Board Directors meet the fitness test and do not meet any of the 'unfit' criteria as per the Fit and Person's Test regulations (Health and Social Care Act 2008 Regulation 2014) and in line with the Trust's Fit and Proper Persons Test Policy. The Board approved the Trust's Fit and Proper Persons Test Policy in 2016 and acknowledged that this policy has been maintained and applied throughout the year. Appropriate checks have been made on appointment of Director level posts made during 2016/17 and relevant checks and supporting information relating to existing post holders

	has been provided, including ongoing review and monitoring of the recording system for all Directors. In addition, self-declarations have been made by all Directors as at 31 March 2017. Comprehensive files containing evidence to support the elements of the fitness test have been retained and regularly reviewed to ensure contents are updated as required. The Board was satisfied that this declaration evidences the embeddedness of processes set in place as part of the Governance Improvement Action Plan (recommendations FF1 (4) and FF (5)) relating to compliance with the Fit and Proper Persons Test. Caroline Maley declared that appropriate checks have been undertaken in reaching her judgment that she was satisfied that all Directors of the Trust, including Non-Executive Directors, and Executive Directors (including voting, non-voting and Acting) are deemed to be fit and that none meet any of the 'unfit' criteria. Specified information about Board Directors is available to regulators on request. **RESOLVED: The Board of Directors received full assurance from the Chair's declaration that that all Directors meet the fitness test and do not meet any of the 'unfit' criteria**
DHCFT 2017/087	**<u>REPORT FROM THE AUDIT & RISK COMMITTEE ON THE EFFECTIVENESS OF BOARD COMMITTEES</u>** Sam Harrison provided a report to the Board on the activity and effectiveness of the Audit and Risk Committee for 2016/17, comparing the work of the Committee to its Terms of Reference. The report was considered by the Audit and Risk Committee at its meeting on 26 April 2017 where the Committee received significant assurance on the effectiveness of the Committee. Although there has been a significant change in membership of the Committee the annual effectiveness survey showed that the Committee was satisfied that it had fulfilled its remit in line with its terms of reference. In addition to this KMPG had provided external clarification that the Committee was effective and had suggested some areas for development for new Committee members. The report provided the Board with assurance on the effectiveness of the Audit and Risk Committee and all other Board Committees, which the Audit and Risk Committee had reviewed at their April meeting in its role of overseeing Board Committee effectiveness. It was noted that a further update on progress is to be provided by the Mental Health Act Committee to the Audit and Risk Committee in October 2017 given the ongoing development of this Committee that is underway. It was also noted that the terms of reference of all the committees will be presented to the Trust Board as part of the annual review of the Corporate Governance Framework in July. **RESOLVED: The Board of Directors:** **1) Received full assurance on the effectiveness of the Audit and Risk Committee during 2016/17** **2) Received significant assurance regarding the discharge of the remit of all other Board committees, as considered by the Audit and Risk Committee.**
DHCFT 2017/088	**<u>REPORT FROM COUNCIL OF GOVERNORS MEETING</u>** Sam Harrison presented the report which provided a summary of issues discussed at the meeting of the Council of Governors held on 6 April and 2 May 2017. The Board noted the report and was assured on the range of key topics presented to and discussed by the Council of Governors. **RESOLVED: The Board of Directors noted the report from the Council of**

	Governors meeting held on 6 April and 2 May 2017.
DHCFT 2017/089	**NHS IMPROVEMENT YEAR-END SELF-CERTIFICATION** Samantha Harrison presented the NHS Improvement year-end self-certification which providers are required to complete after the financial year-end relating to compliance with the following NHS provider licence conditions: • The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) • The provider has complied with required governance arrangements (Condition FT4(8)) • If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3) The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions and providers may carry out this process as they see fit. DHCFT proposes to present the proposed relevant declarations to the Trust Board. The Board • Confirmed it had met the criteria for holding a licence (condition G6) • Declared that the licensee has a reasonable expectation that the licensee will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. • Confirmed that it complies with all elements of the Corporate Governance Statement (condition FT4) • Was satisfied that during the financial year ended 31 March 2017 the Trust had provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they were equipped with the skills and knowledge they need to undertake their role. **RESOLVED: The Board of Directors:** **1) Confirmed agreement with the proposed declarations for signature by the Chair and Chief Executive.** **2) Agreed to the publication of the self-declarations within one month of the declaration by the Trust Board.**
DHCFT 2017/090	**ANY OTHER BUSINESS** Carolyn Green pointed out that she was mindful of the need to plan for changes to the Mental Health Act that might arise from the Government's manifesto. In response, the Board proposed discussing this further outside of the meeting.
DHCFT 2017/091	**2017/18 BOARD FORWARD PLAN** The forward plan was noted by the Board. **RESOLVED: The Board of Directors noted the forward plan for 2017/18.**
DHCFT 2017/092	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK**

	A full report on the BAF will be presented at the meeting to be held in July. The Board discussed the issue of capacity and demand within the Trust as exemplified in the Deep Dive for paediatrics and CAMHS services. Ifti Majid is to review the relevant risks within the BAF with a view to proposing an increase in risk rating to reflect the operational pressures and related risks faced by the Trust.
DHCFT 2017/093	**MEETING EFFECTIVENESS** The Board agreed that sufficient time was allowed to discuss the IPR report and requested that thirty minutes be devoted to the Deep Dives in future meetings.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 28 June 2017.

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

1) **Please can we have clarification on exactly what has happened to the HR departments in DHcFT and DCHS?**

On 22nd May we closed the first stage consultation with the senior staff across DHCT and DCHS regarding future senior roles for a joint HR/Workforce/OD team. The feedback is being reviewed and outcome will be discussed with the senior team over the next week before confirming who will be in what senior roles in the future. The next stage is for Amanda Rawlings to work with the senior team to develop the business case for stage 2 which will cover the wider HR/Workforce/OD teams across both trusts.

2) **What was the justification for this change?**

The direction came from NHSI in June 2016 asking STP's to collaborate on back office functions. DHCT and DCHS have agreed to work together and we have started with HR/Workforce/OD and Estates.

The Carter Review, and indeed Lord Carter's review of pathology services some 15 years ago, demonstrated that there is still a significant potential saving if back office services and pathology services are consolidated on a regional basis. Indeed, back office services in the NHS have not consolidated in the way they have in many other sectors and I know that many STP areas are already developing plans in this area. We will therefore be asking all STP leads to develop proposals to consolidate back office and pathology services with outline plans, initially on an STP footprint basis but with a mind to consolidate across larger areas over time, to be agreed before the end of July. Jeremy Marlow, Director of Operational Productivity and lead director for Carter Implementation will be heading this work, working closely with STP leads.

JIM MACKEY **ED SMITH**
Chief Executive NHSI **Chairman NHSI**

3) **What were the perceived risks, and the perceived advantages?**

As with all service changes there is a period of uncertainty for staff and the challenge of embedding a new structure and service. The positive is that a new larger team will provide more capacity and resilience to DHCT than we have today and some efficencies.

4) **Was NHSI informed prior to the changes taking place?**

NHSI are not required to approve or agree with this arrangement, but are aware from our regular meetings with them about the work we are doing back office and our approach is in response to their national directive.

5) **Relating to Question 4, when and why did you inform/not inform NHSI?**

As above

6) **Why did you not inform governors?**

We have approached this change like we do with other service changes and discussed at the relevant governance committees. The full business case is yet to be developed and approved. The Council of Governors will up dated as we progress further with the back office work programme.

7) **Why did you choose to implement this re-structuring prior to completion of the OBC and the crucial decision on whether to proceed to FBC?**

The sharing of back office functions is separate to the OBC/FBC and we are working on separate timetable.

8) **How does this re-structuring change the viability of Collaboration, rather than Acquisition?**

The approach we are taking with back office is about increasing our collaboration and partnership working and is not related to the acquisition.

9) **What other departments are you considering re-structuring prior to April 2018?**

We are currently working together on HR/Workforce/OD and Estates.

10) **Will you be informing governors, so that they can perform their task of 'holding to account' during the process, rather than when it is a 'fait accompli'?**

The Non-Executive Directors through the governance process will scrutinise and hold the Executives to account on this work programme.

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - JUNE 2017			Enc C
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
1.3.17	DHCFT 2017/046	Board Assurance Summaries & Escalations	Amanda Rawlings	Workforce Plan to be submitted to the April Board meeting	28.6.2017	Deferred to June meeting - report due to be received for June agenda	Green
26.4.17	DHCFT 2017/058	Integrated Performance And Activity Report	Mark Powell	Specific areas will be investigated where bed occupancy is high to establish any links and incorporated into an enhanced narrative in the next report	28.6.2017	An enhanced narrative is provided in the June IPR.	Green
26.4.17	DHCFT 2017/060	Integrated Performance And Activity Report (EDS2)	Amanda Rawlings	Top six priority actions and EDS2 SMART implementation plan to be received at the May 2017 Board meeting	28.6.2017	Deferred to June meeting - report due to be received for June agenda	Green
26.4.17	DHCFT 2017/064	Business Plan 2017-18	Sam Harrison	Quarterly update reports on the Business Plan 2017-18 to be incorporated into the Board forward plan	24.5.2017	Business Plan 2017-18 featured in forward plan on a quarterly basis	Green
24.5.17	DHCFT 2017/073	Service Receiver Story	Carolyn Green	**ACTION TRANSFERRED TO THE QUALITY COMMITTEE** Carolyn Green will work with the Nursing and Quality team specifically Allied Health professionals to develop a recovery and enablement strategy that will be submitted to the Quality Committee to focus upon employment and a positive approach to recovery	29.11.17	The recovery and enablement strategy is currently in development and will be submitted to the October Quality Committee.	Yellow
24.5.17	DHCFT 2017/078	Acting Chief Executive's Report	Mark Powell	Report on recent cyber-attack to be received at the June meeting	28.6.2017	Report due to be received for June agenda	Green
24.5.17	DHCFT 2017/079	Integrated Performance Report (IPR)	Mark Powell Carolyn Green	Summary report on Safer Staffing to be regularly included in the IPR	28.6.2017	Safer Staffing narrative included in IPR from June onwards	Green
24.5.17	DHCFT 2017/079	Integrated Performance Report (IPR)	Carolyn Green	Report on safer staffing mitigation plans to be received by the Quality Committee	28.6.2017	Safe Staffing is being addressed at the Trust Management Team meeting and risk based mitigation plans are monitored throughout the year by the Quality Committee.	Green

Resolved	**GREEN**	7	88%
Action Ongoing/Update Required	**AMBER**	0	0%
Action Overdue	**RED**	0	0%
Agenda item for future meeting	**YELLOW**	1	12%

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors - 28 June 2017

Acting Chief Executive's Report
To The Public Board

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. This month saw the release of the response to the first consultation associated with the CQC's new 5 year strategy, *Shaping the future*, published in May 2016. The strategy set out a vision for a more targeted, responsive and collaborative approach to regulation, supporting more people to get high-quality care. Between December 2016 and February 2017, the CQC consulted on how to develop and evolve their approach to implementing the strategy. This was the first of three Next Phase consultations. Feedback from phase 1 from providers included 3 key themes:
   - The need to ensure clarity, consistency and transparency in implementing the change
   - The need for flexibility in our approach, avoiding a one-size-fits-all approach in processes and methods
   - The need for proportionate regulation and closer and more collaborative working with other organisations at local and national level.

   The CQC have said they will introduce the new assessment framework and approach for NHS trusts from the second half of June 2017. This means that the first new provider information requests (PIRs) will be sent at that point, the first internal regulatory planning meetings will take place from August, the first next phase inspections will take place between September and November 2017, and the first next phase ratings and inspection reports will be published in early 2018.
   The CQC plan to roll out this approach slowly to enable them to evaluate, improve and refine this planned approach however they intend to fully embed the approach by spring 2019, by which all trusts can expect to have an assessment of the well-led key question and at least one core service inspection approximately once each year.

   It is important to note these changes as the Board is aware we are anticipating a further comprehensive review later this year. The Quality Committee will be key in managing this preparation and monitoring of the new inspection process.

2. After the recent cyber-attacks, NHS Improvement and NHS England have been tasked with working with NHS Digital's CareCERT team to check that the NHS is protected against any further attacks. All providers were required to complete a template which set out 39 of the critical CareCERT advisories issued over the last three months. These have been deemed most critical in preventing successful cyber-attacks. We were asked to note which of the 'advisories' our organisation has acted on. Once

again thanks to our internal IM&T Team and ArdenGem for ensuring that as a Trust we complied with this screening and improvement process. More details and importantly the learning from this serious incident for the whole NHS are being discussed later in today's agenda.

3. It is of interest to the Derbyshire system that the Health Service Journal has completed some research on provider contracts and there is a significant increase in acute Trusts moving away from payment by result activity sensitive contracts on to block type arrangements. The analysis suggests 1 in 4 acute providers have now moved onto some form of block payment system an increase from 1 in 6 last year. Payment by Results was introduced by the Department of Health in the early 2000s, with the aim of improving efficiency, volume of activity and quality of care. But it has been increasingly criticised for creating perverse incentives and encouraging competition over collaboration and not supporting the move from hospital based care to a more community focus. NHS England had previously urged caution around the move to block contracts with concerns around capacity to respond to demand however this clearly suggests a shift in their approach. This is something that could be a significant plank in the strategy adopted by our system collaboration to support a more equal share of risk as long as it is considered in a way that supports transformation and development of community capacity rather than 'squeezing the funding bubble risk' from commissioners to providers.

Local Context

4. The Derbyshire Sustainability and Transformation Partnership continues to develop its reinvigorated approach with Board being asked to review and agree a revised system governance structure, principles for system working and a memorandum of understanding. As importantly each of the newly re-launched workstreams have been asked to submit their workplans and identified outcomes to form part of the STP update due for submission to NHS England during June. As the lead for the Mental Health Workstream I have agreed we will be focussing on the following 4 domains:
   - Mental Health Primary Care Support
   - Responsive Community Services
   - Dementia and Delirium
   - Forensic and Rehabilitation pathways

   Each domain is made up of a number of programmes of work and individual projects that will support the delivery of the agreed deliverables. This is a very significant alteration in the way we have historically worked. This mental health system plan is supported by senior staff from all Organisations and is the sole mental health plan for Derbyshire.

5. On Tuesday the 6th June the Trust's Board of Directors reached a decision to no longer proceed with the proposed merger of our organisation with DCHS. We have informed DCHS and NHS Improvement of this decision. This was a decision considered very carefully by the Board and there are several reasons why we took this decision:
   - We know that services across our Trust are currently under a lot of pressure. Demand is very high, and resources are stretched. We feel that the Trust as a whole needs a period of consolidation so that we can focus on maintaining our day-to-day quality of care, backed up by good governance and strong financial management. Developing the business case for a potential merger with DCHS has

put significant pressure on a wide range of staff, and we feel we must take that pressure off staff with immediate effect.

- The clinical case for change was the driving force behind the proposed merger. There has been a lot of important and beneficial work done through clinical workshops to explore the potential benefits for patients, and it seems that some of our services – those that share a clinical pathway with DCHS – may be able to see benefits from working more closely with teams at DCHS. However we no longer believe that a merger of the two organisations is the only way to achieve this.
- The landscape in which we are operating has changed since we began our work with DCHS last year. Health and care organisations across Derbyshire have strengthened their commitment to working more closely together. The Sustainability and Transformation Partnership (STP) is gaining momentum. Meanwhile there is a new national direction of travel towards the development of Accountable Care Systems (ACS) that will seek to establish new models of care, meaning that services previously provided separately will be more integrated. We feel that we should focus our attention on the potential development of an ACS for the whole of Derbyshire, and the benefits that could bring – not least in ensuring that mental health is valued equally with physical health.

Over the next month, we will be working closely with colleagues at DCHS to build on the work done so far and to understand where opportunities for closer integration might lie. We are anticipating that these will be presented in a paper to both our Boards at the end of July. We will also continue to work with our colleagues at DCHS to integrate our support services, such as our Workforce & Organisational Development and Estates services. This is part of a wider NHS efficiency programme associated with Lord Carter's work on NHS efficiency.

Over the last few weeks Board members have been engaging directly with staff to talk about this decision along with starting a conversation about which priorities from our Trust Strategy we must now focus on as we move to consolidate those significant gains we have made around quality and governance. The Trust has received strong support from its Council of Governors and our Staff Side colleagues in relation to this decision.

Within our Trust

6. At the last Board meeting I alerted the Board to planned CQC visits during June and July focussing on Community Treatment Orders and a review of the mental health act application across a pathway – we have now been informed by the CQC these visits are cancelled.

7. During April the Trust received feedback from Deloitte who were carrying out a formal review as a follow up to the well led review they conducted in February 2016.I am delighted to share that Deloitte reflected significant progress in all areas. The review focused on three key areas - human resources and culture, governance and Board effectiveness. Significant improvements identified include:
   - Greater leadership from the Board, including increased levels of communication and engagement
   - Clearer governance structures and processes, resulting from the rigorous implementation of the Governance Improvement Action Plan (GIAP)
   - Significant improvements in both the performance and dynamics of the People and Organisational Effectiveness team.

This is a real achievement and I am immensely proud of the improvements we have made over the last year. There is now a need to ensure these changes are embedded fully into our everyday ways of working and that we continue to develop and make ongoing progress in all respects.

There are further recommendations that Deloitte have made about how we can maintain and continue this progress. We are committed to keep learning from their advice and implement all recommendations in full. For example this includes fully implementing divisional governance ensuring clear connectivity between division, the Board and its committees and to fully implement the new People Plan. However, Deloitte have reflected that the arrangements in place that they observed during their visit, firmly place the Trust alongside other well performing trusts. The Deloitte report can be seen in full as Appendix 1

This positive report then acted as a catalyst for NHS Improvement to review the breach to our provider licence following the well led reviews by both Deloitte and the CQC back in February 2016. I am delighted that the result of this review was that NHS Improvement have now formally confirmed that we are free of all former licence breaches, a testament to the hard work and dedication of staff at all levels within our Trust. The official notification from NHS Improvement can be seen in Appendix 2.

8. Wednesday the 7th June saw BME staff from our Trust joining forces with Executive Directors with the support of Stacy Johnson, Associate Professor from the University of Nottingham to develop our reverse mentoring for inclusion and diversity programme. We have some work to do to agree the details of this scheme but motivation is very high and Stacy did a great job in starting the conversations we need to have to make this a reality. This will form part of Harinder Dhaliwal's routine Equality and Diversity brief to the Board.

9. Over the last two weeks I have been able to visit a number of corporate teams to discuss with them the decision to not progress the acquisition but also other issues they wanted to raise. At the point of writing the report I had visited Finance, Workforce& OD and Estates. Feedback about our Trust decision was positive but clearly we now must focus on understanding more about the business case for our back office integration programme with DCHS, the models and benefits. In addition we have held two (at the point of writing) open engagement sessions with staff at Kingsway and Chesterfield. These sessions were fairly well attended and feedback was positive and we had some good conversations about what stability would look like to our staff, succession planning and the importance of creating career structures both inside our organisation and in the STP more broadly.

- On the 14th and 15th June myself, Caroline Maley and Lynn Wilmot-Shepherd attended the 2017 NHS Confederation Conference in Liverpool. I think we all felt the conference had a less vibrant feel about it than previous years, possibly linked to the closeness of the election and the uncertainty around its impact, lack of clarity around Brexit and the recent atrocities in Manchester and Liverpool. That said it was good to hear Claire Murdoch, national mental health lead praise our Trust's CAMHS services – with only a bit of prompting from me! The work we have commenced around reverse mentoring for diversity and inclusion featured in one of the workshops I attended re-enforcing our decision to invest our time and support in this model.

  Jim Mackay CEO of NHS Improvement shared the state of the NHS data as part of his

address with some of the key points being

- Average provider CIP 16/17 was 3.7%
- 91% providers earned STF
- 85% of providers reported in year reduction I agency spend
- So far this year 4 Trusts rated inadequate by the CQC
- Referral to Treatment Target compliance is reducing and needs increased focus
- We must achieve the 95% A&E standard this year
- If all Trust hit their plan in 17/18 £496 million deficit for NHS planned and improvement from 16/17

I was also struck by his view around the fragility in the system, the need to focus on strong leadership, a focus echoed by Simon Stevens as well, and that workforce and morale are the real challenge in the NHS.

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

Assurances

- Our strategic thinking includes national issues that are not immediately in the health or care sector but that could be of high impact.
- The Board can take assurance that Trust level of engagement and influence is high in the health and social care community
- Feedback from staff is being reported into the Board
- There is a new risk for the BAF related to IPP – this will require mitigations

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

Public Sector Equality Duty & Equality Impact Risk Analysis The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people).	
There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	x

Actions to Mitigate/Minimise Identified Risks

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

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

That said some of the reports both nationally and regionally have the potential to have an adverse impact on people with protected characteristics (REGARDS).

Internal Trust and wider system transformation schemes all need to involve an appropriate equality impact assessment in order to mitigate any risks that are identified in actions being proposed

That equality impact assessment needs to determine a response to the three aims of the general equality duty:

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

Transformation done well has the potential to *improve* our delivery of equality, by for example, increasing the opportunity for communities to come together in more positive ways than those that exist in the way we currently deliver services

The Reverse Mentoring training is a specific example where the outcomes will positively impact on all three aims of the Equality Act for groups of staff, i.e. the BME staff community, in helping the executive to identify barriers and remove them, increase the opportunities for positive outcomes for BME groups, and support the creation of opportunities to bring communities and groups together in positive ways.

I believe the integrated approach we are taking to delivering the mental health transformation programme as part of the STP supports our need to focus through individual clinical pathways on protected groups to ensure that in each clinical pathway area we have a clear understanding of the barriers to engagement and outcomes for those groups within our communities.

Recommendations

The Board of Directors is requested to:

1) Scrutinise the report, noting the risks and actions being taken
2) Challenge myself or the Executive on the content therein.

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

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

Deloitte.

Derbyshire Healthcare NHS
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust

Independent follow-up review of governance arrangements and HR related functions

Deloitte.

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Board of Directors
Derbyshire Healthcare NHS Foundation Trust
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24 April 2017

Dear Board of Directors

Independent follow-up review of governance arrangements and HR related functions

In accordance with our change order dated 22 July 2016 (the 'Contract'), for the independent follow-up review of governance arrangements and HR related functions at Derbyshire Healthcare NHS Foundation Trust (the 'Trust'), we enclose our Final Report dated 24 April 2017 (the 'Final Report').

The Final Report is confidential to the Trust and is subject to the restrictions on use specified in the Contract. No party, except the addressee, is entitled to rely on the Final Report for any purpose whatsoever and we accept no responsibility or liability to any party in respect of the contents of this Final Report. This report is prepared for the Board of Directors as a body alone, and our responsibility is to the full Board and not individual Directors.

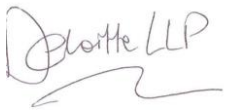
The Final Report must not, save as expressly provided for in the Contract (including, inter alia, in clauses 5.3 and 5.4 of the Terms of Business) be recited or referred to in any document, or copied or made available (in whole or in part) to any other person.

The Board is responsible for determining whether the scope of our work is sufficient for its purposes and we make no representation regarding the sufficiency of these procedures for the Trust's purposes. If we were to perform additional procedures, other matters might come to our attention that would be reported to the Trust.

We have assumed that the information provided to us and management's representations are complete, accurate and reliable; we have not independently audited, verified or confirmed their accuracy, completeness or reliability. In particular, no detailed testing regarding the accuracy of the financial information has been performed.

The matters raised in this report are only those that came to our attention during the course of our work and are not necessarily a comprehensive statement of all the strengths or weaknesses that may exist or all improvements that might be made. Any recommendations for improvements should be assessed by the Trust for their full impact before they are implemented.

Yours faithfully



Deloitte LLP

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Draft report issued:	19 April 2017	**Client sponsors:**	Interim Chair and Interim CEO
Factual inaccuracies received:	20 April 2017	**Distribution:**	Trust Board
Final report issued:	24 April 2017		

Executive summary

Executive summary

Introduction and conclusion

Scope and approach

- This subsequent Final Report sets out the findings from our independent follow-up review of governance arrangements at the Trust, focussing in particular on the extent of progress against the recommendations set out in our initial Report dated 22 February 2016.
- As part of this review, we have focussed on three specific areas, namely:
  - Human Resources and culture;
  - Governance; and
  - Board effectiveness.
- The findings set out within this Final Report have been grouped into these three theme areas.

Our approach to delivering the project scope has consisted of:

- Conducting a desktop review of key Trust documentation;
- Conducting 1-1.5 hour non-attributable interviews with all Board Members;
- Conducting 1 hour non-attributable interviews with members of staff across a range of clinical and operational roles;
- Observation of the March 2017 Board meeting, the People and Culture Committee in March 2017, the Finance and Performance Committee in March 2017, and the Audit and Risk Committee in March 2017;
- Distributing and analysing a survey to all Board members (13 out of 15 Board members completed this);
- Facilitating a focus group with a sample of the Council of Governors (6 attended); and
- Providing verbal feedback to the project sponsors in April 2017.

We would like to thank Trust Board members, staff and governors for their engagement in this project.

Please refer to Appendix 7 on page 30 for a glossary of terms used in this report.

Overall conclusion

Overall we have found that significant improvements have been made, with a concerted and consistent commitment from the Executive Team, Acting Chair and new Non-Executive Directors. Particular areas of note are:

- **Greater leadership from the Board, and in particular from Executive Directors, including increased levels of communication and engagement;**
- **Clearer governance structures and processes, owing to the rigour of the implementation of the governance improvement action plan (GIAP); and**
- **Significant improvements in both the dynamics and performance of the People and Organisational Effectiveness team.**

Further improvements have also been noted across all three areas of our scope, namely Board effectiveness, governance and HR-associated functions, such that the Trust now meets the benchmark we would associate with organisations rated amber-green* through our reviews of governance against NHS Improvement's Well-led Framework.

This is particularly notable given the Trust has been seeking to implement its governance improvement action plan in the context of significant strategic flux, owing to the development of the Sustainability and Transformation Plan and collaboration discussions with Derbyshire Community Health Services NHS FT (DCHS). The Board has also seen a number of changes to its composition, with a number of new and interim Board Members in place.

Recognising this level of progress, there remains a need to embed these changes more fully. Where this is the case, we have found high levels of self-awareness and clear action plans in place, including:

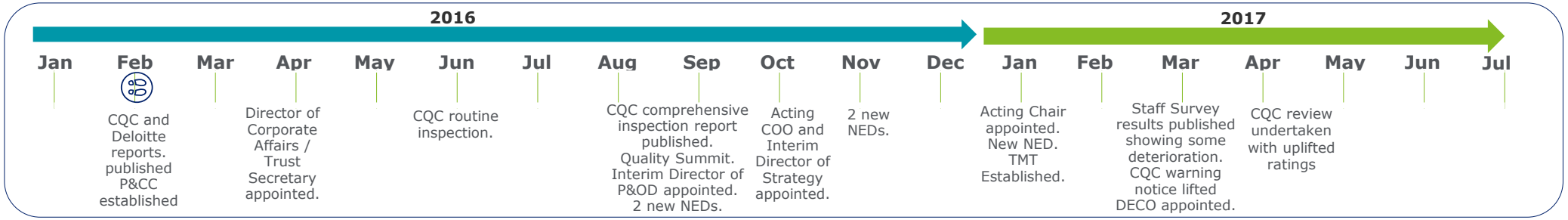
- **A need to fully implement and embed the revised divisional governance arrangements, ensuring that there is clear connectivity of these arrangements to the Board and it's Committees; and**
- **Implementing the revised People plan and structure for the People and Organisational Effectiveness team.**

Finally, whilst we found levels of engagement with governors to have significantly improved, the Board needs to ensure that these changes are maintained and that open dialogue continues.

* As per NHS Improvement's definition set out in the Well-led Framework for governance reviews

Executive summary

Context and key changes to the Trust's governance and leadership



Context

- Authorised in February 2011, Derbyshire Healthcare NHS Foundation Trust (the "Trust") provides mental health, learning disability, and a range of specialist services in Derby city and the wider Derbyshire county. The Trust employs around 2,500 staff and serves a catchment area of around 1,000,000 people.
- In February 2016, we issued our initial report in relation to governance arrangements and HR related functions, following the events surrounding a high-profile Board level employment tribunal.
- This work, alongside a targeted investigation from the Care Quality Commission (CQC) and the Alan Yates Report, culminated in a number of similar themes and actions, which the Trust coordinated into the GIAP.
- The CQC have since carried out their comprehensive inspection in June 2016 which gave an overall rating of Requires Improvement and the issuing a Section 29a warning notice, due to their findings that:
  - Serious safeguarding issues had not been recognised on older people's mental health wards;
  - Staff lacked confidence in the senior leadership team; and
  - There was variability in the quality of clinical services provided, including in relation to safeguarding, the application of the Mental Health Act (MHA) and Mental Capacity Act (MCA) and the safety of environments.
- In October 2016, we also undertook a review of the robustness of project management of the GIAP. This found that significant efforts had been made to develop and monitor action plans to improve governance arrangements within the Trust, although in some cases the level of internal scrutiny around this needed to be further increased. Following this work, further changes were made to the governance of the GIAP, including greater rigour in relation to the sign-off of actions and formal collation of evidence to support assertions made.
- Alongside the work currently undertaken around the GIAP, the Trust has also commenced discussions regarding collaboration with DCHS. Proposals range between greater collaboration on back office functions to full merger. We acknowledge the scale of work brought about by these proposals, in tandem with implementing the actions from the GIAP and CQC action plans, along with broader system wide change through the STP.
- The timeline above illustrates the scale of events and changes made in the 15 months since our first review, which has been significant. We note in particular that the CQC warning notice was lifted in March 2017.
- Further key changes include:
  - The establishment of the People and Culture Committee;
  - The development of the Corporate Governance and Accountability Frameworks; and
  - The establishment of the Trust Management Team to enhance a shared oversight of quality and operations.

Executive summary

Key findings

1. Board effectiveness

- The composition of the Executive team has had a number of changes over the last year which has strengthened both capability and leadership in a number of areas. NEDs bring a broad range of experience with most bringing prior experience of operating on NHS boards. This has aided with transition given the extensive change to the NED cohort over the last year.
- A broad range of Board development has been undertaken, which has covered the majority of areas of focus we outlined in our previous report. It is intended that this programme of activities will continue, with an emphasis on dynamics and softer skills, particularly given the extensive changes to the composition of the Board.
- Board and Committee debate has improved from that observed during our previous review, and whilst a number of NEDs are still new, they are already positively impacting on the quality and content of challenge and discussions. The Board needs to continue to focus on developing debate as both new Board Members grow into their role, and as newly formed governance processes and structures embed.
- We also noted that a number of executives are now operating more effectively as corporate directors, with greater contribution to the debate across a broader range of topics.
- The Board, and in particular Executive Directors (EDs), are viewed as providing greater leadership over the last year, providing a clear signal that change needed to happen within the Trust and outlining a clearer sense of direction of the actions required. It is recognised that this now needs to further evolve through the implementation of the revised accountability structures, thereby ensuring greater connectivity of the Care Groups to Board and Committee governance arrangements.

2. Governance arrangements

- Committee effectiveness has been a key area of focus through the GIAP and we have identified a number of improvements, particularly in relation to agenda structure, focus of meetings, and quality of debate. These improvements are particularly noticeable in the Audit and Risk Committee and Finance and Performance Committee. Committees remain, however, at varying stages of maturity and the Board are sighted on the need to make further changes to ensure that these improvements are consistently applied across all meetings.
- An accountability framework was agreed by the Board in November 2016, and this is now starting to be rolled out across each of the four clinical divisions. The Board has recognised this as an area requiring further development and has continued to provide regular progress updates to the Board, relevant committees and the Executive Team. In our view, the agreed structure (already in place in the Children's and CAMHS division) will bring arrangements more in line with comparable organisations once fully rolled out.
- The previous Performance Contracting and Oversight Group has been replaced with the Trust Management Team (TMT), which brings EDs, senior clinicians and operational management together into a single decision-making forum. We are supportive of this development, which enables joint oversight of operational and quality performance which is more aligned to good practice we see elsewhere. As TMT becomes more embedded, we are of the view that a further, but proportionate, structure will be required to support effective holding to account for divisional performance.
- Improvements to the profile of the Board within the Trust have been made, with greater opportunities for staff to engage with the Board and increased communications. This brings the Trust more in line with other organisations we have worked with, although the Board is conscious of the need to continue to develop arrangements in this area. Governors in particular reported greater levels of transparency and access to Board Members to enable them to enact their statutory role effectively.

3. People and Organisational Effectiveness function

- The overall leadership of the function has significantly improved since our initial review, with extensive work undertaken in recent months to reshape the function with a renewed strategic direction and clarity of purpose.
- The People Plan has been extensively updated and is now more closely aligned to the Trust strategy and the Trust's key workforce challenges. A number of enabling strategies are in development to support the delivery of this plan. The culture within the function has improved markedly, with a significant quickening of pace from the beginning of the calendar year.
- Protracted internal employee relations cases have hampered timeframes to implement a revised model and associated structure. However, there are now clear plans for a new model and structure for the function for the next 12 months. A period of consultation for this plan commenced during the course of our review

Executive summary

Key findings

- There has been clear progress and a sustained programme of work to revise, update and streamline HR policies and procedures. This has included a much shaper focus on partnership working, with staff-side partners now actively involved in the review and revision process. In addition, the use of workforce information and KPIs to drive decision making in the People and OE function is a substantial progression from 12 months ago.
- The People and Culture Committee was understandably initially focussed on the implementation of the actions outlined within the GIAP. The meeting continues to evolve, having recently been reconstituted to focus more on strategic issues and assurances, and will change further once the model and new structure for the function is fully implemented. During our observation of this meeting, the level of challenge and debate from NEDs was good and added value to the overall People and OE agenda.

Next steps

We suggest that the Interim Chair and Acting Chief Executive, in consultation with the Board, consider the findings outlined within this report and collectively agree a response to the matters raised.

This response should align to the current GIAP programme, including:

- clearly aligning recommendations to executive leads;
- aligning groups of recommendations to the appropriate committee to enable oversight of progress;
- defining clear timescales for delivery; and
- defining outcome measures and KPIs against which impact can be measured.

Basis of our work

- Our findings in this report are based upon the views expressed by Board Members, staff across the Trust and our own observations. We have assumed that the information provided to us and management's representations are complete, accurate and reliable; we have not independently audited, verified or confirmed their accuracy, completeness or reliability. In particular, no detailed testing regarding the accuracy of any financial information has been performed.
- Our work, which is summarised in this Final Report, has been limited to matters which we have identified that would appear to us to be significant within the context of the scope.
- In particular, this review will not identify all of the gaps that exist in relationship to the Trust’s approach to governance and HR-related functions; rather the review will seek to consider performance against good practice to identify the most material gaps, key exceptions or areas where insufficient evidence may give rise to the identification of material gaps in the future.

Observations

1. Board effectiveness

Key findings

1.1 Board composition

The composition of the Executive team has had a number of changes over the last year which has strengthened the capability and leadership in a number of areas. NEDs bring a broad range of experience with most also having prior experience of operating within NHS boards. This has aided with transition given the extensive change to the NED cohort over the last year.

- There have been a number of changes to the composition of the Executive Team over the last year, with the previous Director of Strategy moving into the COO role, and an interim director moving into the strategy role to backfill this position. The team have also been joined by an experienced HR Director from September 2016. These changes were viewed positively by those we spoke to, noting that the *"team are now playing to our strengths"*.
- Throughout our review, Board Members and staff outlined support for Executive Directors, who are seen to have continued to grow as a cohesive team over the last year, and have increasingly become more visible within the Trust. Staff also highlighted greater leadership from Executives, noting that the interim CEO has led the organisation through a difficult period, and that other members of the team have also provided greater leadership in their respective portfolio areas. (See also 1.4)
- Capacity of the team is an acknowledged risk which has been openly discussed, particularly given the ongoing work across the STP, discussions around potential collaboration with Derbyshire Community Services NHS FT (DCHS), as well as the ongoing work within the Trust to improve and embed governance and operational performance changes.
- For example, sustaining progress in HR is seen a potential risk given that this has been led by the new Interim Director of People and OE, however in response to this the Trust has recently approved a model which will see this function continue to develop across DHC and DCHS even if the collaboration agenda does not progress further.
- Steps have also recently been taken to increase support to the Medical Director (MD) in recognition of the capacity constraints in this area (see also Appendices 2 and 4).
- Alongside the changes to the Executive team, the NED cohort has seen significant change with only the current Interim Chair remaining. As part of the appointment process for these new NEDs, the Trust has deliberately sought NEDs with an understanding of the NHS given there was a need to 'hit the ground running'. NEDs now bring a broad range of skills including clinical, business, NHS and broader public sector experience, and whilst there is some variation in the Board survey in this area no significant gaps were noted. See fig. 1.
- New NEDs were positive about their initial experiences of the Trust, noting that they had received significant support from Executives and the corporate team. Several points for improvement in the Trust induction programme were raised, and we understand the Trust is already in the process of responding to these views.

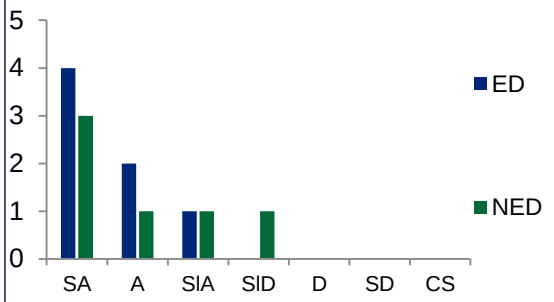
1.2 Board development

A broad range of Board development has been undertaken, which has covered the majority of areas of focus we outlined in our previous report. It is intended that this programme of activities will continue, with an emphasis on dynamics and softer skills, particularly given the extensive changes to the composition of the Board.

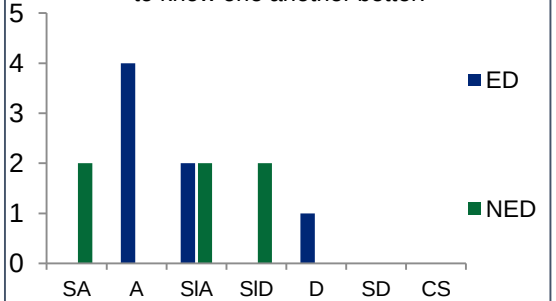
- Over the last year the Board has undertaken a range of Board development activities, including a focus on strategy development, effective Board challenge and debate, as well as training on specific areas such as risk management and the MHA. It is acknowledged that given the change to the composition of the Board further work is now required to continue to develop the Board as a team, including spending more informal time together.

Board survey

1. The backgrounds and skills of the Board are sufficiently diverse.



2. Board members spend sufficient informal time together as a group to get to know one another better.



1. Board effectiveness

Key findings

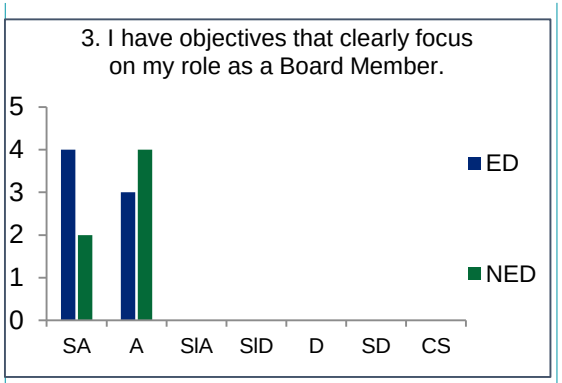
- A programme for these Board development activities is currently being developed for 2017/18 under the direction of the new interim Chair and Deputy Chair. It is intended that this will include a continued focus on learning as well Board dynamics. Aligned to this, whilst not significant, we have noted some minor points around team dynamics which is inevitable within any new team (see fig. 2). These points have been fed back to the Trust and should be kept under review.
- Clear objectives and responsibilities for the Board are documented through the corporate governance framework, and the Board 360 feedback process has just been completed for 2017. NEDs are continuing to meet with the new interim chair to ensure that they are successfully inducted into the organisation.
- In line with good practice, the Board is continuing to monitor its own progress through internally facilitated Board surveys, as well as reflections on the quality and impact of discussions at the end of Board and Committee meetings (refer to 1.3).
- Succession planning for the Board as a whole is seen as an area requiring greater focus, although it is recognised that this is difficult to plan with any certainty given the ongoing collaboration talks with DCHS. Work has however commenced in this area, and includes early plans to develop succession planning at divisional leads and down to area and service line managers (see also Section 3).

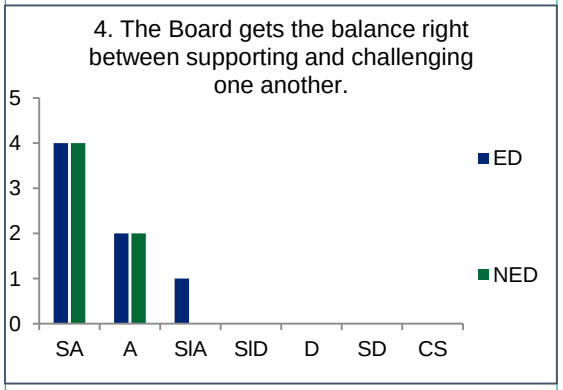
1.3 Board debate

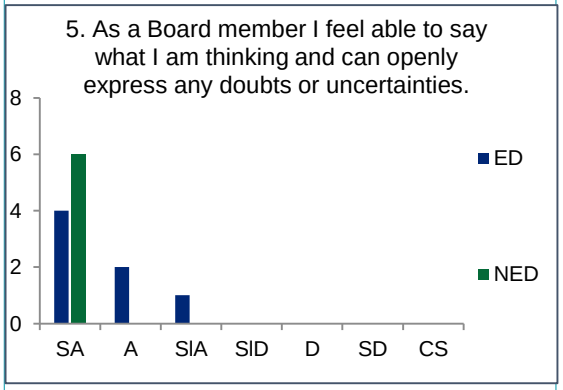
Board and Committee debate has improved from that observed in our previous review, and whilst a number of NEDs are still new they are already impacting on the quality and content of challenge and discussions. The Board need to continue to focus on developing debate as both new Board Members grow into their role, and as newly formed governance processes and structures embed. We also noted that a number of Executives are now operating more effectively as corporate directors, with greater contribution to the debate across a broader range of topics.

- In the main we have observed much improved debate. Notably, contributions from several Executives has increased with many now operating more in line with the corporate director role, providing challenge and insight across a broader range of topics. Responses to queries are open and transparent providing explanation and context which is particularly important given the newness of the NED cohort. We have also observed sensible push back from Executives where this has been appropriate to do so, for example to query the impact of additional work requested by NEDs and to suggest alternative courses of action.
- NEDs provide good input to the debate, particularly when considering that the majority have not been at the Trust for long. However, we did note that some are still developing their understanding of the Trust and therefore there can be a tendency towards points of clarification. There is also a need to be mindful not to be overly operational in committee meetings, to minimise the use of overly long statements where not value adding, and whilst we wouldn't expect every member to contribute on every agenda item there is a need for some to increase their level of contribution.
- Examples of particularly good debate we observed included around the development of the strategic workforce plan (during the March Board meeting), the financial plan for 2017/18 (at the Finance and Performance Committee) and around the IT systems procurement (during both Board and committee meetings). Board Members also consistently highlighted the recent debate around 'red lines' for the collaboration talks with DCHS, which is an area where the new NEDs were seen to have brought a fresh perspective and input to the debate.
- There were some areas where we would have expected more rigour and input to the challenge, an example of this is in relation to the operational performance agenda where debate we observed was primarily led by Executive Directors. See fig. 3 and 4.

Board survey







1. Board effectiveness

Key findings

R1: Recognising the improvements made, the Trust should continue to focus on the quality and impact of Board and Committee debate through the programme of Board development and individual feedback.

- Throughout our observations we have noted good reflection on both the quality of debate and the appropriateness of the agenda at the end of each Board and Committee meetings. Board Members have used these items to openly reflect on strengths of the meeting as well to outline views on areas for further refinement. For example, the points raised in relation to the need to further develop the structure of deep dives at the Audit and Risk Committee were well made, and represented an honest reflection of the meeting.

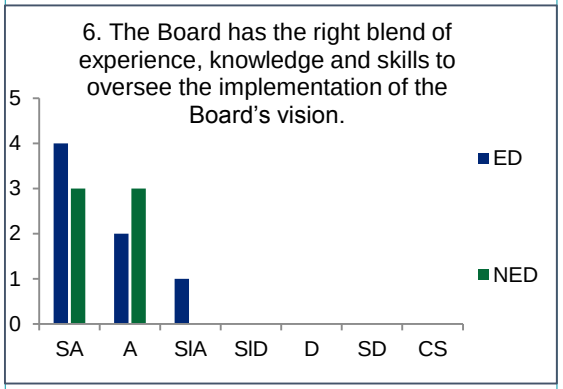
1.4 Board leadership

The Board, and in particular Executive Directors, are viewed as providing greater leadership over the last year, providing a clear signal that change needed to happen within the Trust and outlining a clearer sense of direction and of actions required. It is recognised that this now needs to further evolve through the implementation of the revised accountability structures, thereby ensuring greater connectivity of the divisions to Board and Committee governance arrangements.

- As outlined in 1.1, the Board, and in particular the executive team, are viewed as having provided greater leadership to the organisation over the last 12 months. Key points highlighted in support of this included:
  - The Board are seen to have responded in earnest to the findings of previous reports, demonstrating a commitment to improvement and learning from the top of the organisation;
  - Aligned to this, Executive Directors are viewed as having provided greater clarity and consistency in the improvement actions that the Trust needs to undertake. This is particularly the case in relation to GIAP actions and the response to the CQC inspection in January 2016 and September 2017;
  - The Board is seen as having a better connection with the Trust, although as outlined in 2.4, this is still developing. For example, the CEO weekly update is viewed as providing an open and informative update to the organisation;
  - Roles and responsibilities of Board Members are clearer, with most Executives now viewed as providing clearer direction in their respective portfolio areas. NEDs have also taken on specific areas of focus, for example in relation to mortality and deaths, the merger programme board, procurement and children's services in order to increase understanding and oversight in these areas.
- Overall we have noted good progress in this area over the last 12 months and there is an acknowledgement that this now needs to continue to evolve and embed. This will be further assisted by fully defining and implementing the performance structure within the Trust, and clarifying the links between divisions, Committees and the Board with most staff still noting a disconnect in this area (refer to section 2.4).
- Further work could also be undertaken to embed and utilise the Board Assurance Framework in order to drive the focus of the Board and Committee meetings as outlined in Appendix 1.

In support of the work undertaken in this area, refer to the need to further develop Board engagement (refer to section 2.4 and Appendix 6) and to embed a clear process for performance management (refer to section 2.3 and Appendix 3)

Board survey



2. Governance arrangements

Key findings

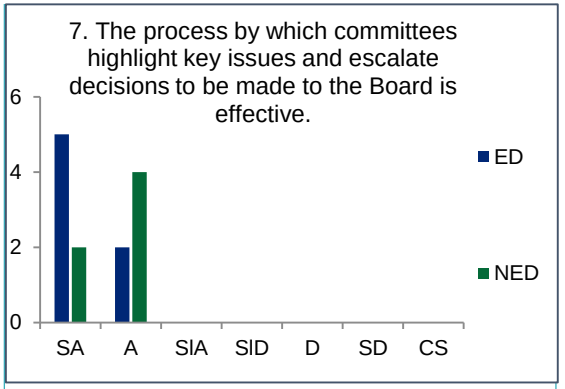
2.1 Committee effectiveness

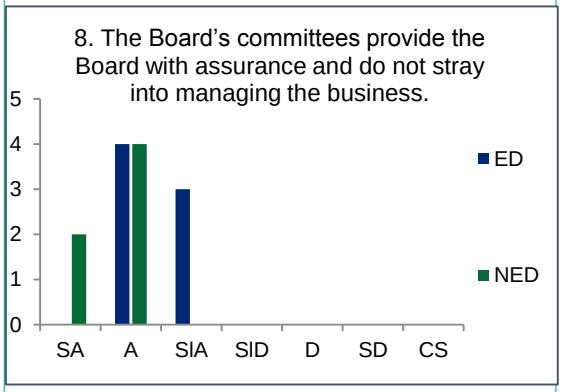
Committee effectiveness has been a key area of focus through the GIAP and we have identified a number of improvements, particularly in relation to agenda structure, focus of meetings, and quality of debate. These improvements are particularly noticeable in the Audit and Risk Committee and Finance and Performance Committee. Committees remain, however, at varying stages of maturity and the Board are sighted on the need to make further changes to ensure the consistent application of these improvements across all meetings.

- The corporate governance framework has been revised in line with our previous recommendation and was signed off by the Board in July 2016. This included a review of all Board committees, for which up to date terms of reference are in place which broadly reflect the areas of good practice we would expect to see. The document also clarified the role of individual Board members and assurance and escalation processes.
- Our review of Board Committees found a number of areas of significant improvement, particularly:
  - The rigour of focus on action tracking and follow-up;
  - A more structured approach summarising items to report and escalate to the Board, with both verbal and written updates in place (see fig. 7);
  - Good use of self-assessments at the end of each meeting to drive continuous improvement and honest reflection; and
  - Reduced duplication of papers and debate across various forums (however refer also to Appendix 2.C in relation to review of the BAF).
- Committees are however at different stages of development and maturity. For example, while we found changes to systems and processes at the Audit and Risk Committee and the Finance and Performance Committee to be well-embedded, the time taken to agree and embed changes to the QLTs has meant that amendments to the format and debate at the Quality Committee are less progressed at this stage.
- The People and Culture Committee (P&CC) has been necessarily focussed on compliance with actions outlined in the GIAP throughout its early stages; There is now a recognised need and appetite among members for this forum to become more strategic in its focus, particularly as it oversees the development and implementation of the strategic workforce plan.
- The Trust are sighted on the need for further improvement at both the Safeguarding Committee and the Mental Health Act Committee (MHAC), with an emphasis on the need for more structured agendas, less operational debate and greater action orientation. In addition, given the CQC findings in these areas that application of relevant guidance and legislation is variable, the effectiveness of these forums will need to improve in order to promote patient safety and experience.
- Through its review of the corporate governance framework, the Board has considered whether the MHAC and the Safeguarding Committee should continue to operate as formal subcommittees of the Board. It was decided that, in light of the aforementioned CQC findings, and also further changes required at the Quality Committee (and particularly the QLTs), it would not be appropriate to further expand the QC supporting structure at this stage. We agree with this rationale, however we would advocate that this structure is further reviewed in six months in light of commentary made in Appendix 2.B.

Detailed recommendations and commentary on individual committees has been provided in Appendix 2.

Board survey





2. Governance arrangements

Key findings

2.2 Accountability framework

An accountability framework was agreed by the Board in November 2016, and this is now starting to be rolled out across each of the four clinical divisions. The Board has recognised this as an area requiring further development and has continued to provide regular progress updates to the Board, relevant committees and the Executive Team. In our view, the agreed structure (already in place in the Children's and CAMHS division) will bring arrangements more in line with comparable organisations once fully rolled out.

- The Accountability Framework was ratified by the Board in November 2016. This document primarily seeks to distinguish between the strategic and assurance seeking arm of the Trust governance structure, and the operational delivery aspects; the latter including the establishment of the Trust Management Team (TMT).
- The framework also proposes the revised structure for QLTs, which was a key area of focus in our February 2016 report. A recent update to the April Quality Committee agreed the standard terms of reference to be implemented across each of the four new 'divisional leadership teams' which bring together the former QLTs and existing operational meetings into one forum, enabling a combined focus on clinical quality and operational performance. This change has been brought about in acknowledgement that quality and operations at the Trust have historically been overly disjointed. Executive Directors are conscious that there is a risk that agendas at these forums may become excessively long, and therefore intend to undertake a post-implementation review at a future date which has yet to be defined.
- We are supportive of this proposal but concur with the majority of Board Member views that this has been an area of slow progress, particularly when compared to other areas of the GIAP. While this structure was signed off in November 2016, at the time of our review, only one division has implemented this structure (via their Clinical and Operational Assurance Team, or 'COAT'). Acknowledging the Board's desire to empower the clinical divisions, some Board Members have reflected that the Executive Team could have done more at an earlier stage to jointly agree the minimum requirements, and communicate this more clearly to divisional leaders.
- We recognise, however, the positive levels of self-awareness shown by EDs through routine GIAP reporting to the Board, committees and Executive Team, highlighting this as an area of slower progress.

R2: Agree a date for the post implementation review of the new divisional leadership teams. Their success should be measured in part by the quality of their reporting to TMT. Refer also to commentary and recommendations made in Appendix 2.B with regard to support in developing agendas and defining escalation processes.

2.3 Oversight of divisional performance

The previous Performance Contracting and Oversight Group has been replaced with the Trust Management Team (TMT), which brings EDs, senior clinicians and operational management together into a single decision-making forum. We are supportive of this development, which enables joint oversight of operational and quality performance which is more aligned to good practice we see elsewhere. As TMT becomes more embedded, we are of the view that a further, but proportionate, structure will be required to support effective holding to account for divisional performance.

- Historically, divisional performance reviews were in place at the Trust, although it was widely acknowledged that these had limited impact and were seen as "adversarial" by many staff. In recognition of this, the Performance Contracting and Oversight Group (PCOG) was established, and this was the primary senior performance management forum at the time of our earlier review. We found however, scope for broader Executive Team attendance and greater focus on holding to account at this group.
- This forum has now been superseded by the TMT which was established in January 2017. The meeting is chaired by the COO and has attendance from the broader Executive Team as well as senior clinicians, operational managers and corporate services. Its function has been described to us as the "engine room" of the organisation and members already see value in its scope for decision making and information sharing given the diversity of its membership. We support the establishment of this forum, which brings operational and quality oversight more in line with structures we have seen at high performing mental health trusts.
- We found, however, scope to strengthen the performance management aspects of this forum. For example, our observation found limited discussion of performance exceptions in the integrated performance report (IPR), which may be attributed to the newness of the forum, or the wide attendance at the meeting. In our view, as the role of TMT becomes embedded, the agenda will likely become too heavy to facilitate effective holding to account of divisions in this forum. This is particularly the case given the large attendance, and also perceptions around the culture of former performance review meetings.

2. Governance arrangements

Key findings

- We would therefore advocate that a separate structure is created to oversee divisional performance and holding to account. Recognising the history of performance reviews at the Trust, this would need to appropriately balance holding to account and support. Also, as two new senior forums have recently been established (being TMT and its new subgroup, the Senior Assurance Group), any new structure would need to be proportionate in terms of meeting length and frequency. The majority of EDs and also senior staff we spoke with were supportive of this.
- A supporting subgroup, the Senior Assurance Group has also been established in March 2017, which focusses on preparation and delivery of the TMT agenda. Acknowledging that this group has only met once to date, interviewees were unclear as to its purpose, and EDs are cognisant of the need to review this once the group is more established.

R3: In support of the work ongoing to strengthen divisional governance, as part of the TMT meeting cycle, introduce rotational 'divisional deep dives' where all aspects of performance are reviewed, including quality, finance, operational and workforce. This part of the meeting should only be attended by the divisional triumvirates or quads and relevant EDs. The Executive Team will also need to review the role of the Senior Assurance Group to ensure that it is value-adding and has a clear purpose in the revised structure.

2.4 Board engagement

Improvements to the profile of the Board within the Trust have been made, with greater opportunities for staff to engage with the Board and increased communications. This brings the Trust more in line with other organisations we have worked with, although the Board is conscious of the need to continue to develop arrangements in this area. Governors in particular reported greater levels of transparency and access to Board Members to enable them to enact their statutory role effectively.

- A number of new mechanisms have been implemented to support high levels of engagement with the Board, including CEO briefing sessions, strategic roadshow type events around the Trust, Board member attendance at team meetings, a new CEO blog and the alignment of all new NEDs to a particular role or service within the Trust.
- Progress to broaden staff engagement more broadly activities was initially stalled due to a lack of consistent HR and OE leadership. However, under the direction of the new Interim Director of People and OE significant progress has been made in recent months, including the introduction of 'pulse' surveys, progression of succession planning and increased focus on staff training and appraisal.
- Following the disappointing 2016 NHS Staff Survey scores and in recognition of the variances across services, actions are being designed at a team level to understand and respond to feedback locally. These will be reported to the April meeting of the TMT.
- Senior divisional staff we spoke with confirmed that Board profile has significantly improved since our previous work, including through the well-established quality visits, Executive Director visits to local team meetings and the recently introduced CEO blog.
- Given the scale of the strategic risk in this area, including vacancy current rates, staff satisfaction and engagement will need to be core Board priorities moving forward. BMs are sighted on this, and the risk is appropriately reflected on the recently refreshed Board Assurance Framework.

R4: Alongside plans already in train through the People Plan, consider further mechanisms which the Board and senior management can adopt to develop staff engagement. Some suggested tools have been set out in Appendix 6.

- There has been a concerted focus on governor engagement through core five of the GIAP. Through interviews, we found a commitment from all BMs to promoting open and transparent relationships between the Board and the CoG. Appendix 4 shows that all actions from our February 2016 report have been implemented.
- In particular, we have found much better BM attendance at CoG meetings, access to BMs and transparency of approach. This was tested by the Board in November 2016 through an internal survey to governors, which showed positive results.
- Refer to Appendix 4 for a detailed follow-up of our February 2016 recommendations.

3. People and Organisational Effectiveness function

Key findings

3.1 Leadership of the People and Organisational Effectiveness function

The overall leadership of the function has significantly improved since our initial review, with extensive work undertaken in recent months to reshape the function with a renewed strategic direction and clarity of purpose.

- Following the recommendations outlined in our initial report, the function was united under a single Executive Director in April 2016. A further change to the leadership occurred in September 2016 and over the past four months the function has begun to stabilise, laying solid foundations for the senior team to begin to deliver a proactive and value adding service.
- Interviewees agreed that the current interim Director of People and OE has been instrumental in driving this progress and feedback from Board Members and staff has consistently been positive about the leadership of the function. See fig. 9. This is of particular note when considering the impact on the function of extended absences of key members of the team which has placed additional capacity constraints.
- The team have valued the positive leadership, accessibility and contribution from the Director of People and OE. However, this post holder remains part time with a neighbouring trust, and a number stated that they would value increased visibility, support and direction. There was no consistent view as to what is driving these perceptions although it was evident some individuals do still require varying degrees of pastoral support.
- Given the impact made by the interim post holder there is a risk to the Trust that the current momentum will not be sustained if these arrangements do not continue, particularly given the requirement to embed the significant programme of change which has only recently commenced. However, as outlined in 1.1, we are aware of the proposed collaboration framework and agreement with DCHS, which seeks to mitigate this risk.
- The complex nature of the plans associated with the back office review have been shared as well as the intention to transfer the People and OE function into DCHS. The Board has agreed a 12 month plan to realise this, which will now need to be implemented, along with robust staff engagement.

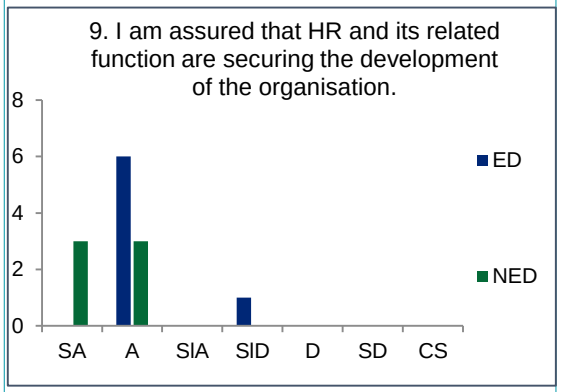
R5: Formalise the substantive arrangements for the Director of People and OE. Alongside this, plans to implement the back office review will need to continue to be developed with appropriate staff engagement.

3.2 Strategy and Culture

The People Plan has been extensively updated and is now more closely aligned to the Trust strategy and the Trust's key workforce challenges. A number of enabling strategies are in development to support the delivery of this plan. The culture within the function has improved markedly, with a significant quickening of pace from the beginning of the calendar year.

- A pragmatic approach has been adopted in order to revise the People Plan for a 12 month period pending the outcome of the proposed merger, with the team reporting being far more connected with the Board and executive colleagues.
- We note the ambitious People Plan sets an aspiration to be a top 20% NHS organisation as a place to work by 2021. While the initial focus of the People Plan is to ensure the "basics" are in place and functioning effectively (such as mandatory training and attendance management), the size and magnitude of the change required to achieve this aspiration is significant given the capacity and capability in the existing function.
- Relationships at a senior level are viewed as being professional and beginning to enable greater matrix and cross function working to the benefit of the wider Trust. A number of examples were cited where a range of professionals from across the function had effectively coordinated their response to address particular issues or hot spot areas.

Board survey



3. People and Organisational Effectiveness function

Key findings

- In particular, an away day for the senior team was cited as being cathartic and providing a catalyst for improved relationships. Opportunities for more junior members to be involved in a similar future events would further enhance behaviours and continue to develop key relationships, particularly as previous silo working had meant that members of the function did not often interface with one another.
- Executive colleagues, in conjunction with staff-side partners, should be commended on the substantial shift in the relationship and development of true partnership working through increased transparency and sharing of information. We found that a maturing relationship is now in place, which has developed significantly from our observations in early 2016.

R6: Provide opportunities for whole team development for the People and OE function. These should incorporate more junior members of staff, and provide a continued focus on behaviours and cross-team working.

3.3 Model and Structure

Protracted internal employee relations cases have hampered timeframes to implement a revised model and associated structure. However, there are now clear plans for a new model and structure for the function for the next 12 months. A period of consultation for this plan commenced during the course of our review.

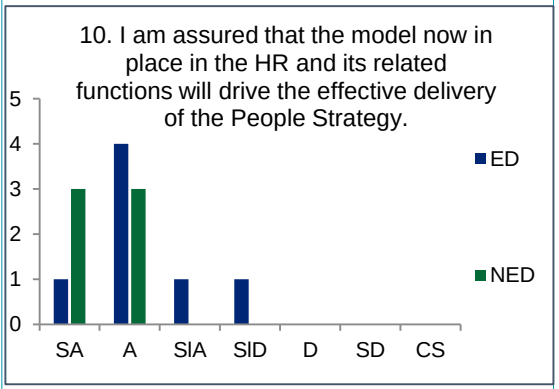
- Resolving several complex and sensitive employee relations cases was always going to be fundamental to the functions ability to renew, and inevitably there is always an unpredictable nature in identifying mutually agreeable resolutions. We are informed that all these cases were resolved at the end of January 2017.
- The plan for the new model for the function, shapes a fit-for-purpose People and OE function with a stronger focus on ensuring sustainability and effectiveness of the Trust. Mobilising and implementing the agreed plan at pace while continuing to develop and get the basics right will invariably challenge and test the team's new found resilience. See fig. 10 which also suggests more mixed levels of confidence among Board members in this area.
- Moving at pace within the boundaries and confines of the Organisational Change policy will be of vital importance in maintaining credibility of the process. A degree of frustration was shared by a number of individuals over the pace of the restructure and associated "job losses" which was first discussed in September 2016. People described being kept informed of progress, however there were some inevitable references to uncertainty and anxiety over the change process to come.
- Capacity within the function was a clear theme to emerge from the team. A review of the current People and OE organisational chart reveals a lean structure, particularly when key absences are taken into account. However, this also needs to be set in context of the recent step change in the pace of delivery from that 12 months ago.

R7: Move at pace to implement the new model and continue to engage the team in the design of the final structure

3.4 Policy and Metrics

There has been clear progress and a sustained programme of work to revise, update and streamline HR policies and procedures. This has included a much shaper focus on partnership working, with staff partners now actively involved in the review and revision process. In addition, the use of workforce information and KPIs to drive decision making in the People and OE function is a substantial progression from 12 months ago.

Board survey



3. People and Organisational Effectiveness function

Key findings

- The Trust has a new system in place (Connect) which tracks all policy areas and provides real time information. As at 16th March 2017, this showed that 97.54% policies were compliant (in date) at the Trust, with the People and OE function reporting full compliance with the exception of the Disciplinary Policy for Medical Workforce.
- Alongside this, there has been a concerted programme of activity to update, revise and reduce the number of HR policies and procedures, with the total number reducing from circa 50 to 40 over the past 12 months. Linked to this a programme of mandatory manager training on key policies has been running since November 2016 and has been extremely well received. This has included a particular focus on appraisals, grievances, and disciplinary processes.
- As at 10th April 2017, the average compliance for completion of this training is circa 55% on a module by module basis; 32% of the 269 line managers have completed all 6 modules, while a further 23% have not attended any session. Further sessions are scheduled over the next few months, and whilst WOD4 is marked on the GIAP as completed with the blue form signed off at the P&CC meeting in February 2017, there is a need to retain a focus in this area.
- There was a general acknowledgement that the application of policies has also improved in the main. The multi disciplinary team approach to reviewing long standing ER cases with staff side and the Trust solicitors has proved successful in highlighting compliance and progressing cases, we would advocate this continuing in the short term.
- We equally understand that the number of disciplinaries has increased since August 2016 which could in part be attributed to the significant improve work and increased knowledge of whistleblowing processes.
- However, despite the great work to date, there appears to remain a small cohort of managers who do not routinely follow Trust policies and procedure. As a result, concerns still persist over the degree to which people are held to account and the perceived consequences of non-compliance with HR policies.
- Workforce Information and KPIs have a far more prominent place at the People and Culture Committee and was reported by the majority of the team as beginning to focus discussion and drive decision making at SMT,
- At the time of drafting the report the results of the HR Pulse survey were not available and we would encourage the review of this data to enable the function to better understand how it is performing.

R8: Review compliance with the People Policy programme and develop a plan to address the shortfall while providing clarity in respects to the potential consequences of non-compliance

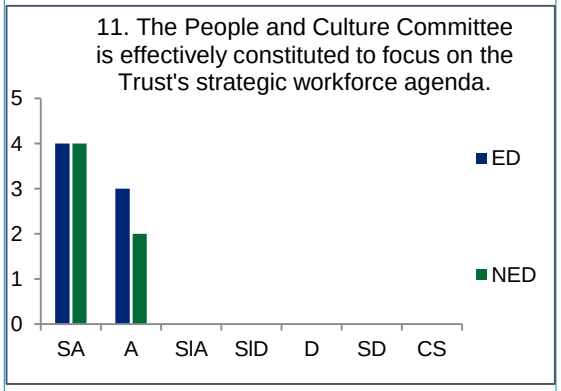
3.5 People and Culture Committee

The People and Culture Committee was understandably initially focussed on the implementation of the actions outlined within the GIAP. The meeting continues to evolve, having recently been reconstituted to focus more on strategic issues and assurances, and will change further once the model and new structure for the function is fully implemented. During our observation of this meeting, the level of challenge and debate from NED was good and added value to the overall People and OE agenda.

- The P&CC is beginning to move on from a predominately GIAP focus agenda. The strategic update from the Director of People and OE is well received and provides an opportunity to focus the debate on assuring the Board on the implementation of the People Plan. See fig. 11.
- The People and OE team firmly believed that the committee was now a pivotal meeting that shaped the direction of the function. The team also described a growing sense of trust from the Committee in their abilities to deliver.

Refer to Appendix 2D.

Board survey

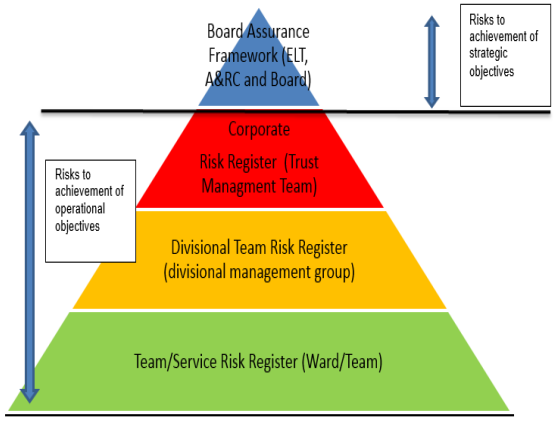


Appendices

Appendix 1

BAF and risk management

	2016	2017
BAF	• Following an IA review of Governance in Oct 2014, we observed mixed progress in the Trust's approach to reviewing the BAF, with frustrated feedback around the slow progress in completing the 'Governance Framework'. Examples of lack of pace in updating actions on the BAF, and hence failing to update the Board and Com's were also observed. • Developments were found relating to how the Board uses the BAF to manage risks with elements of confidentiality. • Board development activities were scheduled Q1 2016, with a focus on the BAF.	• The format of the BAF has been refreshed, based on input from NEDs, EDs and Internal Audit. This will be used by the Trust from April 2017, with quarterly reviews continuing to be undertaken by the Board. • A Board development session on the BAF was also held in February 2017, facilitated by Internal Audit. This included discussion on how risks with an element of confidentiality are managed • During our observation of the public Board we noted discussion of risks facing the Trust, with references to the need to updated the BAF accordingly. • Internal Audit have also taken a review of risk management processes throughout the Trust in March 2017 with positive findings
Committees	• Committees undertook BAF deep dives and regular reviews of their effectiveness, with examples of poor quality papers and duplication of work hindering the effectiveness of Board Committees. Hence, recommendations were made around reviewing ToRs and communication between Chairs to address this. • Further, it was recommended that committee chairs should reintroduce short summary reports to supplement minutes when escalating issues to the Board, to help identify key risks and decisions.	• The Audit Committee is now the Audit and Risk Committee, which has continued the programme of deep dives into risks. (This commenced later in 2015/16, but a full programme has now been performed throughout 2016/17). • Whilst we support the use of deep dives in this way, there is scope to more clearly define the purpose of these deep dives, with some repetition with the work of other committees (see also Audit Committee review). • At present the BAF is not yet fully used within Committees, for example to shape debate. However, there are plans to implement this shortly at the Finance and performance committee and there is an awareness that this needs to be rolled out across all committees. • We have noted that both F&P and QC consider BAF risks relating to their remit as an agenda item at each committee, and review of BAF risks is now a standing item on all committee forward plans. However, some minutes show limited discussion of this item.
ELT	• Not applicable	• The Head of Risk and Governance meets with all Executives on a monthly basis to go through their sections of the BAF to confirm and challenge the content. • Following these updates, the BAF is then presented to ELT on a quarterly basis for collective review before being presented to A&RC and then Board • During our observation of ELT, we observed a significant number of papers and debate around risk updates.
Divisions	• Not applicable	• The Trust has refreshed the risk management strategy (December 2016) and has moved toward retaining all information on Datix. • It is recognised that further work could be undertaken to embed the review of risk more fully at this level, although the recent Internal Audit review referenced above was positive about improvement and performance in this area.



Extract from Trust risk management policy

Appendix 2.A

Committee overview

1. Finance and Performance Committee

Key findings

There is good evidence to suggest the committee has implemented our previous recommendations and has closely monitored the embeddedness of these through its routine self-assessments. A new committee Chair is now in place, and we are aware of early plans to further develop a number of areas, for example committee reporting. We are supportive of these plans, which in our view will further improve the effectiveness of the F&PC.

2016	2017
The F&P agenda required a review to ensure it covered all expected areas.	• The latest ToR are dated December 2016 and were updated to include areas of development identified in our previous report (such as lack of discussion around forecasting and approval of business cases). • A clear forward plan has been mapped to these, to ensure that all requisite items are covered through the year. • The annual committee self-assessment (dated January 2017) did not identify any particular areas for further development, although feedback from an external observer from another trust highlighted scope for greater rigour around action tracking and adherence to the forward plan. • While this self-assessment was comprehensive, we found scope to make more explicit use of all members' views, such as through a survey to all members and regular attendees.
There was a need to review the ToR following the establishment of the P&CC.	• All workforce matters have been transferred to the P&CC, although the September minutes reference some reporting overlap between the two committees. The committee therefore resolved to have a joint member to reduce scope for overlap between the two forums and this has since been implemented. NED chairs also meet regularly to mitigate against duplication of work.
Concerns were raised in relation to the length of agendas and quality of papers received.	• Length of agendas has been reduced through the transfer of workforce matters to the P&CC. • Committee members and attendees were satisfied with the quality of reports, and our review of the finance report found that this reflects a number of elements of good practice. Some members referenced further plans to introduce more granular metrics to financial reporting, including monthly forecast run rates, aged debt and a greater level of detail on cash flow. • We understand that the IPR is also undergoing further review at both Board and committee level to introduce greater use of trajectories, and also that training has been arranged for senior leaders on high quality report writing.
We found a need for much clearer summarisation of debate to 'close' items and ensure shared understanding of action.	• This finding has been monitored through a verbal review of committee effectiveness at the end of each meeting. Our review of minutes found improvements in this area, with resolutions and actions clearly identified. • Our observation found clear summation following each agenda item, with items to report and escalate to the Board.
We found a need to ensure that all agenda items are afforded sufficient debate from all attendees.	• The agenda and workplans have been refreshed, in line with the above, however committee minutes suggest that meetings have on occasion continued to run over. Members have suggested that too much focus on matters of operational detail could have caused this, although we observed good self-awareness in this area, and a propensity to 'draw back' when discussion became too operational on occasion.

Next steps and recommendations

R9: Annual self-assessments for all committees should take into account a greater breath of members' views, such as through use of a survey. Many trusts now use their internal audit function to facilitate this.
No further recommendations have been raised as, where we have identified scope for further improvement above, the committee is sighted on these areas (including amendments to committee reporting and the need to maintain focussed debate).

Appendix 2.B

Committee overview

2. Quality Committee

Key findings

We found that concerted work has been undertaken to address some of our recommendations, and notably with regards to focus on the Quality Strategy. The extent to which the committee can be strategically focussed, however, continues to be constrained by the lack of a fully effective supporting quality governance structure. As per section 2 of this report, plans are now in place to establish this across the Trust, with reporting via TMT. This has not yet been rolled out sufficiently to comment on the strength of the revised process, and moving forward, routine and formal reporting will be critical in assessing the effectiveness of the revised QLTs.

2016	2017
We found a need for increased challenge from a wider proportion of attendees, with greater scrutiny required in certain areas.	• Our observation of the March 2017 meeting was somewhat atypical as the usual committee Chair was absent, although we observed a good level of input from most members and attendees, particularly considering that some NEDs are newer to the committee. Both our observations and review of minutes found scope for the MD to contribute more actively on occasion.
We found a need for increased focus on the Quality Strategy and Quality Goals via effective use of the Quality Dashboard.	• The updated ToR and forward plan formalised the role of the committee in providing assurance in delivery of the Trust strategic objectives. An updated Quality Strategy and Framework were presented to the October 2016 meeting, and we note that (since February 2017) relevant strategic risks are reviewed at the start of each meeting. • The Quality Dashboard is received at each meeting and this reflects a number of elements of good practice, including links to CQC compliance and strategic goals. There are plans to introduce greater use of trajectories and early warning indicators to this report, which should be implemented from Autumn 2017 (when all services will be using electronic reporting). • Some interviewees nonetheless reported a further need for committee debate to become less operational. Refer to commentary below in relation to QLTs.
There was the need to establish an executive-chaired quality governance group, where sub-groups and divisions report, allowing the QC to become more effective and less operationally focussed.	• QLTs have continued to report directly into the QC to date, although the frequency and quality of reporting has been variable. In our view, this structure and the associated issues with successfully forming the QLTs may have contributed to the level of operational debate referenced by some interviewees, who also said there is still a need to refer a number of agendas items down to subgroup level. While our desktop review did not find an untoward number of "operationally" focussed papers, we noted scope for papers to be more exception focussed, with clearer use of executive summaries. • A quality-focussed executive subgroup has not been established per se, however the revised QLTs will now report into TMT. Robust and formal reporting from TMT will therefore be important moving forward, in order to enable the Quality Committee to focus on exceptions, themes and learning, and delivery of the Quality Strategy.
We found a need to condense the number of sub-groups.	• The number of subgroups have now been rationalised to five, excluding the QLTs, namely: the SIRI Group, Physical Health Care Committee, Drugs and Therapeutics Committee and the Patient Experience Group.

Next steps and recommendations

R10: As each clinical division board / COAT is established, the DoN and COO should:
- **Collaboratively review their terms of reference to ensure that all requisite areas are covered;**
- **Provide written guidance around the minimum requirements of their agendas to encourage both innovation and compliance;**
- **Clearly define the reporting requirements to TMT to enable the Quality Committee to receive appropriate levels of assurance.**

As per R2, a post-implementation review date will need to be agreed for the new clinical division boards / COATs. Part of this review will also need to focus on the extent to which the revised structure has enabled the Quality Committee to become more strategic and assurance seeking in nature.

Appendix 2.C

Committee overview

3. Audit and Risk Committee

Key findings

Both our observations and desktop review found the committee to be operating effectively. Model ToR are in place with a clear workplan, which has been reviewed alongside other committees to reduce any unnecessary overlap. Greater clarity should now be provided to members and attendees to ensure that BAF deep dives at the Audit and Risk Committee focus on process and structures, instead of the effectiveness of individual controls.

2016	2017
We found a requirement to reduce discussion of operational detail.	• The committee ToR show exemplar levels of compliance with good practice, which is supported by a clear forward plan. • A number of audit committees we have worked with are now beginning to adopt a slightly broader focus around key areas of control, such as links with clinical audit and reviews of data quality. These should now be considered in future iterations of the DHC Audit and Risk Committee ToR. • In July 2017, it was recommended to the Board that the Committee be renamed the Audit and Risk Committee to reflect the fact that it is the Board Committee which will have overall oversight of risk management processes, including: seeking assurance on the effectiveness of the risk management strategy, oversight of the BAF, and seeking assurance from other committees that robust procedures are in place to monitor and scrutinise clinical and operational risks. • The reviews of committee effectiveness at the end of each meeting have returned broadly positive feedback, although there has been some references to meetings over-running and scope for discussion to be more efficient.
There was a need to revise the mechanisms by which the committee gained assurance over the effective operation of other committees to minimise duplication with the role of the Board.	• Assurance summary reports from other committees were received by the Audit Committee until October 2016. • These have since been submitted directly to the Board, with assurance of committee effectiveness now sought through the annual committee self-assessments which are reviewed by the Audit and Risk Committee.
We found a need to bring structure to Executive Director updates to provide clarity over escalation.	• Our observation of the committee found examples of proactive and efficient Executive Director contribution to the committee. In particular, we note that the committee has received draft versions of the Trust's Annual Report to enable early opportunity for commentary and scrutiny.
There was a need to review its work plan to reduce duplication with other committees.	• The committee forward plan for 2016/17 has been rationalised to remove any duplication with other committees. Our review of this and other committees' work plans found no obvious areas of overlap. This has also been a key area of focus through GIAP action CorpG4 – 'Review the operation of all Committees seeking to minimise duplication'. • There is however a need to more clearly distinguish the role of the Audit and Risk Committee from other Board committees in relation to the BAF deep dives. For example, while some presenters focussed clearly on the assurance and control mechanisms, others provided more detailed updates on the detail of controls and mitigating actions in place, which may lead to duplication with the other committees. The Board is aware of this, and some members emphasised the need to cross-refer more detailed matters to other committees.

Next steps and recommendations

R11: Clarify the role of the BAF deep dives undertaken at the Audit and Risk Committee (as opposed to other Board committees) to ensure that their focus is on the structures and processes in place to provide the Board with assurance, as opposed to the detail of controls. Those presenting on individual BAF deep dives should be suitably briefed on this prior to the meeting.

Appendix 2.D

Committee overview

4. People and Culture Committee

Key findings

The Committee has evolved significantly over the past 12 months. Over that period it has understandable focused on delivery of the GIAP and is now beginning to move to an assurance orientated committee in respects to delivery of the People Plan. The level of NED contribution was strong, with significant challenge and debate observed amongst members. It is of note that the agreement to sign off a number of blue forms was deferred following strong challenge from the Interim COO.

2016	2017
There was a need to revise the membership of the People Forum to secure the right dynamics.	The membership of the Committee has been revised with new Non-Executive Directors to the Trust providing robust challenge, debate and dialogue at Committee meeting. Attendance at the meeting will change once the new model and structure for the function is implemented.
Maintain a focus on KPIs and performance, with an emphasis on rigour and holding to account for actions.	The Workforce KPI Dashboard (People Performance Report), is received monthly at P&CC, presenting data one month in arrears going back 12 months historically. The report shows good use of local and national benchmarking, trend and RAG analysis and hotspots and triangulation down to ward level granularity. The report is discussed in some detail, with actions focussing on creating supporting reports / analysis, and ensuring that triangulation is discussed at ELT.
Uphold the timeliness and quality of papers received.	Reduced evidence of papers not being received at Committee, with reference to the improving quality of papers in Nov 2016 increasing the efficiency of the meeting. Committee action matrix shows no evidence of overdue actions since Sept 2016.
Facilitate the successful development and implementation of the People Strategy.	The Committee has effectively used the GIAP, (namely progress against - Core 2 GIAP – PC4)– to facilitate this. A draft Plan was received at P&CC April 2016, with subsequent reviews to ensure KPIs, ownerships and timescales were embedded to increase assurance. The People Strategy was approved in July 2016, with a revised version approved Jan 2017. Committee to receive progress reports as a standing item on forward plan going forward.

Next steps and recommendations

The interim Director of People and OE has a clear plan to evolve the committee further with new people in attendance once the new structure is fully implemented. **R12 The Committee has a heavy agenda and although the appropriate place to review key strategy documents a more realistic assessment of the time for debate in order to allow dialogue needs to be considered.**

Appendix 2.E

Committee overview

5. Mental Health Act Committee

Key findings:

- Terms of reference are in place for the committee, dated March 2017. The purpose of the committee is clearly stated: to obtain assurance that safeguards and provisions of the MHA and other relevant legislation is appropriately applied. Despite stating that meeting frequency will be quarterly, our desktop review found this to be unclear with gaps of two, three and four months between meetings.
- We have reviewed papers from the last six months, through which we found that:
    - Agendas lack structure, with no clear link to an overarching plan;
    - On occasion high levels of apologies have been received;
    - The committee is not yet fully driving CQC compliance, for example in the November 2016 CQC update, 9 out of 21 actions were overdue for completion;
    - Members have reflected during effectiveness reviews that the committee is overburdened, with between 15-20 agenda items in a three hour meeting; and
    - Attendance can be unwieldy, for example, there were 20 people in attendance in March 2017;
- A number of interviewees reported that some of the issues above are linked to the constrained capacity of the Medical Director given his clinical commitments.
- In light of the CQC's findings during its comprehensive review that application of the MCA is inconsistent, this is a key area of risk. We understand that the Trust is currently working with another organisation's equivalent committee to take learning and good practice from elsewhere. As part of this, the committee has had external observers to provide feedback on its effectiveness. The Trust Chair has also offered to join the committee to provide additional oversight.

Next steps and recommendations

R13: Given the scale of risk associated with the MHAC's remit, a full review of the committee should be undertaken, to include:

- **The establishment of a working group beneath the MHAC to support the delivery of its key priorities (such as CQC actions). This group should provide clear reports to each MHAC meeting;**
- **Greater focus on holding to account for delivery of CQC associated actions; and**
- **The existing workplan should be reviewed to understand which items can be delegated this subgroup, to enable the committee to focus on assurance seeking.**

6. Safeguarding Committee

- Terms of reference are in place for the committee dated July 2016. The forum is an assurance committee of the Board, meets at least quarterly and is chaired by a NED with a experience in the safeguarding agenda.
- The ToR reference at least 20 members and attendees, which interviewees confirmed is too many in practice which can lead to a lack of focus in debate.
- Agendas are structured around the safeguarding of adults, children, families and policy review. Our review of minutes found some scope for minor improvements, including consistent attendance from key attendees, and clearer use of executive summaries to ensure clear NED understanding of the key issues raised in papers.
- There was a view expressed from some attendees and members that given that this forum is a full assurance committee of the Board, its focus is excessively operational and should become a subgroup of the Quality Committee, more akin to the structure of other mental health trusts.
- This matter has been recognised by the Board, which has previously reviewed this structure. However, as per section 2.1, a conscious decision has been taken to make no further changes in light of the CQC findings and until the Quality Committee's supporting structure becomes fully effective.

Next steps and recommendations

R14: As part of the post-implementation review of the clinical division boards / COATs, the Board should decide if the Safeguarding Committee can become a subgroup of the Quality Committee, bringing this structure more in line with other mental health trusts.
R15: To encourage more focussed debate, the membership of the Safeguarding Committee should be rationalised.

Appendix 3

Oversight of divisional performance – Benchmarking of your structures

Through our work with the Trust in 2015/16, we found that a number of mechanisms were in place to monitor divisional performance at a Board and committee level, although there was a recognition that a clearer performance management framework was needed. We recommended that an Accountability Framework was introduced to fully engage staff in these changes and to enable more robust holding to account. While this has been agreed, there is now a need to embed this in practice through routine accountability meetings which appropriately balance challenge and support, and build on recently introduced structures such as TMT.

The table below sets out various mental health trusts' approaches to performance management and holding to account.

Good practice area	Derbyshire Healthcare NHS FT	Mental Health comparator 1	Mental Health comparator 2	Mental Health comparator 3	Mental Health comparator 4
Clearly documented Accountability Framework	Yes, but does not reference performance review	In development at the time of our review	⊗	✓	✓
Senior operational forum attended by EDs and senior Trust leadership	✓	✓	✓	✓	✓
Routine divisional performance reviews with the ET	⊗	⊗ Removed as part of new Trust leadership to signal a shift in culture	✓ 'Delivery executive team meetings' with all divisions present	✓ Quarterly 'Accountability Review' meetings	✓ Quarterly 'annual plan reviews'
Similar mechanisms are in place to also hold corporate services to account	⊗	⊗	⊗	⊗	⊗
Regular, less formal meetings with the COO (or equivalent) to provide ongoing feedback and support	✓	✓	✓	✓	✓
Divisional level dashboards	⊗	✓	✓	✓	✓

The benchmarking shows that, whilst the Trust's performance management structures do show some elements of good practice we see in other mental health trusts, further enhancements are needed to support the structure recently introduced through TMT, including routine divisional performance reviews with the Executive Team and the development of divisional dashboards. **Refer to R3.**

Key ⊗ Not in place

✓ In place

Appendix 4

Follow up review of governor engagement

2016	2017
There were 12 governor vacancies and no partner governors in post.	• Significant recruitment has been undertaken to the CoG and after recent elections, only four vacancies remain, including one constituency, one partner governor (although this had been sought from the Police) and two from the voluntary and community sector. The Trust is also aware of the need to recruit to all governor vacancies.
Attendance from both NEDs and EDs at CoG meetings needed to be increased.	• Our review of minutes found that CoG meetings are regularly attended by at least four NEDs, and that there is typically attendance of at least six EDs. This benchmarks strongly against other boards we have worked with, although governors reported that a small number of BMs have very low visibility at CoG meetings. • An annual CoG survey has been introduced, the results of which were shared with governors in November 2016. These showed positive progress made, including good levels of engagement with the Board. There was however appetite for greater interaction with the MD.
There was a need to introduce changes to the format of CoG meetings to enable more informal interaction.	• A revised policy is in place which sets out engagement requirements between the CoG and Board of Directors, which was approved in September 2016. This clearly sets out the requirement for NEDs to attend and present at CoG meetings in order to increase visibility and build cohesion. We note however that the majority of agenda items are presented by EDs. • During the focus group, governors agreed that BMs could do more to encourage more active debate. Acknowledging the scale of the Trust's current agenda, most of those present reported that discussion can feel "stifled" and some did not feel comfortable speaking openly in meetings.
Following the employment tribunal, there had been a loss of confidence in some BMs.	• The policy for engagement between the Board and the CoG includes biannual Board and CoG development sessions, nominated governors to attend Board meetings and observe committees and a review of the role of Lead Governor. • Informal governor and NED sessions have also been introduced to support improved dynamics and understanding. • During our focus group, governors reported "transformed" relationships with the Board and described high levels of confidence in all Board members, and particularly the Acting CEO. • There was however an appetite for greater visibility among a small minority of Board members.
Establish a governor development programme, with a focus on behaviours and the statutory role of the governor	• The CoG Governance Committee now oversees the governor development programme, which has included topics such as behaviours, values and effective meetings. The annual governor effectiveness survey showed good progress in this area • A Governor Code of Conduct was also agreed by the CoG in September 2016. This will shortly be reviewed again to ensure fitness for purpose. • Governors also reported that attending quality visits is a valuable mechanism to supporting understanding of services.
Amend the format of the CoG to enable more informal interaction.	• Governors described that CoG meetings continue to be formal in nature, and would welcome more interactive discussion as discussions regarding the merger develop. • They also reflected that EDs tend to deliver the majority of updates to the CoG and felt that NEDs should take on a greater presenting role to facilitate governors' role in holding NEDs to account, which we would agree with.

Summary and next steps

Significant progress has been made in rebuilding relationships with the CoG and governors reported a "transformed" dynamic. There is an emerging view however that more could be done to maintain this progress, particularly to ensure transparency and open dialogue so that governors are able to effectively hold NEDs to account, and that the CoG is able to make a value-adding contribution.

R16: The Board should introduce routine NED presentations from committee chairs at CoG meetings, both to provide greater insight into key areas of assurance and to facilitate holding to account of NEDs.

R17: In its next joint development session, the Board needs to reflect on governor feedback regarding the visibility of all BMs, and views around the quality and openness of debate in CoG meetings.

Appendix 5

HR effectiveness

The table below explores the themes from our review in 2016 in respect to the effectiveness of the HR and associated functions. We have detailed our findings from our more recent review and included observations to support the development journey.

Theme	2016	2017
Leadership	There was a requirement to bring the leadership of the function under one director and secure the necessary support from the wider system	An Interim Director is now in place and support has been obtained from the local health system - DCHS.
Strategy	Trust leadership needed to update the model and structure	A clear plan to update the model and structure is in place with agreement from the Trust. The plan needs to be implemented at pace while working within the boundaries of the Organisational Change Policy
Culture	There was an urgent need to address relationship issues within the senior team	The senior team described relationship within the function as significantly improved with clear strategic direction and matrix working encouraged by the Director
Policy	Policies and procedures needed to be revised, and there was also a need to ensure their compliance and consistency in application	An extensive policy update and reduction process has been delivered. Compliance with and consistency in the application of policies is reported to have improved
Metric and evaluation	We recommended that the Board measured and evaluated the impact of the function through use of ongoing feedback	The P&CC and the People and OE SMT now regularly received KPI and workforce data. This appears to be driving decisions making and identification of hot stops areas. The function has sought feedback, although the outputs of this process is not yet know

Summary and next steps

There has been significant progress against the GIAP and more importantly to ensure the Trust has a People and OE function that is fit for purpose. It is our reflections that the programme of improvement and progress has not been linear with substantial progress made from November 2016 onwards. The model and structure has yet to be implemented and although overall progress is positive, a number of initiative have yet to be fully embedded and evaluated for their effectiveness and impact on the wider Trust. There are several further recommendations in section 3 that aim to support the great work underway and to ensure the People Plan is fully embedded.

Appendix 6

Culture and staff engagement

Our February 2016 report provided an appendix setting out a range of good practice mechanisms used in other trusts to promote high levels of staff engagement and satisfaction. Some of these have now been implemented at the Trust.

Below we have collated a bank of other good practice elements used by other trusts which have high levels of staff engagement. Some of these are already in place by DHC (indicated by bold and italicised text), and others could be considered by the Board to support the successful delivery of the People Plan.

Positive Board profile	Highly engaged triumvirates and / or quads	Successfully embedded values and behaviours	Further mechanisms to consider
Unstructured Board member visits to services, such as using the '15 steps' methodology	***Director shadowing programme***	***Regular 'pulse check' surveys to ensure ongoing understanding of engagement levels***	Linking all Board and committee reports to the Trust values
Service visits programme for other senior managers to create more time for informal debate and to cover wider shift patterns	A rolling programme of 'Board conversations' sessions with Divisional leaders to ensure ongoing dialogue re strategy and performance	***Values based appraisals and recruitment***	Mechanisms to develop an internal talent pool and actively manage talent
Use of social media, and particularly by the Medical Director and Chief Nurse to reach clinical staff	'Team Brief' to ensure cascade of key messages into clinical services	***Local ownership of Staff Survey actions***	***Targeted interventions with 'teams in need' identified through pulse checks and triangulation of data***
Listening into Action	Strong divisional engagement in the annual planning process	***Mechanisms to champion / support E&D***	Consideration of 'softer' workforce metrics at Board and committee level
'Key messages to cascade' as a standing Board agenda item	Access to aspiring directors programmes	***Raising concerns policy***	***Healthy lifestyles programmes***
		Clear and accessible leadership development programmes	Local ownership of Staff Survey actions

Appendix 7: Glossary

BAF	Board Assurance Framework
CAMHS	Children and Adolescent Mental Health Services
CEO	Chief Executive Officer
COAT	Clinical and Operational Assurance Team
CoG	Council of Governors
COO	Chief Operating Officer
CQC	Care Quality Commission
DCHS	Derbyshire Community Health Services FT
DoN	Director of Nursing
ED	Executive Director
ER	Employee Relations
ET	Executive Team
F&PC	Finance and Performance Committee
GIAP	Governance Improvement Action Plan
HR	Human Resources
MCA	Mental Capacity Act
MHA	Mental Health Act
NED	Non-Executive Director
NHSI	NHS Improvement
OE	Organisational Effectiveness
P&CC	People and Culture Committee
PCOG	Performance, Contracting and Oversight Group
QLT	Quality Leadership Team
STP	Sustainability and Transformation Plan
TMT	Trust Management Team
ToR	Terms of Reference

Deloitte.

NHS Improvement

From the office of Fran Steele
Delivery and Improvement Director North Midlands

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24 May 2017

Mr Ifti Majid
Acting Chief Executive
Derbyshire Healthcare NHS Foundation Trust
Trust Headquarters
Kingsway Hospital
Kingsway
Derby
DE22 3LZ

Dear Ifti

Derbyshire Healthcare NHS Foundation Trust ('the Trust') – Decision to Issue Compliance Certificate

I am writing to advise you of NHS Improvement's decision in respect of the Trust's Enforcement Undertakings accepted on 25 February 2016.

NHS Improvement has decided to issue a compliance certificate in respect of the entirety of the Trust's Enforcement Undertakings.

NHS Improvement will publish the compliance certificate on its website.

As a result of this decision, the Trust will move from segment 3 to segment 2. The NHS Improvement website will be updated to reflect the change in segmentation in due course.

If you have any queries relating to the above, please contact Brendan Carey by telephone on 0203 747 0912 or by email: brendancarey@nhs.net.

Yours sincerely

Fran Steele
Delivery and Improvement Director, North Midlands

Enc: Compliance certificate

NHS Improvement

Wellington House
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T: 020 3747 0000
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

CERTIFICATE OF COMPLIANCE

LICENSEE:
Derbyshire Healthcare NHS Foundation Trust
Trust Headquarters
Kingsway Hospital
Kingsway
Derby
DE22 3LZ

Any reference to "NHS Improvement" in this certificate is to be taken as a reference to Monitor.

In accordance with paragraph 12(1) of Schedule 11 to the Health and Social Care Act 2012, NHS Improvement hereby certifies that in respect of paragraphs 1, 2, and 3 of the Trust's Enforcement Undertakings accepted by NHS Improvement on 25 February 2016, the Trust has been fully compliant.

Signed:

Fran Steele
Position: Director of Delivery and Improvement, North Midlands

Date: 24 May 2017

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 28 June 2017

Integrated Performance Report Month 2

Purpose of Report

This paper provides Trust Board with an integrated overview of performance as at the end of May 2017. The focus of the report is on workforce, finance, operational delivery and quality performance.

Executive Summary

The Trust continued to perform well against many of its key indicators during May. This Executive Summary draws out a number of key issues for discussion by the Board of Directors.

For this month's report most of the Divisional KPI's have had targets added. At this stage these are draft and will evolve during the coming months. In addition, two 'example' daily staff fill rate graphs have been added to the report to enhance Board discussion on ward staffing alongside the Director of Nursing's assurance set out in this report

Key themes for month 2 / year to date

1. Continued concerns about high levels of patient activity and clinical capacity in community services to provide good quality and safe services.

Board members will note that the neighbourhood dashboard shows community caseloads remaining high, but also that waiting time for care coordination remains long because there isn't enough care coordination capacity to enable shorter wait times.

Quality Committee have previously received assurance that mitigating actions are being delivered to maintain the current position. The mitigation plan was reviewed again at the Trust Management Team on 19th June, with assurances being received that small improvements have been made in recruitment, which in turn has enabled the position to continue to be maintained.

2. Acute inpatient bed occupancy

Activity pressures continue on both Radbourne and Hartington Units and are highlighted by very high bed occupancy across all wards, resulting in a significant number of patients being placed out of area during May. This provides for a very poor patient experience and is very costly to the Trust. Patients being placed out of area in June had fallen considerably at the time of writing this report.

On 19th June, the Trust Management Team received an update on the work programme being undertaken to deliver the bed optimisation project. One of the aims of this project is to reduce length of stay and thus create bed capacity. Although difficult to deliver, it is envisaged that this work programme will have a positive impact.

In addition, the Trust has secured support from NHSI's improvement team to work with the Trust on understanding how we might better improve the flow of patients across our inpatient wards and through community services. This will also include the implementation of a Red2Green project, which is essentially an approach to minimise delays in patients pathway and improve collective decision making and accountably at ward level.

3. Staffing challenges

Despite the delivery of recruitment activities, staffing remains a constant challenge for many Trust services. As requested by the Board of Directors, the Director of Nursing has reviewed

the safer staffing report.

The Trust wide vacancy rate is 8%. This is well below the national and regional average.

There is a high level of RMN/ RNLD in the Trusts workforce. In addition, Campus skill mix is set at 5 staff on shift which is set at three registered professionals. This is above the national average.

Acute areas have had very traditional skill mix models, over 2016/ 17, pilots of occupational therapists working day shifts at the Hartington unit have been undertaken and in design at the Radbourne unit.

This is modelling recommended good practice by NHS Improvement and positive pilot work in South Staffordshire /Shropshire and Coventry and Warwickshire. In addition medicine optimisation technician trials are in planning and some wards (Tansley) have appointed staff into post.

In addition, Neighbourhood teams have been recruiting and these posts have become very attractive to in-patient staff who are actively applying for promotion to Band 6 opportunities.

There are specific campus areas that are experiencing fluctuations in vacancy rates as trust turnover remains stable, with staff moving from in-patient to community settings.

There are however some wards with no vacancies in specialist services and that have medium rates of vacancies (similar to Nottinghamshire Healthcare, and lower than Oxleas NHS Foundation Trust and South London and Maudsley NHS FT).

Trust recruitment rates and acute unit recruitment rates remain high in our organisation, however staff moving on from acute care is experiencing higher rates of turnover. This is a pattern also found in the US, Australia and in other organisations.

Bank rates remain over target in our campus areas however our own clinical staff are present and maintain consistency in care and practice.

Although we have key wards with lower staffing than planned rates, bed occupancy in the Cubley service and unit must be considered.

The Director of Nursing has partial assurance on staffing levels, against planned standards, however, is assured that safe and effective operational management is in place to mitigate all risks, however our performance in filling ward staffing is fluctuating significantly.

There needs to be a continued focus over the summer to restabilising key campus sites and ensure proactive operational management and planning. To mitigate this in particular at the Hartington unit, additional senior management support will be meeting with the Hartington campus team to ensure full mitigating actions are put in place to maintain safe services over this period.

If operational vacancies and mitigating plans are not fully realised there is a risk to patient experience and to the quality of the service which we provide.

Additional recruitment programmes led by Nursing, AHP and Quality service, to drive forward some recruitment diversification from RGN's, social workers and Occupational therapists are being additionally supported.

Staff have raised in engagement events that there continues to be posts advertised as nursing positions and not opened to Mental Health practitioners, this is being acted upon to address this issue.

Quality and Operational Performance

There are signs of improvement in the uptake of supervision in some service areas. However, there remains a concerted effort to create sufficient time to enable supervision to be undertaken.

The quality visit programme continues to focus on the importance of both innovation and key

workforce metrics of supervision and appraisal, with a clear steer that they are equally important. This has impacted upon morale of some staff, which have been rated inadequate at their Quality visit for well led for their performance in this area. Overall services do understand the rating grid and the clarity of expectation and there are signs of performance improvement.

The quality committee has reviewed longitudinal data on the positive and safe strategy considering the use of restraint and seclusion. Overtime this continues on a downward trajectory and performance this month with the number of episodes of patients held in seclusion has increased needs to be reviewed in this context.

The number of inpatients with a VTE assessment is increasing, although compliance remains low and has limited improvement. It has been recommended that this continues to be a main focus for the Executive Director for physical health and campus ACD's with their wider teams to significantly improve this trajectory. This is a key indicator for our emerging Physical Healthcare strategy which is in design and will be completed in September 2017.

Linked to the above, there has been increase in the number of serious incidents reported to the CCG and an increase in the number of incidents meeting the duty of candour requirements. This shows good governance of our model of operations in this area. The quality committee will assess and benchmark whether there is a trend over one quarter.

The no of incidents of patient to patient and patient to staff abuse has increased. We specifically monitor whether this related to clinical disturbance and or smoking related incidences. The June Lancet published the NIHR funded - Effect of implementation of a smoke free policy on physical violence in a psychiatric inpatient setting: an interrupted time series analysis established that smoke free strategies and policies actually reduced violence and resulted in a 39% reduction in physical assault. This research finding has been established in other international studies and can be replicated.

The number of falls on inpatient wards has increased, however initial base analysis demonstrates this is related to good reporting and less actual harm. The Director of Nursing has reviewed an analysis and the full analysis will be included in the Quality committee report in September.

Operational performance remains relatively stable with the vast majority of KPI's being achieved.

However, there are a number of indicators where it is becoming increasingly difficult to meet the require standard. The pressure to deliver core targets such as Care Programme Approach, Early Intervention in Psychosis and breastfeeding has, at times, been impacted on by the need to spread resources more widely. Management capacity has started to be refocused on the delivery of core standards. This has been discussed at length recently with NHSI to provide assurances that our focus remains on these key quality standards.

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

<u>People Performance</u>

Staff attendance remains a significant challenge to the Trust with an annual sickness absence rate of 5.53%. In May the sickness absence rate for the month was 5.30% which is lower than the annual rate and 0.02% lower than in the same period last year (May 2016).

Compulsory training compliance remains high at 87.73% which is below our 90% target but above our main contract non CQUIN target of 85%. There has been a slight decrease in appraisal completion at 74.62% against a target of 90%; however medical staff appraisal completion has increased by 3.92% to 85.29%.

The budgeted full time equivalent vacancy rate for May was 8.43%, an increase of 0.39% compared to the previous month. During May 28 employees left the Trust and 20 people joined the Trust as new starters. Over the previous five months 97 employees have left the

Trust and 128 people joined the Trust. Changes in the 2017/18 budget included a large reduction in full time equivalents from 2016/17 investment not materialising and Cost Improvement Programmes.

Work continues on the recruitment action plan which covers how we plan to tackle each vacancy and includes campaigns and open days across the UK, incentives where necessary and overseas recruitment for hard to fill posts. Our recruitment process continues to improve with the introduction at the end of March 2017 of a new e-Recruitment system (TRAC) which enables managers and candidates to utilise a streamlined, interactive and responsive process, which reduces or eliminates paperwork and unnecessary delays.

Financial Performance

In surplus terms, the Trust is slightly behind plan in the month by £4k but is ahead of plan by £17k year to date. The forecast is to achieve the control total at the end of the financial year.

With regard to other financial performance factors, the Use of Resources (UoR) metrics is a 1 year to date and is forecast to be a 2 at the end of the financial year. Current performance is strong in all measures. Forecast-wise four of the five metrics remain strong at 2, 1, 1 and 2, but there is deterioration in agency spend against ceiling, which is forecast at a 3 by year end. This is, however, still better than last year and would meet our objective of being less than 50% above the ceiling. We also expect to achieve the required reduction in medical agency spend compared to last year.

Planning continues for cost improvement action required to achieve 17/18 control total financial plan. Plans exist for some of the Trust CIP cost reduction of £3.85m and work continues to close the gap. The Commissioner-driven QIPP disinvestment schemes that require £3.05m income and cost reduction are not yet agreed. These are incorporated into the Mental Health STP work stream planning

The numbers reported in this report are consistent with the numbers reported in the monthly finance return to NHS Improvement.

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

Assurances

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

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

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

Consultation

This paper has not been considered elsewhere however 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

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

Recommendations

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

In addition, Board members are asked to provide feedback on KPI's where draft targets have been added.

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

Financial Perspective

Highlights
- Surplus slightly ahead of plan year to date
- Forecast achievement of control total
- Cash better than plan
- All UoR ratings strong YTD
- Agency spend is contained in ceiling (YTD)

Challenges
- Delivery of Cost Improvement Programme
- Containment of agency expenditure within ceiling set by NHSI

Operational Perspective

Highlights
- Underperformance against the breastfeeding coverage targets has been addressed

Challenges
- Achieving priority metric compliance
- Clustering
- Outpatient cancellation compliance
- Outpatient letters sent in 10 & 15 working days
- Discharge fax sent in 2 working days
- Delayed transfers of care

People Perspective

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
- Appraisal compliance rates remain low

Quality Perspective

Highlights
- No of patients with a Safety Plan is steadily increasing
- No of inpatients with a VTE assessment is increasing, although compliance remains low
- No of patients with a HCR20 assessment completed is increasing
- There has been a reduction in the number of complaints opened for investigation
- % of staff who have received clinical and management supervision has increased
- No of outstanding actions following serious incident investigations has reduced

Challenges
- No of incidents resulting in moderate to catastrophic actual harm has increased this month
- Linked to the above, there has been increase in the number of serious incidents reported to the CCG an increase in the number of incidents meeting the duty of candour requirements
- No of episodes of patients held in seclusion has increased
- No of incidents of patient to patient and patient to staff abuse has increased
- No of falls on inpatient wards has increased

FINANCIAL OVERVIEW – May 2017

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Governance	Use of Resources (UoR) Metric	Overall Use of Resources Metric	YTD	1	1	Y	→	In May the Use of Resources Rating is an overall '1'. Forecast is a rating of '2' which is slightly worse than the plan of '1'. This is mainly driven by the agency metric which is forecast at a '3' for the end of the financial year. Following the lifting of the breech of our licence conditions we have moved out of segment 3 and into segment 2.
			Forecast	1	2	Y	→	
		Capital Service Cover	YTD	2	2	Y	→	
			Forecast	2	2	Y	→	
		Liquidity	YTD	1	1	G	→	
			Forecast	1	1	G	→	
		Income and Expenditure Margin	YTD	1	1	G	→	
			Forecast	1	1	G	→	
		Income and Expenditure variance to plan	YTD	1	1	Y	→	
			Forecast	1	2	Y	→	
		Agency variance to ceiling	YTD	1	1	Y	↑	
			Forecast	1	3	A	→	
	Single Oversight Framework	NHS I Segment	YTD		2	n/a	n/a	

				Plan	Actual	Variance	Trend	
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	285	281	R	↑	At the end of May the surplus is slightly ahead of plan by £17k and is forecast to achieve the control total at the end of the financial year. EBITDA is slightly behind plan at the end of May by £31k and forecast £72k behind plan. This is offset by small underspends below the line on depreciation and Public Dividend Capital payments.
			YTD	463	480	G	↑	
			Forecast	2,765	2,765	G	→	
		Underlying Income and Expenditure position £'000	In-Month	246	241	R	↑	
			YTD	384	401	G	↑	
			Forecast	1,971	1,971	G	→	
		Normalised Income and Expenditure position £'000	In-Month	246	252	G	↑	
			YTD	384	452	G	↑	
			Forecast	1,971	2,162	G	↓	
	Profitability	Profitability - EBITDA £'000	In-Month	898	890	R	↑	
			YTD	1,728	1,697	R	↑	
			Forecast	10,159	10,087	R	→	
		Profitability - EBITDA %	In-Month	8.0%	7.6%	R	↗	
			YTD	7.7%	7.4%	R	↗	
			Forecast	7.6%	7.3%	R	→	

Liquidity	Cash	Cash £m	YTD	13.424	14.638	G	↑	Cash is ahead of plan year to date and is forecast to be ahead of plan at year end. This mainly relates to additional STF income from 2016/17 that will be received during 2017/18. This additional income may be spent on capital bids, but this is not yet included in the capital or cash forecast. Net Current Assets are less than plan due to the removal of an Asset Held for Sale.
			Forecast	12.193	12.770	G	→	
	Net Current Assets	Net Current Assets £m	YTD	7.535	4.531	R	↑	
			Forecast	8.345	4.661	R	→	
	Capex	Capital expenditure £m	YTD	0.198	0.125	R	↓	
			Forecast	3.338	3.338	G	→	

Efficiency	CIP	CIP achievement £m	In-Month	0.321	0.311	R	↑	CIP is currently behind plan. An additional amount of savings has been included in the forecast. However work continues to fully assured the CIP in totality.
			YTD	0.642	0.448	R	↓	
			Forecast	3.850	3.850	G	↑	
			Recurrent	3.850	1.170	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 – MAY 2017

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up (M)	Month	95.00%	98.18%	G	→	All NHSi metrics are all compliant except "Priority Metrics" which is a new indicator since April 2017. Plans are being formulated to address the under-performance. For each metric we have indicated if it is monitored by NHSi Quarterly (Q) or Monthly (M).
			Quarter	95.00%	98.11%	G	↑	
		Data completeness - Identifiers (M)	Month	95.00%	99.38%	G	→	
			Quarter	95.00%	99.44%	G	→	
		Data completeness - Priority Metrics (M)	Month	85.00%	71.56%	R	↓	
			Quarter	85.00%	69.97%	R	↓	
		Crisis Gatekeeping (Q)	Month	95.00%	100.00%	G	→	
			Quarter	95.00%	100.00%	G	↑	
		IAPT RTT within 18 weeks (Q)	Month	95.00%	99.73%	G	→	
			Quarter	95.00%	99.88%	G	→	
		IAPT RTT within 6 weeks (Q)	Month	75.00%	94.23%	G	↑	
			Quarter	75.00%	93.94%	G	↑	
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Month	50.00%	92.00%	G	↑	
			Quarter	50.00%	86.54%	G	↓	
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Month	50.00%	50.00%	G	↓	
			Quarter	50.00%	52.73%	G	↓	
		Patients Open to Trust In Employment (M)	Month	N/A	8.99%		→	
			Quarter	N/A	8.76%		→	
		Patients Open to Trust In Settled Accommodation (M)	Month	N/A	59.64%		↓	
			Quarter	N/A	57.60%		→	
		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%	52.25%	G	↓	
			Quarter	50.00%	54.04%	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

↑ → ↓ Trend compared to previous month/quarter

Achieving target

Not achieving target

OPERATIONAL OVERVIEW – MAY 2017

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	95.59%	G	→	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.
			Quarter	90.00%	95.38%	G	→	
		CPA Employment Status	Month	90.00%	96.85%	G	→	
			Quarter	90.00%	96.59%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.38%	G	→	
			Quarter	99.00%	99.44%	G	→	
		Data completeness - Outcomes	Month	90.00%	93.94%	G	→	
			Quarter	90.00%	93.60%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	77.31%	R	↓	
			Quarter	80.00%	77.62%	R	→	
		Patients Clustered regardless of review dates	Month	96.00%	94.03%	R	→	
			Quarter	96.00%	94.02%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	93.65%	R	↓	
			Quarter	95.00%	95.74%	G	↓	
		Ethnicity coding	Month	90.00%	92.08%	G	↓	
			Quarter	90.00%	92.00%	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%	95.45%	G	→	
			Quarter	95.00%	94.67%	R	↓	
		Community Care Data - Activity Information Completeness	Month	50.00%	94.46%	G	→	
			Quarter	50.00%	94.47%	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%	73.46%	G	↓	
			Quarter	50.00%	73.84%	G	↓	
		Early Interventions New Caseloads	Month	95.00%	143.50%	G	↑	
			Quarter	95.00%	143.50%	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 – MAY 2017

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Schedule 6	Consultant Outpatient Trust Cancellations	Month	5.00%	12.34%	R	→	The most common reason was clinician absent from work.
			Quarter	5.00%	11.96%	R	↓	
		Consultant Outpatient DNAs	Month	15.00%	16.83%	R	↓	
			Quarter	15.00%	15.47%	R	→	
		Under 18 admissions to Adult inpatients	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Outpatient letters sent in 10 working days	Month	90.00%	88.46%	R	→	
			Quarter	90.00%	89.24%	R	↑	
		Outpatient letters sent in 15 working days	Month	95.00%	94.51%	R	→	
			Quarter	95.00%	95.26%	G	↑	
		Inpatient 28 day readmissions	Month	10.00%	6.94%	G	↑	
			Quarter	10.00%	7.22%	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%	97.27%	R	↓	3 discharge faxes were sent outside the target
			Quarter	98.00%	98.68%	G	→	
		Delayed Transfers of Care	Month	0.80%	0.96%	R	→	2 patients on Ward 34 are causing the target to be breached
			Quarter	0.80%	0.80%	G	→	
		18 Week RTT Less Than 18 Weeks - Incomplete	Month	92.00%	95.80%	G	↓	
			Quarter	92.00%	95.67%	G	↓	

OPERATIONAL OVERVIEW – MAY 2017

Enc E

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%	95.80%	G	↓	
			Quarter	92.00%	96.89%	G	↑	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Completion of IAPT Data Outcomes	Month	90.00%	97.39%	G	↑	
			Quarter	90.00%	96.78%	G	→	
		Ethnicity coding	Month	90.00%	92.65%	G	→	
			Quarter	90.00%	92.76%	G	→	
		NHS Number	Month	99.00%	100.00%	G	→	
			Quarter	99.00%	100.00%	G	→	
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	100.85%	G	→	Compliant with Health Visiting Targets
			Quarter	98.00%	100.63%	G	↑	
		% 6-8 Week Breastfeeding coverage	Month	98.00%	99.10%	G	→	
			Quarter	98.00%	99.18%	G	→	
	IAPT	Recovery Rates	Month	50.00%	52.19%	G	↓	Compliant with IAPT Targets
			Quarter	50.00%	53.80%	G	→	
		Reliable Improvement Rates	Month	65.00%	69.28%	G	↓	
			Quarter	65.00%	70.85%	G	↑	
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	100.00%	99.3%	G	→	Detailed ward level information shows specific variances
			Quarter	100.00%	99.4%	G	↑	

WORKFORCE OVERVIEW – May 2017

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**May-17**	10%	**10.59%**	↗	G	↓	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 13.03% (as at March 2017 latest available data). The monthly sickness absence rate is 0.85% higher than the previous month, however compared to the same period last year (May 2016) it is 0.02% lower. The annual sickness absence rate is running at 5.53% (as at April 2017 latest available data). The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.20% (as at February 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 28.98% of all sickness absence, followed by surgery at 19.74% and other musculoskeletal problems at 8.28%. The Funded Fte vacancy rate has increased slightly by 0.39% to 8.43%. The number of employees who have received an appraisal within the last 12 months has decreased slightly by 0.09% to 74.62%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £57k. Compulsory training compliance has decreased slightly by 0.44% to 87.73% but remains above the 85% main contract non CQUIN.
			Apr-17		10.16%		G		
		Sickness Absence (monthly)	**May-17**	5.04%	**5.30%**	↗	R	↓	
			Apr-17		4.45%		G		
		Sickness Absence (annual)	**Apr-17**	5.04%	**5.53%**	↘	R	↓	
			Mar-17		5.54%		R		
		Vacancies (including funded fte flexibility / cover)	**May-17**		**8.43%**	↗			
			Apr-17		8.04%				
		Appraisals (**all staff** - number of employees who have received an appraisal in the previous 12 months)	**May-17**	90%	**74.62%**	↘	R	↓	
			Apr-17		74.71%		R		
		Appraisals (**agenda for change staff only** - number of employees who have received an appraisal in the previous 12 months)	**May-17**	90%	**74.13%**	↘	R	↓	
			Apr-17		74.83%		R		
		Appraisals (**medical staff only** - number of employees who have received an appraisal in the previous 12 months)	**May-17**	90%	**85.29%**	↗	A	↑	
			Apr-17		81.37%		A		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**May-17**	£0	**£0.707m**	↗	R		
			Apr-17		£0.352m		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**May-17**	0%	**8.83%**	↗	R		
			Apr-17		0.51%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**May-17**	90%	**87.73%**	↘	A	↓	
			Apr-17		88.17%		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%)

QUALITY OVERVIEW – MAY 2017

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Safe	No of incidents of moderate to catastrophic actual harm	Month	29	38			Plan: average last fin yr 2016/17 (month).
			Quarter	88	102			Plan: average last fin yr (Qtr) 2016/17. Actual: 2016/17 Q4 data
		No of deaths of patients who have died within 12 months of their last contact with DHcFT	Month	104	114			
			Quarter	312	458			Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data. *Alert as data for Qtr not complete*
		No of serious incidents reported to the CCG	Month	5	14			Plan - average last fin yr (month)
			Quarter	16	10			Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data
		No of episodes of patients held in seclusion	Month	10	22			
			Quarter	30	21			Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data
		No of incidents involving patients held in seclusion	Month	16	13			
			Quarter	47	39			Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data
		No of incidents involving physical restraint	Month	48	54			
			Quarter	143	170			Plan: average last fin yr (Qtr). Actual: 2016/17 Q4 data
		No of incidents involving prone restraint	Month	10	13			Month plan based on average from 1/7/16 when prone restraint collected on Datix as defined field
			Quarter	29	46			Qtr plan based on average for Q2/Q3/Q4. Actual 2016/17 Q4 data
		No of incidents of physical assault - patient on patient	Month	12	14			
			Quarter	37	31			Actual: 2016/17 Q4 data
		No of incidents of physical assault - patient on staff	Month	19	20			
			Quarter	56	42			Actual: 2016/17 Q4 data

QUALITY OVERVIEW – MAY 2017

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Safe	No of falls on in-patient wards	Month	32	32			
			Quarter	96	94			Actual: 2016/17 Q4 data
		No of incidents of absconsion	Month	33	30			
			Quarter	99	120			Actual: 2016/17 Q4 data
		No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	77.00%			
			Quarter	100%	77.77%			
		Of above, no of patients with a Safety Plan	Month	90%	21.30%			Safety Plan replaced FACE from 1/4/2017
			Quarter	90%	7.90%			
		% of staff compliant with Level 3 Safeguarding Children training	Month	85%	80.37%			
			Quarter	85%	NA			Qtr comparison not available
		% of staff compliant with Think Family training	Month	85%	82.60%			
			Quarter	85%	NA			Qtr comparison not available
		% of staff compliant with Clinical Safety Planning eLearning	Month	95%	95.12%			
			Quarter	95%	NA			Qtr comparison not available
		No of people with LD or Autism admitted without a CTR (Care & Treatment Review)	Month	0	NA			Concern re data quality . More robust systems to ensure data quality being worked up imminently with Commissioners.
			Quarter	0	NA			
		% of compliance with inpatients VTE assessment	Month	95%	9.02%			
			Quarter	95%	NA			
		HCR20 assessment completed, Low Secure	Month	100%	16.6%			Indicator relates to no of patients with HCR20 assessment completed in time. All assessments now completed, but these were not within the timescale. Variance shown as amber, if a breach occurs going forward, the variance will return to red.
			Quarter	100%	NA			

QUALITY OVERVIEW – MAY 2017

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Caring	No of complaints opened for investigation	Month	12	9			
			Quarter	37	43			Actual: 2016/17 Q4 data
		No of concerns received	Month	35	31			
			Quarter	104	84			
		No of compliments received	Month	100	76			
			Quarter	300	236			
		No of investigations by the Parliamentary Ombudsman	2016/17	NA	0			Data is provided cumulatively from 1st April each year
			2017/18	NA	0			
		% of complaints upheld (full or in part) by the Parliamentary Ombudsman	2016/17	2	0			1 ongoing and 5 no further action
			2017/18	0	0			
		% of responded to (orange) complaint investigations completed within 40 working days, opened after 01/04/2016	Year	100%	19%			As at 26/05/2017, 174 (orange) complaints. 83 not responded to within 40 working days. 57 ongoing
			Year	100%	0%			As at 26/05/2017, 7 (red) complaints. 4 not responded to within 60 working days. 3 ongoing.
		No of incidents requiring Duty of Candour	Month	1	5			These figures will fluctuate based on the outcome of investigations.
			Quarter	2	2			
	Effective	% of in-patients with a recorded capacity assessment	Month	100%	90.19%			
			Quarter	100%	91.00%			
		% of patients who have had their care plan reviewed and have been on CPA > 12months	Month	90%	95.25%			
			Quarter	90%	95.95%			
		No of seclusion forms not received by MHA Office	Month	0	8			Seclusion pathway being moved to PARIS. From June 18
			Quarter	0	2			Actual: 2016/17 Q4 data
		% of CTO rights forms received by MHA Office	Month	100%	97.0%			
			Quarter	NA	NA	NA	NA	
		% of in patient older adults rights forms received by MHA Office	Month	100%	91.5%			
			Quarter	NA	NA	NA	NA	

QUALITY OVERVIEW – MAY 2017

Enc E

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Responsive	% of staff uptake of Flu Jabs	Month	45%	NA			Data to end of 30/11/16
			Year	45%	38.40%			Relates to 2016 campaign. Final data as shown in 16/17 Quality Account
		% of policies in date	Month	95%	94.14%			As at 07/06/2017
			Quarter	NA	NA	NA	NA	
	Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	100%	57.47%			% target increased to 100% to be in line with overall reporting
			Quarter	100%	NA	NA	NA	
		% of staff who have received Management Supervision, within defined timescales	Month	100%	67.90%			% target increased to 100% to be in line with overall reporting
			Quarter	100%	NA	NA	NA	
		No of outstanding actions following serious incident investigations	Month	0	30			Total overdue actions as at 31/05/2017
			Quarter	0	NA		NA	
		No of outstanding actions following complaint investigations	Month	0	56			Total overdue actions as at 31/05/2017
			Quarter	0	NA	NA	NA	
		No of outstanding actions following CQC comprehensive review report	Month	0	64			Figure as at 02/06/2017

Financial Section

Governance – Use of Resources (UoR) Rating

Enc E

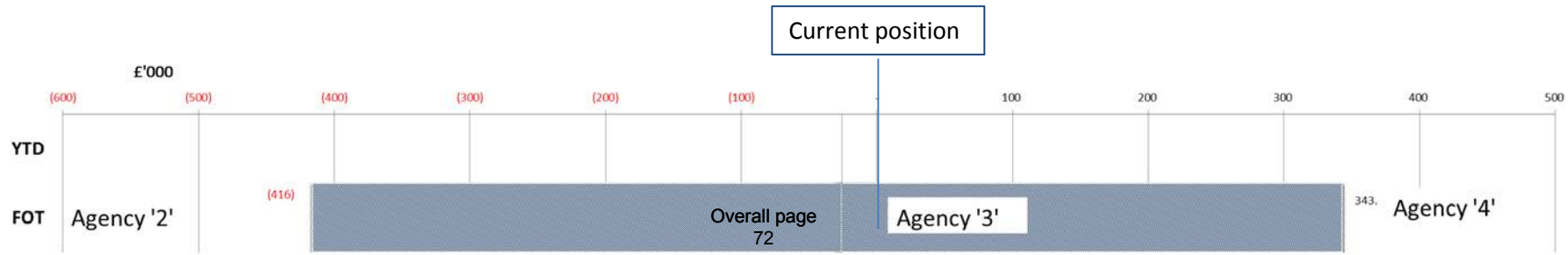
The Use of Resources rating at the end of May is a '1', with only the Capital Service Cover metric being at a '2'. The forecast rating is an overall '2' with the agency metric moving to a 3'.

The I&E Margin distance from plan starts to move from a '1' to a '2' at the end of quarter 1. This is because the actual I&E margin (2.3%) is -0.12% different to the planned I&E margin (2.4%). This is mainly driven by a lower forecast surplus and income being forecast higher than the plan due to the forecast assumptions for QIPP (in the forecast QIPP income has not been removed from the contract).

	YTD May 17		YTD @ Quarter 1		YTD @ Quarter 2		YTD @Quarter 3		YTD @ Quarter 4	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Capital Service Capacity rating	2	2	2	2	2	2	2	2	2	2
Liquidity rating	1	1	1	1	1	1	1	1	1	1
I&E Margin rating	1	1	1	1	1	1	1	1	1	1
Distance from Financial Plan	1	1	1	2	1	2	1	2	1	2
Agency distance from Cap	1	1	1	2	1	2	1	3	1	3
UoR	1	1	1	2	1	2	1	2	1	2
4 on any metric	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger	No Trigger
UoR	1	1	1	2	1	2	1	2	1	2

As most of the metrics are in a healthy position and it is the agency metric that is driving the lower rating in the forecast, this is the area of focus from a headroom perspective.

The agency metric is currently forecast at a '3' for the end of the financial year. In order to reduce that metric down to a '2' by the end of March then we need to reduce agency expenditure by £416k. However if we spend an additional £343k above the current forecasted levels then this would move the metric to a 4 and trigger an override.



Income and Expenditure

Statement of Comprehensive Income — May 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	10,379	10,675	296	20,758	21,214	457	124,378	127,793	3,415
Non Clinical Income	792	974	182	1,584	1,762	178	9,822	10,375	554
Employee Expenses	(7,947)	(8,205)	(258)	(15,915)	(16,366)	(451)	(95,932)	(99,029)	(3,097)
Non Pay	(2,325)	(2,554)	(228)	(4,698)	(4,913)	(215)	(28,108)	(29,053)	(944)
EBITDA	**898**	**890**	**(8)**	**1,728**	**1,697**	**(31)**	**10,159**	**10,087**	**(73)**
Depreciation	(278)	(273)	6	(556)	(543)	14	(3,338)	(3,318)	21
Impairment	0	0	0	0	0	0	(300)	(300)	0
Profit (loss) on asset disposals	0	0	0	0	0	0	0	0	0
Interest/Financing	(176)	(180)	(4)	(390)	(361)	30	(2,146)	(2,120)	26
Dividend	(159)	(157)	2	(318)	(314)	4	(1,910)	(1,884)	26
Net Surplus / (Deficit)	**285**	**281**	**(4)**	**463**	**480**	**17**	**2,465**	**2,465**	**0**
Technical adjustment - Impairment	0	0	0	0	0	0	(300)	(300)	0
Control Total Surplus / (Deficit)	**285**	**281**	**(4)**	**463**	**480**	**17**	**2,765**	**2,765**	**0**
Technical adjustment - STF Allocation	40	40	0	79	79	0	794	794	0
Underlying Net Surplus / (Deficit)	**246**	**241**	**(4)**	**384**	**401**	**17**	**1,971**	**1,971**	**0**

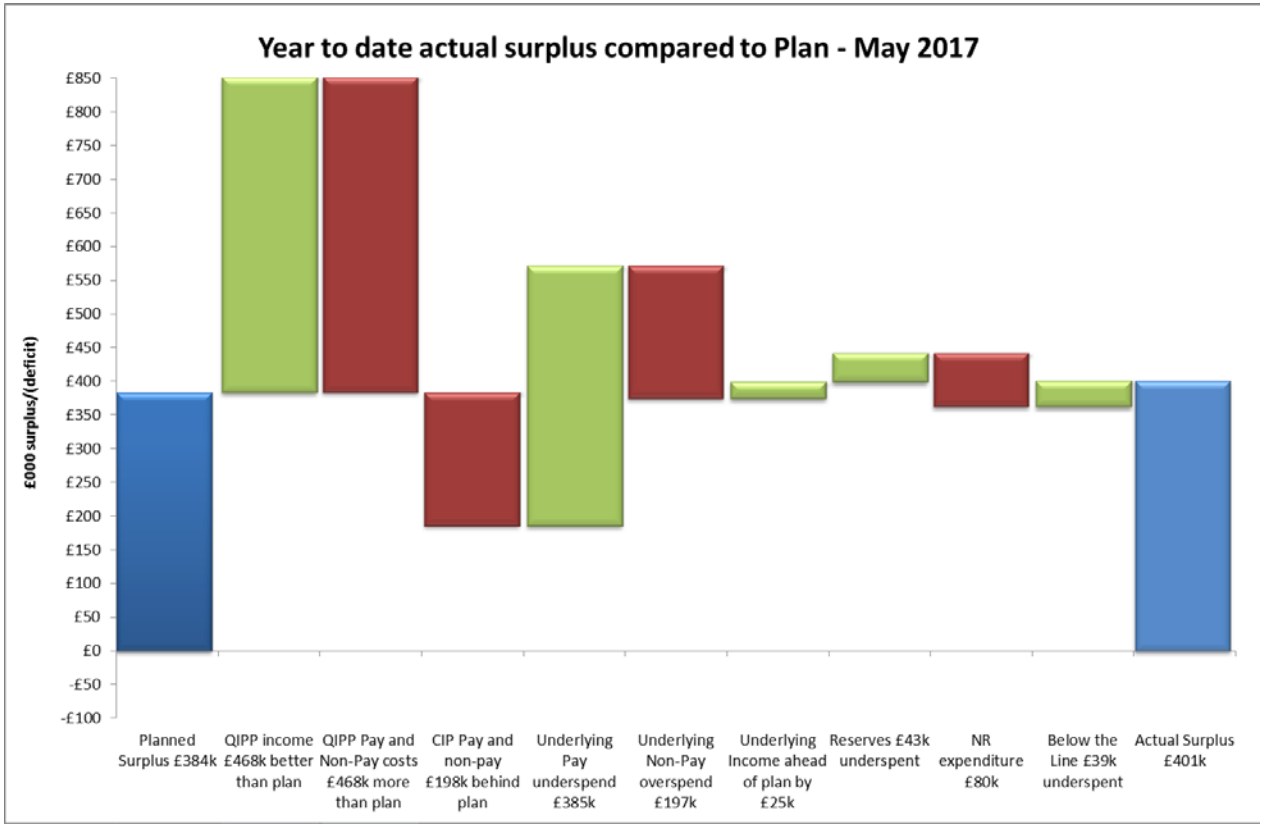
The Statement of Comprehensive Income shows both the control total surplus of £2.77m which includes the Sustainability Transformation Fund (STF) income and the underlying surplus / (deficit) against the underlying plan with the STF income excluded £1.97m.

Clinical Income is £457k more than plan year to date and at the end of the year is forecast to be £3.4m ahead of plan. This is mainly due to the income related to QIPP disinvestments not being removed from the contract as currently no further disinvestments have been identified (offsetting expenditure).

Non Clinical income is ahead of plan year to date by £178k and has a forecast outturn of £554k ahead of plan. This mainly relates to secondments (with corresponding expenditure) along with Education and Training income being higher than planned.

Pay expenditure is £258k more than the plan in the month and forecast £3.1m more than plan. This relates to costs not yet being released relating to QIPP disinvestments (offsetting income) and CIP forecast to be delivered in a different way to the plan.

Non Pay is underspent in the month by £228k but is forecast to be £944k more than plan at the end of the year which mainly relates to the overspend on the Acute Out of Area budget partly offset by other underspends.



Summary of key points for YTD variances

Eric L

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

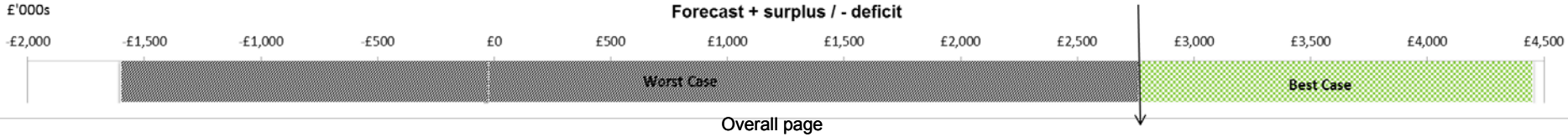
- QIPP income is more than plan which is equally offset by pay and non-pay expenditure being more than plan . This is due to the disinvestment not yet being fully agreed with Commissioners.
- CIP is currently behind plan in the month.
- Underlying pay underspends (exc. QIPP/CIP) due to various vacancies across the Trust, partially offset by bank and agency expenditure.
- Underlying non-pay overspend (exc. QIPP/CIP) driven by out of area expenditure higher than plan.
- Non-recurrent expenditure related to some temporary posts along with non-recurrent transaction costs.

Forecast Range

Best Case	Likely Case	Worst Case
£4.4m surplus	£2.7m surplus	£1.6m deficit

Forecast Range

The main variables in the forecast range are: STF income loss, agency expenditure, CPC income and other unexpected pay and non-pay costs.



Normalised Income and Expenditure position

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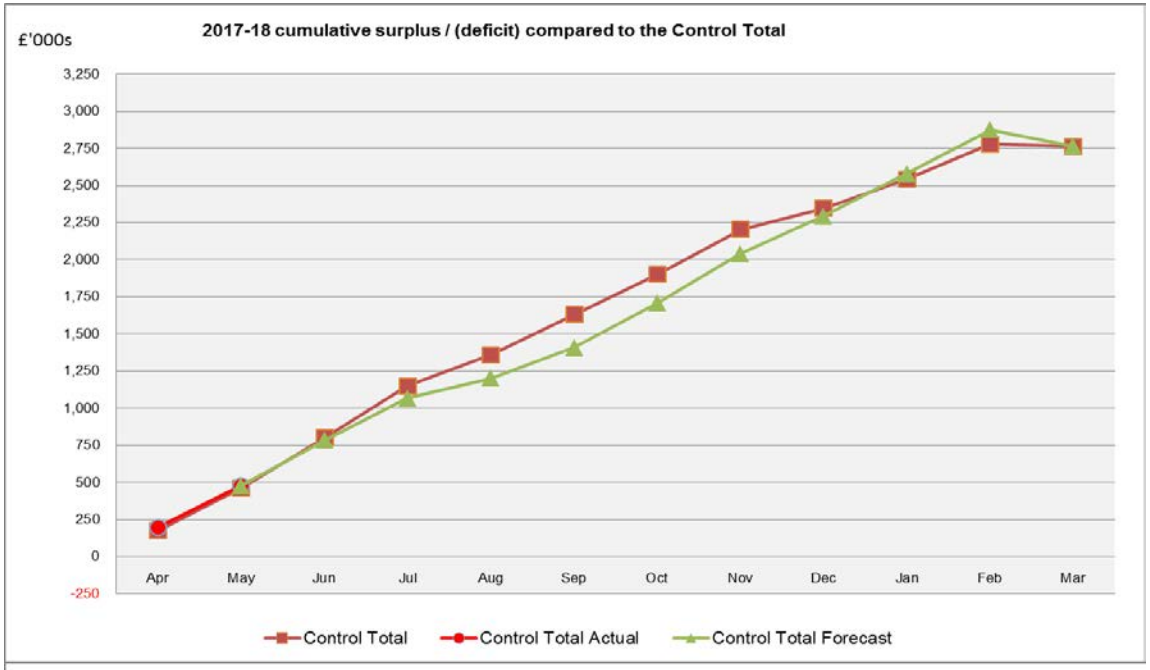
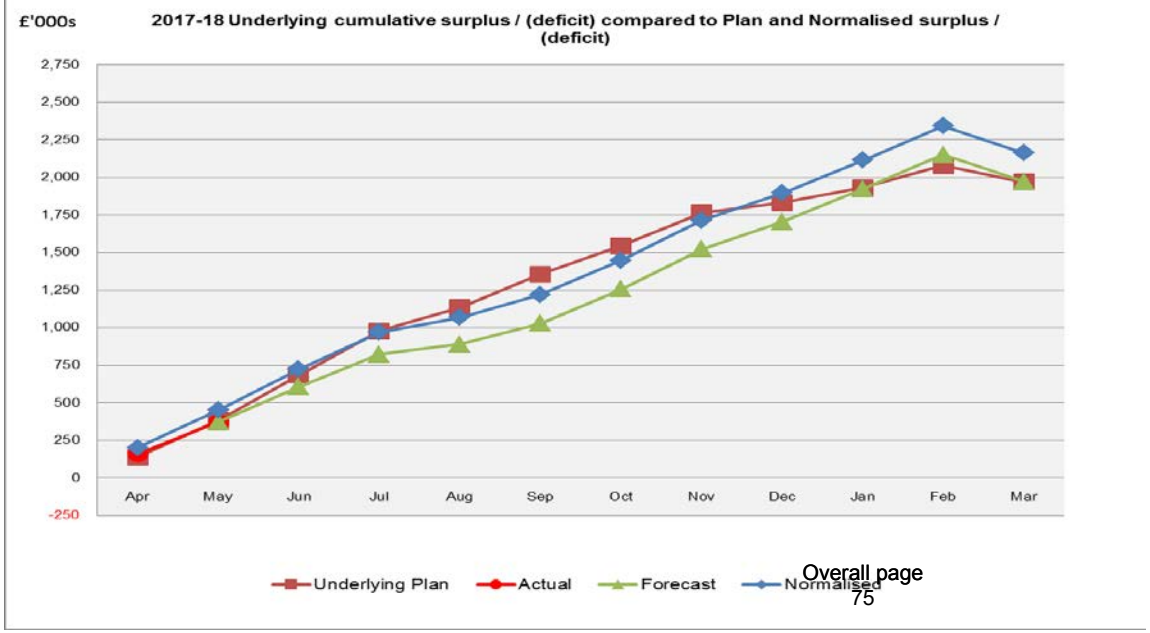


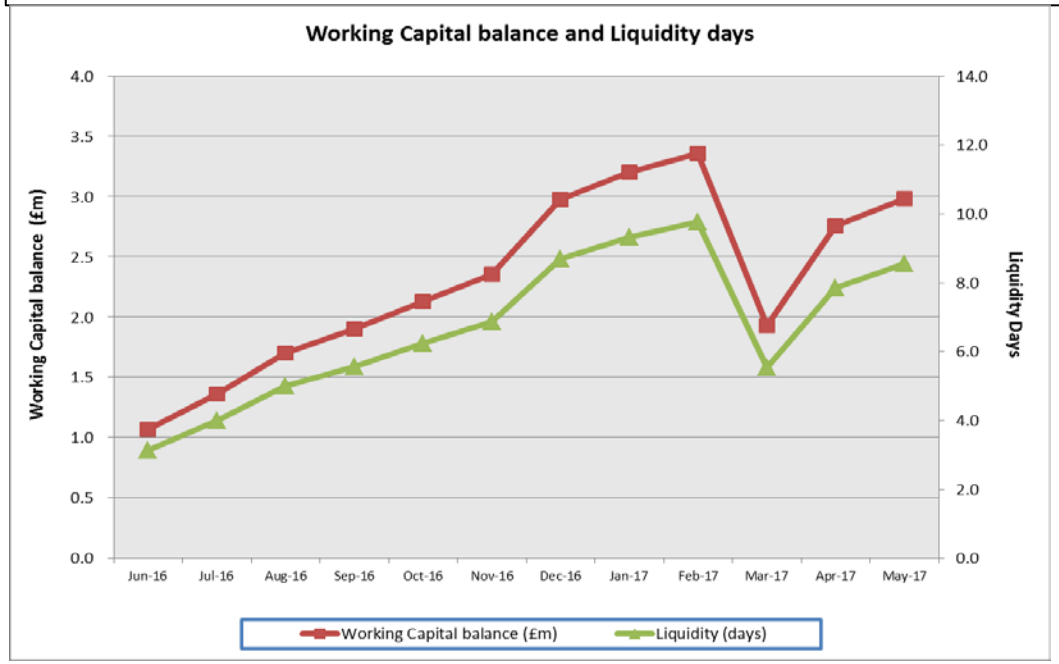


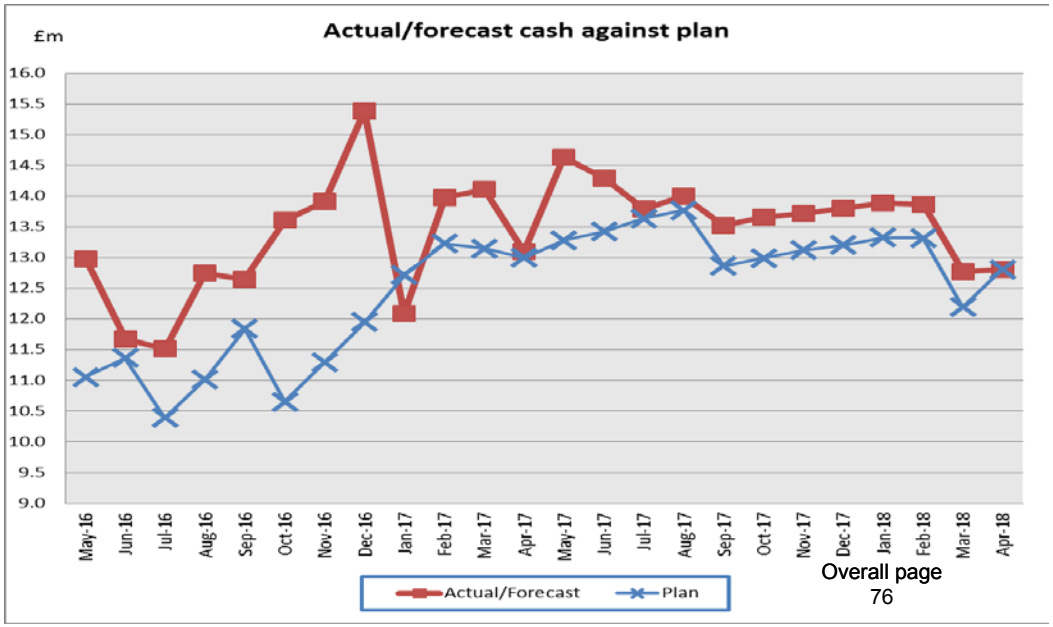
The first graph shows the actual cumulative surplus against the control total (including the Sustainability Transformation Fund (STF).
The second graph shows the underlying actual surplus against the underlying plan excluding the STF.

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 expenditure in the position related to temporary staff posts for part of the financial year, along with non-recurrent transaction costs. In the normalised position these have been removed.
As shown in the graph if these non-recurrent costs were not incurred then the forecast outturn would be higher than the plan.

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 the last 12 months working capital and liquidity continues to improve due to higher cash levels. The downturn in March is reflective of the increase in year end transactions such as provisions, along with an increase in payables mainly related to capital as works have concluded at the end of March.
The liquidity at May is just over 8 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 +19 days, therefore our liquidity must remain a strategic priority for us to continue to improve and protect.

Cash is currently at £14.6m which is £0.9m better than the plan at the end of May and is forecast to be above plan by £0.6m. This is mainly due to the additional STF income related to 2016/17

Capital Expenditure

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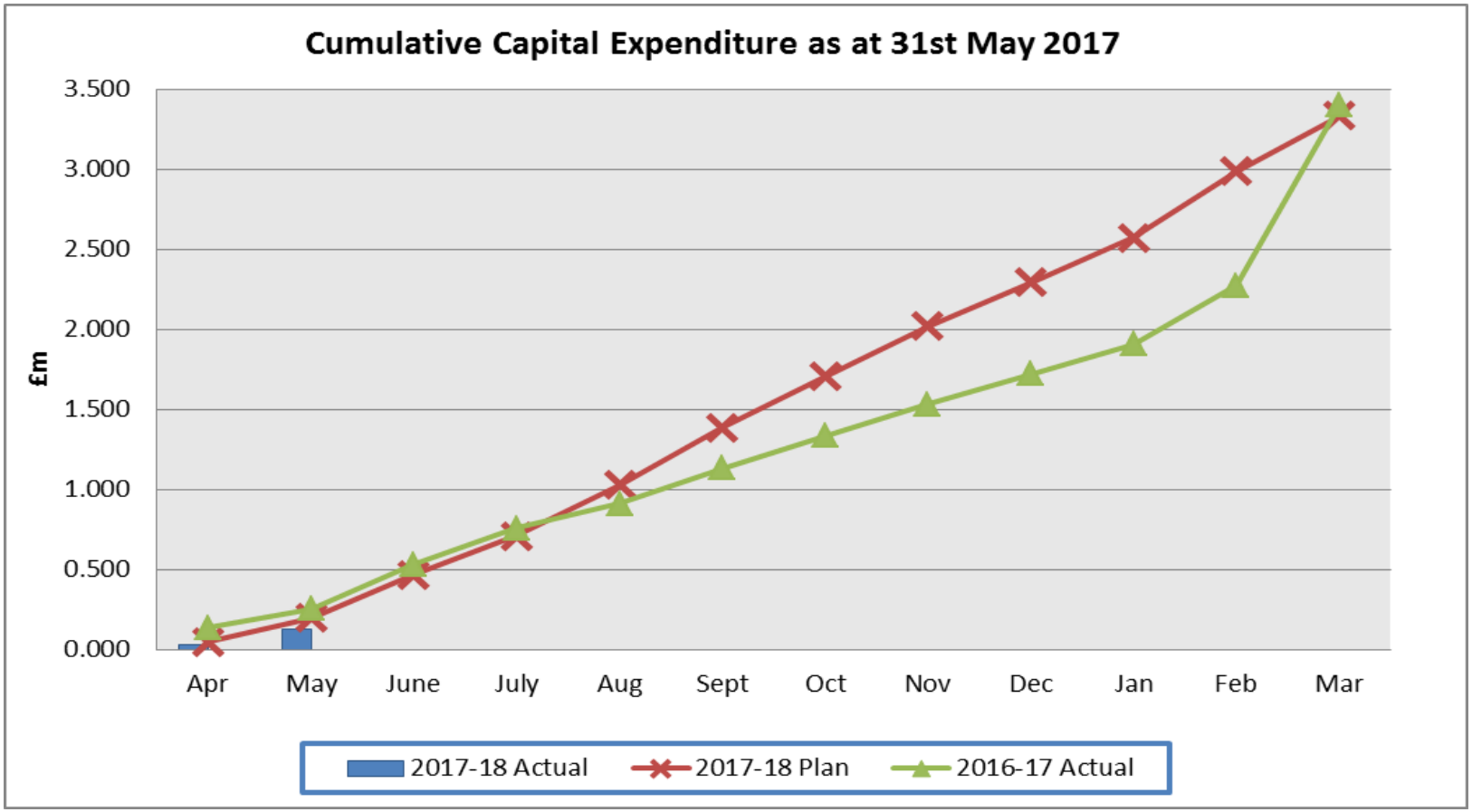
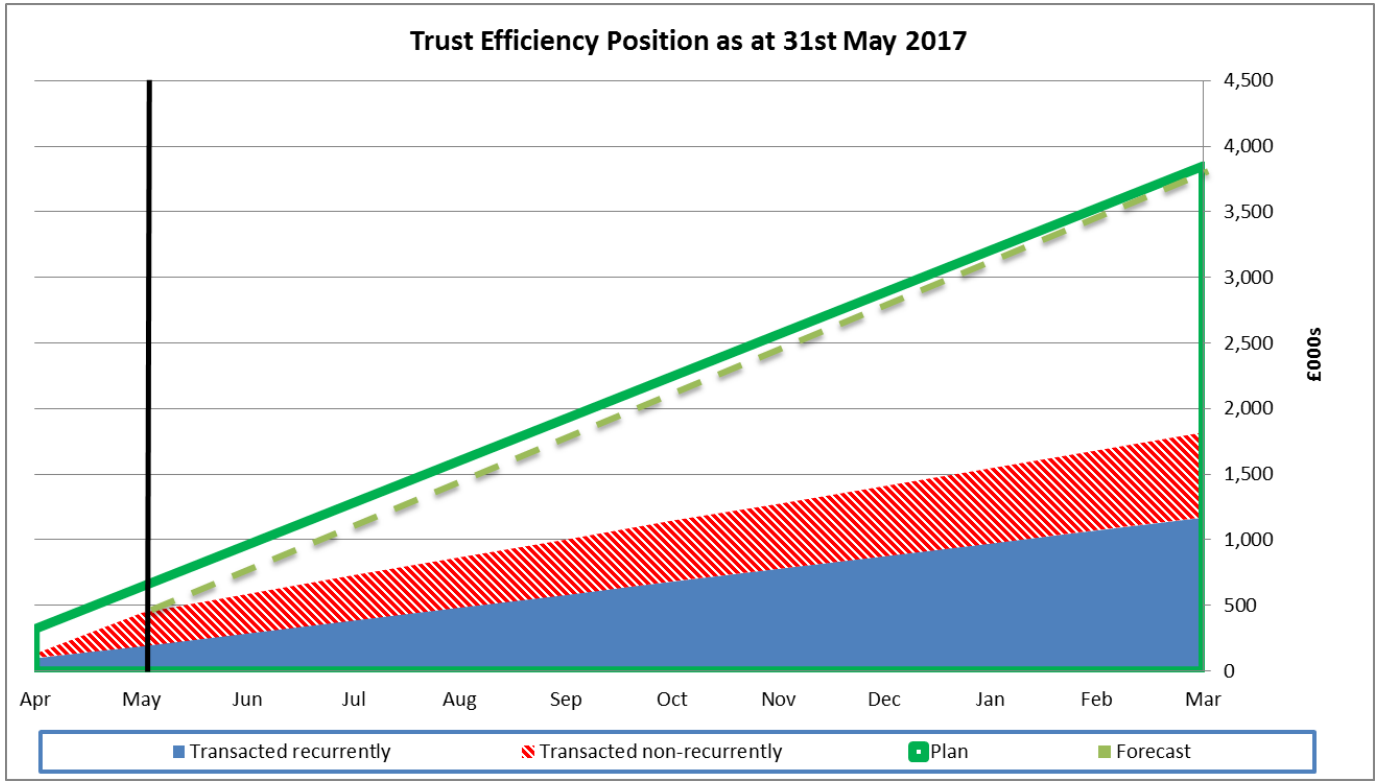


Capital Expenditure is behind plan by £89k at the end of May. There is a fully committed plan which may need to be re-prioritised in year to take into account any urgent bids that arise, which will be monitored by the Capital Action Team.

Additional STF income which was notified to us in 2016/17 and will be paid in this financial year is expected to be added to the capital plan. This could be invested in schemes that will drive further efficiencies across the Trust.

Cost Improvement Programme (CIP)

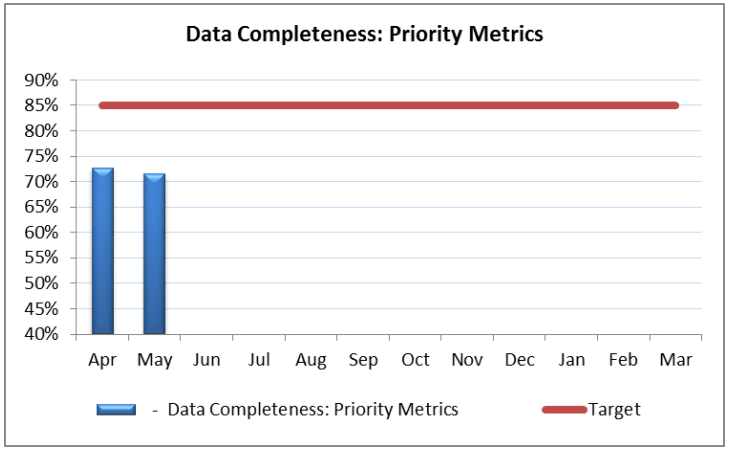


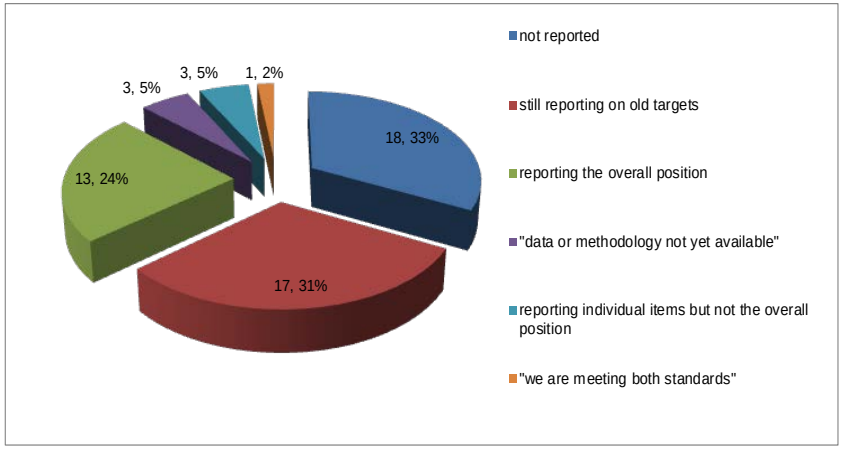
At the end of May there was £1.8m of assured CIP against a plan of £3.8m, which left a gap of £2m. Of this £1.8m assured CIP, £0.65m was assured non-recurrently. In order to achieve the control total the full CIP target needs to be achieved.

Trust Management Team and Executive Leadership Team 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

Data Completeness: Priority Metrics





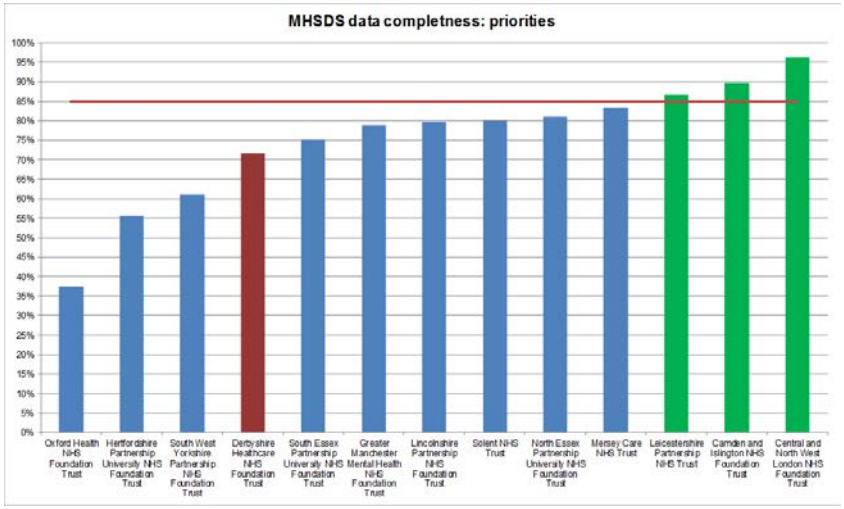
As previously reported, the performance dashboard was amended on 1st December 2016 to reflect the NHS Improvement Single Oversight Framework targets which came into force from 1st October 2016. The national requirement is to achieve the priority metrics target of 85%. Achieving this target will be extremely challenging without additional resource. There are currently 14,659 bits of additional patient information that need sourcing and inputting into the patient records concerned, which is an increase of 520 since last month. It is acknowledged there are capacity issues.

The national picture:

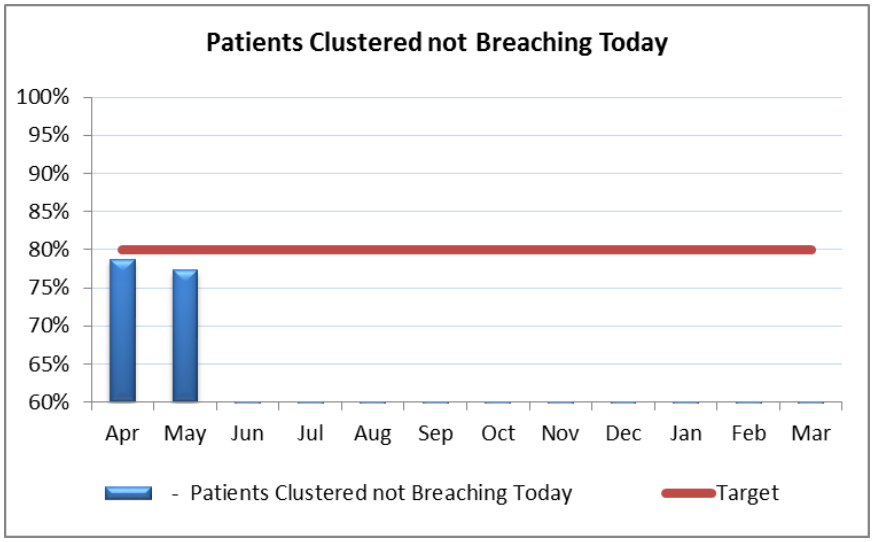
- Less than a quarter of Trusts in the country publish their position against this target, of which only 3 are exceeding the target threshold.
- Almost a third of Trusts are still reporting on the old MHMDS targets.

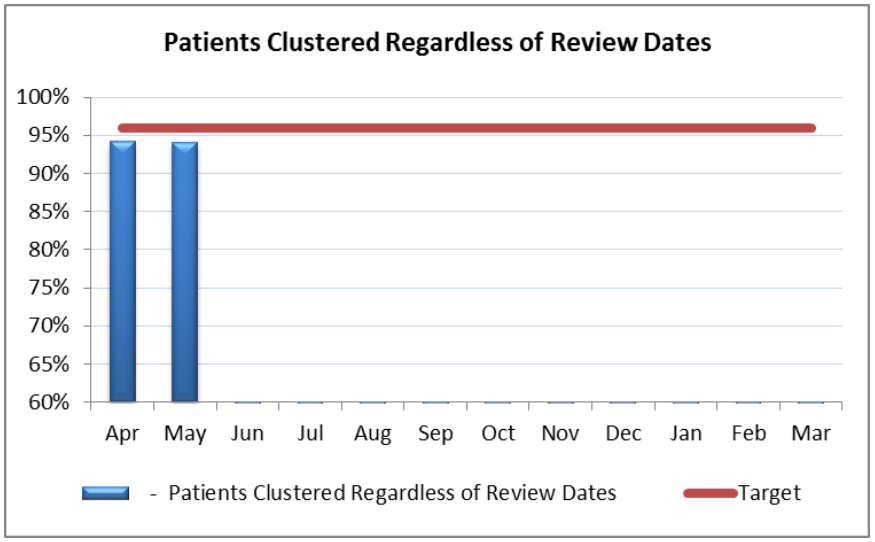
Actions:

Further more detailed discussion to take place between the respective MHSDS experts within our Trust and Central & North West London NHS Foundation Trust to establish whether there are any technical differences in our reporting methodologies which might explain the performance difference.



Patients Clustered not Breaching Today and Patients Clustered regardless of review dates



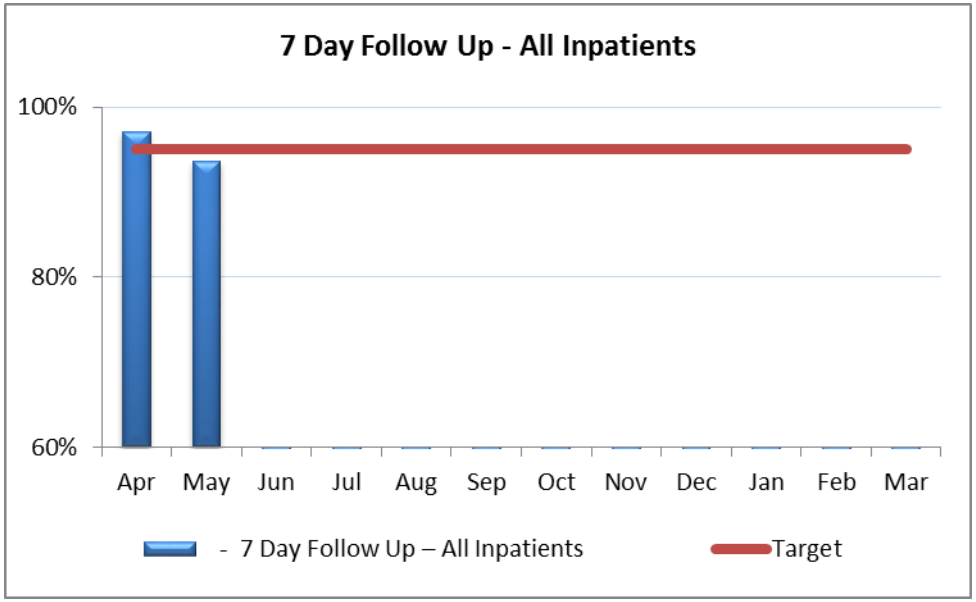


A paper was presented to the F&P Committee on the 22nd May. Standards need to be raised due to the importance of care clustering locally and nationally.

The following recommendations to be made into an action plan to be submitted to the next F&P 24th July:

- Staff should be encouraged to undertake training (with a particular focus on individual or teams where performance is weakest)
- Supervision - caseloads should be reviewed to include cluster information
- Audit/review to be undertaken focusing on anomalous clustering and red rules deviation
- Work to develop the integration of clusters into care pathways to be expedited
- The current two targets to be augmented by the schedule of 17 quality indicators approved by the Quality Committee

7 Day Follow-up - all inpatients

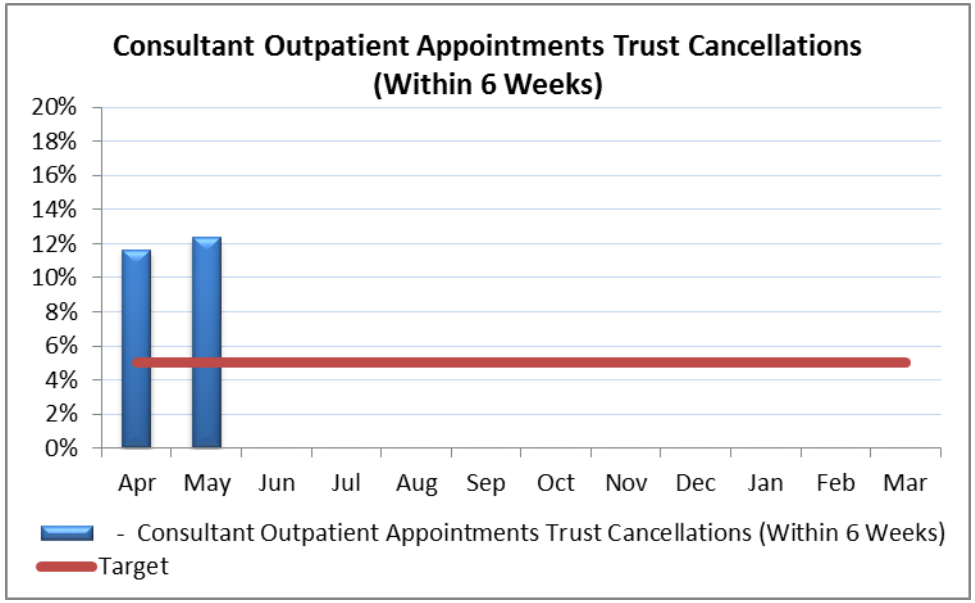


This locally agreed target was missed by 1 follow-up. Every effort is made to follow-up all discharged patients, but on occasion patients refuse to engage with services. An exception report is completed whenever a patient is not followed up In addition, if a patient is on CPA, has a history of self harm and/or has a medium to high suicide risk, it will be reported on Datix as a near miss incident. This enables us to establish whether any lessons could be learnt or improvements made to processes in order to minimise future breaches. Of the 6 patients not followed up within 7 days:

- Successful contact was made with 4 patients within 2 weeks of discharge
- 1 patient was readmitted before contact had been made
- 1 patient – numerous attempts to make contact but to date has been unsuccessful. Reported on Datix.

Action: Summary of each breach to be provided to commissioners. Quarterly review of breaches at Campus Assurance Meetings

Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)



The majority of cancellations were owing to clinician absence, staffing issues and having no consultant.

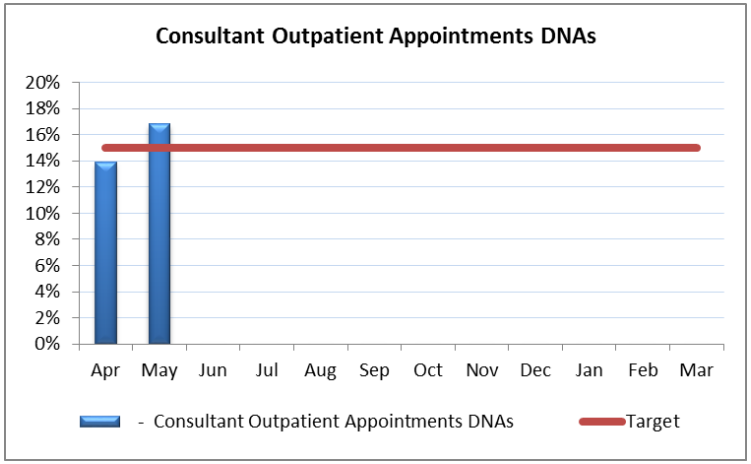
The number of appointments cancelled for annual leave was also high.

Actions:

- recruitment to vacant consultant posts is progressing slowly
- Review of annual leave cancellations to ensure patients are not being inconvenienced

Att Type	n	%
Clinician Absent From Work	331	30%
Moved - Staff Issue	157	14%
No Consultant	148	13%
Moved - Clinic Cancelled	127	11%
Clinician On Annual Leave	110	10%
Moved - Trust Rescheduled	99	9%
Moved - Location Issue	61	5%
Clinic Booked In Error	40	4%
Clinician Must Attend Meeting	14	1%
Clinician Must Attend Tribunal	8	0.7%
Paris System Issue	7	0.6%
Clinician on call/ night duty	5	0.4%
Clinician Must Attend Training	4	0.4%
MHA Assessment Urgent Work	1	0.1%
Grand Total	1112	100%

Consultant Outpatient DNAs

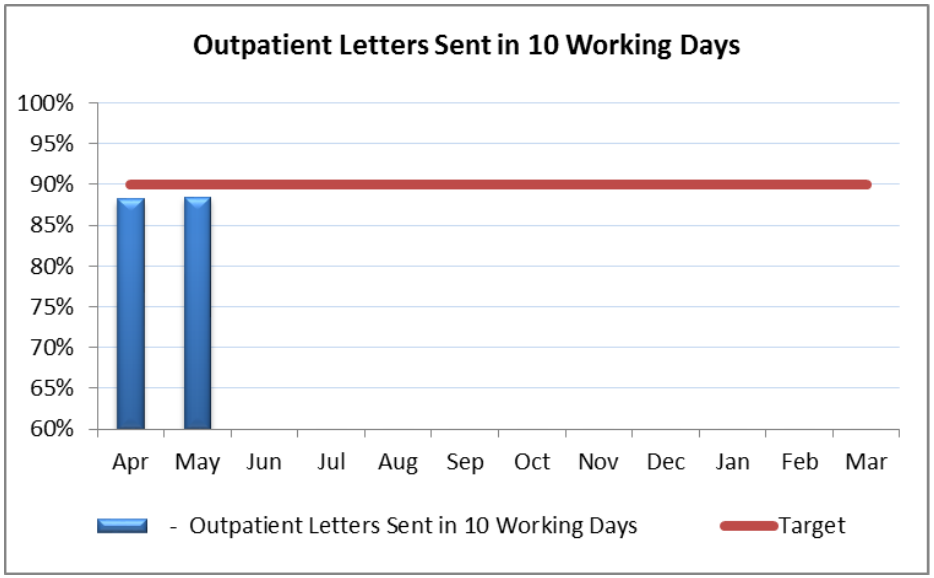


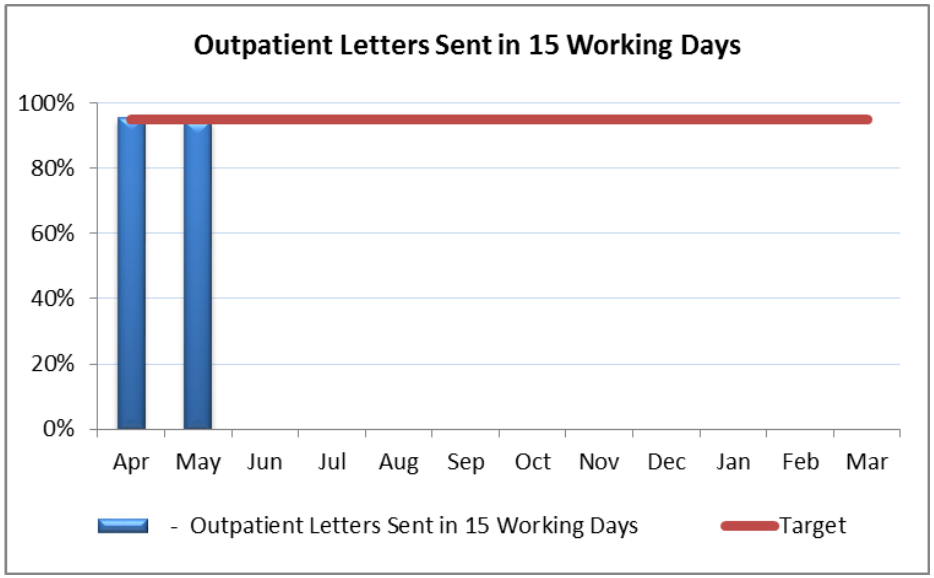
Despite the trust sending text message appointment reminders, the number of patients who did not attend scheduled outpatient appointments in May was high.

The most recent national data – quarter 4 2016/17:

Org Name	Total outpatient appts	DNA rate
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	4,681	23%
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	47	21%
LANCASHIRE CARE NHS FOUNDATION TRUST	6,917	21%
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	4,129	20%
BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	8,594	19%
PENNINE CARE NHS FOUNDATION TRUST	8,660	18%
SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	5,176	17%
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	2,788	16%
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	29,835	16%
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	11,272	15%
DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	9,498	15%
SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	3,736	15%
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	5,325	15%
NORTH EAST LONDON NHS FOUNDATION TRUST	9,811	15%
LEICESTERSHIRE PARTNERSHIP NHS TRUST	869	14%
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	3,717	12%
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	2,411	12%
WORCESTERSHIRE HEALTH AND CARE NHS TRUST	8,731	12%
OXLEAS NHS FOUNDATION TRUST	868	12%
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	1,365	11%
SOLENT NHS TRUST	6,182	10%
STAFFORDSHIRE AND STOKE ON TRENT PARTNERSHIP NHS TRUST	6,790	9%
CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	1,532	9%
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	1,498	9%
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	1,004	8%
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	3,277	8%
SOUTHERN HEALTH NHS FOUNDATION TRUST	8,912	8%
HUMBER NHS FOUNDATION TRUST	1,409	7%
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	888	7%
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	400	6%
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	548	0%
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	272	0%
EAST LONDON NHS FOUNDATION TRUST	2,666	0%
NAVIGO	-	-
WEST LONDON MENTAL HEALTH NHS TRUST	-	-
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	-	-

Outpatient letters sent in 10 & 15 working days

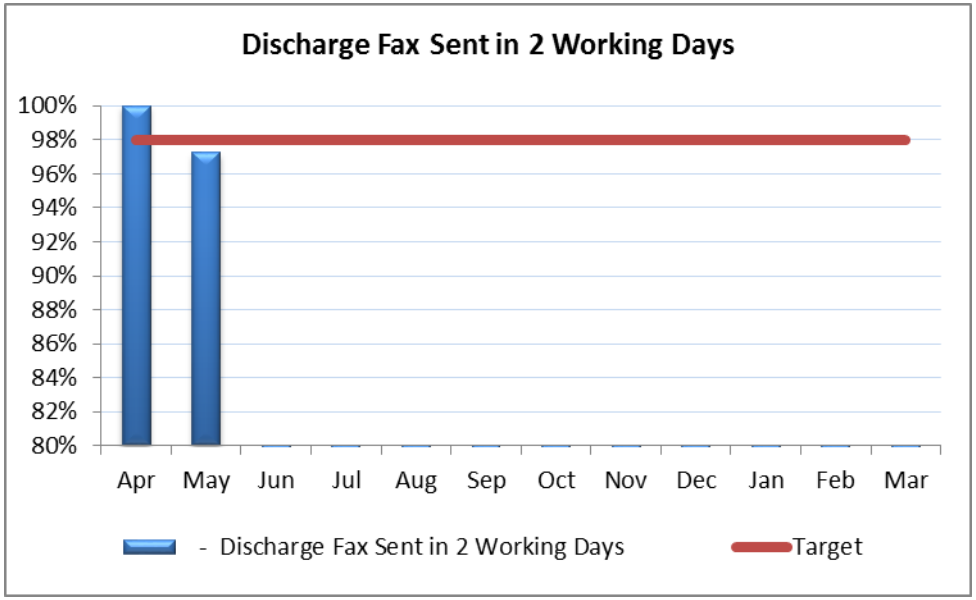




An action plan was devised and implemented towards the end of May which should start to have a positive impact on turnaround times. A summary of the action being taken is as follows:

- Support Consultants and Junior Doctors to ensure that letters have been dictated following outpatient appointments.
- Timely transcription of Letters on DictateIT
- To include Associate Clinical Directors in any escalation communications re late/delayed uploads
- Swift resolution of any queries which prevent transcription
- Prioritisation of letters awaiting transcription on DictateIT
- Support Consultants and Junior Doctors to ensure that letters are e-signed following typing

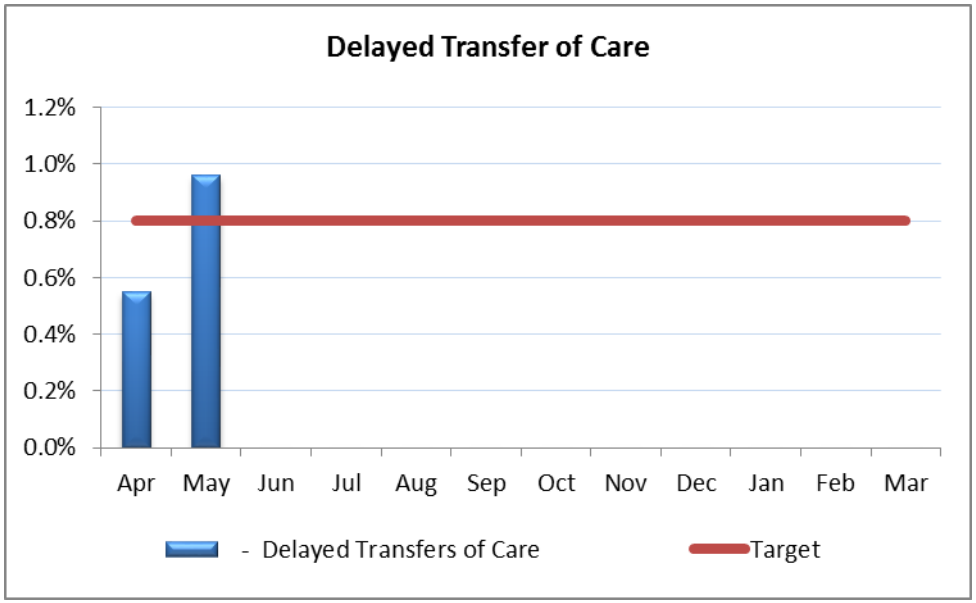
Discharge Fax sent in 2 working days



All but 3 discharge correspondences to GPs were sent within 2 working days.

The 3 minor delays were attributed to ward administrator illness. These were sent on day 3, 4 and 6.

Delayed Transfers of Care

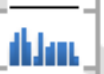


There are currently 2 patients, on ward 34, who are ready for discharge but whose discharge is being delayed. One delay is attributed to social care: awaiting provision of emergency accommodation; the other is attributed to both health and social care: awaiting funding and placement.

Campus Division Performance Dashboard 2017/18 Month 2

Enc E

Quality, Safety and Experience

Indicator	Period	Target	Actual	RAG	Previous months
CPA 7 day follow-up	Monthly	95%	98%	G	
Delayed transfers of care	Monthly	0.8%	1.0%	R	
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	4	N/A	
Crisis gatekeeping	Monthly	95%	100%	G	
Mixed sex accommodation breaches	Monthly	0	0	G	
Under 16 admissions to adult facilities	Monthly	0	0	G	
New complaints opened for investigation	Monthly	<=4	1	G	
New concerns	Monthly	<=7	6	G	
Complaints upheld/partially upheld	Monthly	<=2	1	G	
Compliments	Monthly	>=40	36	R	
Friends and Family Test % positive	Monthly	89%	87%	R	
Complaint response breaches (final response sent >60 working days)	Monthly	0	2	R	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
Hartington Unit bed occupancy – including leave	Monthly	85%	96%	R	
Hartington Unit bed occupancy – excluding leave	Monthly	85%	82%	G	
Hartington Unit length of stay	Monthly	36	57	R	
Radbourne Unit bed occupancy – including leave	Monthly	85%	102%	R	
Radbourne Unit bed occupancy – excluding leave	Monthly	85%	91%	R	
Radbourne Unit length of stay	Monthly	36	56	R	
Kingsway bed occupancy – including leave	Monthly	85%	73%	G	
Kingsway bed occupancy – excluding leave	Monthly	85%	68%	G	
Activity against contract – inpatient rehab.	Monthly	95%	70%	R	

People

Indicator	Period	Target	Actual	RAG	Previous months
Vacancy rate	Monthly	10%	7.0%	G	
Turnover	Monthly	10%	12.2%	R	
Sickness – in month	Monthly	5%	5.5%	R	
Annual appraisals	Monthly	90%	76.3%	R	
Mandatory training	Monthly	85%	88.4%	G	
Agency staff use	Monthly	1.9%	0.64%	G	
Bank staff use	Monthly	5%	12.7%	R	
Clinical supervision	Yearly	100%	41%	R	
Managerial supervision	Yearly	100%	49%	R	

Pulse Check

Indicator	Period	Target	Actual	RAG	Previous months
Kingsway					
Staff recommending as a place for care and treatment	Quarterly	79%	63%	R	
Staff recommending as a place to work	Quarterly	64%	39%	R	
Hartington Unit					
Staff recommending as a place for care and treatment	Quarterly	79%	Data not provided	N/A	

Staff recommending as a place to work	Quarterly	64%	Data not provided	N/A	
Radbourne Unit					
Staff recommending as a place for care and treatment	Quarterly	79%	Data not provided	N/A	
Staff recommending as a place to work	Quarterly	64%	Data not provided	N/A	

Finance

Indicator	Period	Target	Actual	RAG	Previous months
Performance against budget £'000s	In month	2547	2628	R	
Performance against budget £'000s	Year to date	5055	5133	R	
Out of area placement expenditure £'000s	Year to date	81	328	R	

General Manager Summary:

- **Delayed transfers of care**
  The guidance for classification of a DTOC has been distributed. The ASMS are monitoring via the their operational meetings. Work is ongoing to improve the correct identification of DTOC.
- **Complaint response breaches**
  It is acknowledged that the sheer volume of complaints and investigations assigned to operational managers makes it very difficult to meet deadlines. As a result, 2 dedicated investigator posts have been created and recruited to. Once in post, the investigators should start to have a positive impact on turnaround times.
- **Adult acute inpatient occupancy and length of stay**
  Length of stay/ out of area placements project has commenced which is focusing on length of stay issues and will involve implementing a structured programme of improvement
- **Inpatient rehabilitation**
  Several discharges happened at once which bought occupancy levels down, including the transfer of a patient back to acute services. Audrey House is currently fully occupied, 2 patients however are on a discharge pathway. Rehabilitation referral process is being streamlined. Inreach work weekly to source referrals to both Hartington and Radbourne. Once a week referral meetings and future weekly updates to the wards to advise of bed occupancy rates and any waiting lists. Some referrals continue to be inappropriate for Rehabilitation services. Management to attend operational meetings to discuss referral process. Meeting being arranged for all referrals to be sent electronically via Paris.
- **Vacancies, sickness and associated bank use**
  Recruitment and Retention group is focusing on these issues.
- **Annual appraisals**
  The position has steadily been improving over time despite the rate of staff turnover and level of vacancy being carried.
- **Supervision**
  The volume of supervision being completed each month has increased significantly each month since March 2016. Owing to the way we report compliance on a rolling 12 months basis, any significant absence through maternity leave, long term sickness etc. makes the target unachievable. In Campus this is the case for 28 of our teams. Operations are currently exploring ways to more effectively capture ad hoc clinical supervision, which should improve the position: anecdotally we are aware that ad hoc supervision takes place which is not being recorded.
- **Finance**
  Overspend in May was as a result of a number of out of area placements and a need for additional temporary staffing at the Radbourne Unit to cover vacancies and acuity. Length of stay/ out of area placements project has commenced which is focusing on length of stay issues and will involve implementing a structured programme of improvement.

Central Services Division Performance Dashboard 2017/18 Month 2

Enc E

Quality, Safety and Experience

Indicator	Period	Target	Actual	RAG	Previous months
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	3	N/A	
New complaints opened for investigation	Monthly	<=2	0	G	
New concerns	Monthly	<=3	4	R	
Complaints upheld/partially upheld	Monthly	<=0	0	G	
Compliments	Monthly	>=12	6	R	
Friends and Family Test % positive	Monthly	89%	null	N/A	
Complaint response breaches (final response sent >60 working days)	Monthly	0	1	R	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
Activity against contract – ASD assessments (cumulative)	Monthly	100%	90%	G	
Activity against contract – perinatal inpatient bed days	Monthly	100%	41%	R	
Activity against contract – perinatal south community contacts	Monthly	161	128	R	
Activity against contract – eating disorder service contacts	Monthly	194	133	R	
Waiting list - ASD assessment: total and average wait (weeks)	Monthly	<=18	366 44	R	
Waiting list - dietetics: total waiting and average wait (weeks)	Monthly	<=18	1 0.4	G	
Waiting list – eating disorders: total waiting and average wait (weeks)	Monthly	<=18	8 5.4	G	
Waits – LD speech & language therapy: total and average wait	Monthly	<=18	171 36	R	
Waiting list - physiotherapy: total waiting and average wait (weeks)	Monthly	<=18	60 8	G	
Waiting list – psychological therapies: total and average wait	Monthly	<=18	69 14	G	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
Waiting list - psychology: total waiting and average wait (weeks)	Monthly	<=18	596 27	R	
IAPT step 2 discharges	Monthly	67	96	G	
IAPT step 3 discharges	Monthly	516	630	G	
IAPT recovery rate	Monthly	50%	52.2%	G	
IAPT reliable improvement & recovery rate	Monthly	65%	69.3%	G	
Substance Misuse City:					
TOPS compliance - start	Quarterly	80%	98%	G	
TOPS compliance - review	Quarterly	80%	91%	G	
TOPS compliance - exit	Quarterly	80%	94%	G	
Waiting time into treatment over 21 days	Quarterly	0%	0%	G	
Substance Misuse County:					
TOPS compliance - start	Quarterly	80%	99%	G	
TOPS compliance - review	Quarterly	80%	93%	G	
TOPS compliance - exit	Quarterly	80%	96%	G	
Waiting time into treatment over 21 days	Quarterly	0%	1%	A	

People

Indicator	Period	Target	Actual	RAG	Previous months
Vacancy rate	Monthly	10%	3.2%	G	
Turnover	Monthly	10%	8.6%	G	
Sickness – in month	Monthly	5%	4.1%	G	
Annual appraisals	Monthly	90%	74%	R	

Central Services Division Performance Dashboard 2017/18 Month 2

Enc E

People					
Indicator	Period	Target	Actual	RAG	Previous months
Mandatory training	Monthly	85%	88%	G	
Agency staff use	Monthly	1.9%	1.0%	G	
Bank staff use	Monthly	5%	2.4%	G	
Clinical supervision	Yearly	100%	66%	R	
Managerial supervision	Yearly	100%	74%	R	

Pulse Check					
Indicator	Period	Target	Actual	RAG	Previous months
Learning Disability					
Staff recommending as a place for care and treatment	Quarterly	79%	65%	R	
Staff recommending as a place to work	Quarterly	64%	34%	R	
Substance misuse					
Staff recommending as a place for care and treatment	Quarterly	79%	78%	R	
Staff recommending as a place to work	Quarterly	64%	66%	G	

Finance					
Indicator	Period	Target	Actual	RAG	Previous months
Performance against budget £'000s	In month	£1792	£1731	G	
Performance against budget £'000s	Year to date	£3560	£3488	G	

General Manager Summary:

- **Complaint response breaches**
  It is acknowledged that the sheer volume of complaints and investigations assigned to operational managers makes it very difficult to meet deadlines. As a result, 2 dedicated investigator posts have been created and recruited to. Once in post, the investigators should start to have a positive impact on turnaround times.
- **ASD assessments**
  Meeting the assessments target for 2016/17 resulted in a backlog reports to be written up. Writing up these reports has impacted on capacity to undertake assessments towards the start of the new financial year. The backlog has now been addressed and we anticipate that the level of assessments completed over the next few months and going forward will bring us back into line with target.
- **Perinatal inpatient and community**
  Referrals to the service have been lower across all three team (including inpatients) which reflects a dip in the birth rate at the moment. Two clinicians (1 North and 1South) have reduced caseloads following returns from long term sickness and the North clinician is due to have surgery on the 7/6/17 so there will be a further absence. Dr Gandhi has introduced a joint antenatal clinic with maternity to screen cases which may have been referred to us previously. A significant amount of activity is not captured whereby professionals phone for advice for patients who are not known to services and there is nowhere to capture this data. A number of referrals in the North for psychological therapy have been declined due to difficulties recruiting into the 0.2 WTE vacancy.
  Actions being taken to improve the position:
  - To review if there are any ways telephone advice can be recorded/reported for patients not referred into the service.
  - To look into the possibility of secondment from DCHS to the one day vacant psychology post in the North. A further two days have been included in the Community Fund Development Bid due to be submitted in November.
- **Eating disorder service contacts**
  The full year target has been increased by 64% since 2016/17 and is set 12% higher than the level of activity achieved last financial year. Team to be briefed about the increased target and to consider ways to achieve compliance. There were reduced patient contacts owing to significant staff sickness/ absence, with 54 days lost during May. We are hoping to soon recruit temporary staff on a fixed term contract in order to address the capacity gap.
- **Annual appraisals**
  We had made some progress but it seems to have reached a plateau. This is a hot spot focus currently with the teams and actions and trajectories are being sought.
- **Supervision**
  This is moving in the right direction. In a few months we should see a step change. Owing to the way we report compliance on a rolling 12 months basis, any significant absence through maternity leave, long term sickness etc. makes the target unachievable. In Central this is the case for 18 of our teams. Operations are currently exploring ways to more effectively capture ad hoc clinical supervision, which should improve the position: anecdotally we are aware that ad hoc supervision takes place which is not being recorded.

Children's Services Division Performance Dashboard 2017/18 Month 2

Enc E

Quality, Safety and Experience

Indicator	Period	Target	Actual	RAG	Previous months
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	0	N/A	
New complaints opened for investigation	Monthly	<=2	2	G	
New concerns	Monthly	<=5	7	R	
Complaints upheld/partially upheld	Monthly	<=2	2	G	
Compliments	Monthly	>=14	8	R	
Friends and Family Test % positive	Monthly	89%	86%	R	
Complaint response breaches (final response sent >60 working days)	Monthly	0	0	G	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
CAMHS RISE – A&E referral rate (as a percentage of total referrals)	Monthly	73%	78.5%	G	
Children in care health assessments – children under 5	Monthly	72%	77%	G	
Children in care health assessments – children 5 and over	Monthly	74%	72%	R	
10-14 day breastfeeding coverage	Monthly	98%	98.6%	G	
6-8 week breastfeeding coverage	Monthly	98%	95.6%	R	
6-8 week breastfeeding prevalence	Monthly	43%	46%	G	
SEND process – letter 1 responses within 15 days	Monthly	79%	100%	G	
SEND process – letter 2 responses within 42 days	Monthly	46%	56%	G	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
Paediatric current waits < 18 weeks	Monthly	92%	60%	R	
Paediatric waiting list: number waiting and average wait (weeks)	Monthly	<=18	988 19	R	
Paediatric new referrals (A) and attended 1st appointments (B)	Monthly	B>A	A 290 B 319	G	
CAMHS current waits < 18 weeks	Monthly	92%	96.4%	G	
CAMHS waiting list: number waiting and average wait (weeks)	Monthly	<=18	309 11	G	
CAMHS activity – attended contacts	Monthly	2037	2351	G	
CAMHS caseload	Monthly	1980	1780	G	
CAMHS RISE – referrals from A&E seen same day	Monthly	59%	71%	G	
CAMHS RISE – discharges with completed ESQ	Monthly	37%	33%	R	
CAMHS RISE – discharges with completed SFQ	Monthly	46%	37%	R	

People

Indicator	Period	Target	Actual	RAG	Previous months
Vacancy rate	Monthly	10%	7.9%	G	
Turnover	Monthly	10%	12.6%	R	
Sickness – in month	Monthly	5%	5.3%	R	
Annual appraisals	Monthly	90%	79.8%	R	
Mandatory training	Monthly	85%	88.1%	G	
Agency staff use	Monthly	1.9%	3.1%	R	
Bank staff use	Monthly	5%	1.8%	G	
Clinical supervision	Yearly	100%	85%	R	
Managerial supervision	Yearly	100%	80%	R	

Children's Services Division Performance Dashboard 2017/18 Month 2

Pulse Check					
Indicator	Period	Target	Actual	RAG	Previous months
Child Therapy & Complex Needs					
Staff recommending as a place for care and treatment	Quarterly	79%	71%	R	
Staff recommending as a place to work	Quarterly	64%	50%	R	
Universal Children's Services					
Staff recommending as a place for care and treatment	Quarterly	79%	80%	G	
Staff recommending as a place to work	Quarterly	64%	50%	R	

Finance					
Indicator	Period	Target	Actual	RAG	Previous months
Performance against budget £'000s	In month	£1233	£1219	G	
Performance against budget £'000s	Year to date	£2440	£2359	G	

General Manager Summary

- **Paediatric current waits < 18 weeks**
  Progress continues to be made towards achieving this objective. Report to be prepared for the next Quality Committee.
- **Sickness absence**
  Recruitment and Retention group has been launched to focus on these issues
- **Agency staff use**
  This issue is specifically impacting upon CAMHS Medical and Community Paediatrics. Recruitment plans are in place to reduce this over the next 2 months.
- **Supervision and annual appraisals**
  GM has generated a supervision and IPR dashboard for May 2017 and each SLM generated an action plan to address shortfall in performance. This is being monitored on fortnightly basis.
  Although significant progress has been made regarding recording, services are struggling to achieve required levels of supervision. Owing to the way we report compliance on a rolling 12 months basis, any significant absence through maternity leave, long term sickness etc. makes the supervision targets unachievable. In Children's Services this is the case for 21 of our teams.
  Operations are currently exploring ways to more effectively capture ad hoc clinical supervision, which should improve the position: anecdotally we are aware that ad hoc supervision takes place which is not being recorded.

Neighbourhood Services Division Performance Dashboard 2017/18 Month 2

Enc E

Quality, Safety and Experience					
Indicator	Period	Target	Actual	RAG	Previous months
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	2	N/A	
New complaints opened for investigation	Monthly	<=6	6	G	
New concerns	Monthly	<=17	14	G	
Complaints upheld/partially upheld	Monthly	<=2	2	G	
Compliments	Monthly	27	25	R	
Friends and Family Test % positive	Monthly	89%	80%	R	
Complaint response breaches (final response sent >60 working days)	Monthly	0	0	G	

Performance					
Indicator	Period	Target	Actual	RAG	Previous months
North Derbyshire					
Community caseload per funded wte care coordinator (exc. waiting list)	Monthly	<=35	50	R	
Community waiting list: number waiting and average wait (weeks)	Monthly	<=18	1951 17	G	
Community referrals (A) and discharges (B)	Monthly	B>A	A 750 B 1070	G	
Community activity	Monthly	5491	5729	G	
Outpatient memory assessment service caseload	Monthly	1104	1070	G	
Outpatient caseload (exc. MAS)	Monthly	5117	5076	G	
Outpatient waiting list < 18 weeks	Monthly	92%	98%	G	
South Derbyshire					
Community caseload per funded wte care coordinator (exc. waiting list)	Monthly	<=35	41	R	
Community waiting list: number waiting and average wait (weeks)	Monthly	<=18	1504 19	R	

Performance					
Indicator	Period	Target	Actual	RAG	Previous months
Community referrals (A) and discharges (B)	Monthly	B>A	A 466 B 495	G	
Community activity	Monthly	4326	4196	R	
Outpatient memory assessment service caseload	Monthly	549	547	G	
Outpatient caseload (exc. MAS)	Monthly	3419	3348	G	
Outpatient waiting list < 18 weeks	Monthly	92%	95.7%	G	
Derby City					
Community caseload per funded wte care coordinator (exc. waiting list)	Monthly	<=35	45	R	
Community waiting list: number waiting and average wait (weeks)	Monthly	<=18	1246 13	G	
Community referrals (A) and discharges (B)	Monthly	N/A	A 477 B 495	G	
Community activity	Monthly	4338	4819	G	
Outpatient caseload	Monthly	3273	3273	R	
Outpatient waiting list < 18 weeks	Monthly	92%	95.0%	G	

People					
Indicator	Period	Target	Actual	RAG	Previous months
Vacancy rate	Monthly	10%	9.0%	G	
Turnover	Monthly	10%	9.3%	G	
Sickness – in month	Monthly	5%	10%	R	
Annual appraisals	Monthly	90%	75%	R	
Mandatory training	Monthly	85%	88%	G	
Agency staff use	Monthly	1.9%	3.9%	R	

Neighbourhood Services Division Performance Dashboard 2017/18 Month 2

Enc E

People

Indicator	Period	Target	Actual	RAG	Previous months
Bank staff use	Monthly	5%	1.7%	G	
Clinical supervision	Yearly	100%	61%	R	
Managerial supervision	Yearly	100%	71%	R	

Pulse Check

Indicator	Period	Target	Actual	RAG	Previous months
Locality 1					
Staff recommending as a place for care and treatment	Quarterly	79%	70%	R	
Staff recommending as a place to work	Quarterly	64%	47%	R	
Response rate	Quarterly	25%	15% (74)	R	
Locality 2					
Staff recommending as a place for care and treatment	Quarterly	79%	79%	G	
Staff recommending as a place to work	Quarterly	64%	63%	R	
Response rate	Quarterly	25%	11% (19)	R	
Locality 3					
Staff recommending as a place for care and treatment	Quarterly	79%	100%	G	
Staff recommending as a place to work	Quarterly	64%	0%	R	
Response rate	Quarterly	25%	19% (5)	R	
Locality 4					
Staff recommending as a place for care and treatment	Quarterly	79%	42%	R	
Staff recommending as a place to work	Quarterly	64%	42%	R	
Response rate	Quarterly	25%	35% (12)	G	

Finance

Indicator	Period	Target	Actual	RAG	Previous months
Performance against budget £'000s	In month	£1951	£1891	G	
Performance against budget £'000s	Year to date	£3861	£3731	G	

General Manager Summary

- **Sickness**
  There has been a sharp increase in sickness absence in the month. Having had a few months where the trend had been more positive this is disappointing, however managers are aware in impacted teams and working to support people back to work as soon as possible.
- **Annual appraisals**
  It is becoming increasingly apparent that the capacity of the neighbourhood staff to meet key performance targets, including appraisals is challenged by the concentration on caseload and waiting lists. There is some capacity calculation work commencing to seek some improvement with this. In the interim all managers are prioritising appraisal completion, together with supervision rates as an urgent matter.
- **Agency staff use**
  We have exceeded target for use of agency staff and this has varied over the year, and between teams, trajectories have been set repeatedly, but are undermined by changing situations. However improving staff well-being and recruitment are key priorities for neighbourhood services through the next 6 months, which should benefit high pressured areas where sickness absence has created gaps and high turnover.
  Recruiting to medical posts has been extremely challenging throughout the year, this is a national issue and we have worked with other Trust departments to try and resolve this. Similar to the nurse situation solutions are found in one area, but then crop up in another. However this does mean that we are able to refine our processes and have more speed about processing solutions where it is possible. The last month has seen the medical gaps being covered more consistently.
- **Supervision**
  Owing to the way we report compliance on a rolling 12 months basis, any significant absence through maternity leave, long term sickness etc. makes the target unachievable. In Neighbourhood this is the case for 33 of our teams. Operations are currently exploring ways to more effectively capture ad hoc clinical supervision, which should improve the position: anecdotally we are aware that ad hoc supervision takes place which is not being recorded. The capacity of Band 6 staff to undertake supervision is being limited by their

having to manage large clinical caseloads. We are looking at freeing up capacity through reducing caseloads, although it is acknowledged this will have a negative impact on waiting lists. We have also set target percentage increases by team by month.

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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	79.35%	147.7%	77.3%	110.2%	84.6%	Yes	The report from the 1st May – 15th May is still stating in the template that we have 10.5 planned registered when it should be 21 registered an no unqualified at nights. However due to sickness and staff being moved to other wards where staffing as been short of qualified there have been times when we have worked on 1 qualified and 1 NA at time.
CHILD BEARING INPATIENT	41.40%	88.0%	69.1%	100.0%	119.4%	Yes	Current fill rate tolerances for registered nurses and care staff on days were broken due to backfill for 0.8 WTE maternity leave and x2 full time preceptorship nurses who are unable to take charge currently. Skill mix was adapted where possible.
CTC RESIDENTIAL REHABILITATION	70.83%	119.7%	75.9%	145.2%	82.3%	Yes	We currently have a some staffing issues.These are skewing the figures on days
ENHANCED CARE WARD	94.84%	84.6%	114.2%	74.2%	156.5%	Yes	These figure again reflect the vacancy rate for ECW in qualified staff. We have two new starter at the end of August unfortunately our second new starter is no longer coming and has taken a position with another trust. I am in process of re advertising posts. Despite vacancies are maintaining trust qualified Nurse in Charge cover on all shifts and competency requirements for same. Increased use of unqualified to cover both shortfalls in registered Nurse cover plus a period of high levels of observations due to clinical risk. Most of this cover has come from newly appointed trust staff, but still reliant on bank staff to cover additional night shifts. We always endeavour to use bank staff familiar with the area and staff with appropriate training in PMOVA where possible
HARTINGTON UNIT - MORTON WARD ADULT	92.20%	104.6%	146.7%	56.5%	277.4%	Yes	On Morton ward we have recently worked on higher numbers of staff due to very high continued activity which has been staffed by unqualified bank staff both during the day and night shifts. We are also carrying a high number of Band 5 vacancies which are covered by bank staff, this results in not being able to staff night shifts with x 2 qualified staff.

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WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		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	95.65%	99.2%	81.7%	44.1%	154.8%	Yes	No comment received
HARTINGTON UNIT - TANSLEY WARD ADULT	98.66%	94.2%	92.5%	56.5%	196.8%	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: Vacancies: in May 4.4 wte Band 5 posts. 1 wte recruited into from October 17 after the candidate qualifies, we have maintained regular contact. 1 wte held for the development of the MOT role (Medicines Optimisation Technician) to support the registered nurses in the safety and governance of medicines we have interviewed and offered. 1 wte identified for a skills uplift to Band 6 and after interview has been offered to a member of staff currently acting into the post. 1.4 wte unfilled and subject to the rolling recruitment process. Absences: 1 wte Band 5 removed from the Ward pending investigation, interview due to take place in February was cancelled by the staff member as his representative was unable to attend, I have no further update. 0.6 wte Band 5 on maternity leave not due back until September. 0.6 wte Band 5 on long term sick however has now completed a phased return to work. 1 wte Band 6 on long term sick and has now completed a phased return to work. In addition to the registered nurses there is the following unregistered nurse absence: 0.5 wte Band 3 remains on long term sick following maternity leave. 1 wte Band 3 has returned from long term sick but is in the process of a phased return to work which includes the use of annual leave untaken from last year.This means that we continue to have Band 5 availability pressures before taking into account short term sickness, training or annual leave in addition only 60% of wte Band 6 is available for duty on day duty to cover Lead Nurse and
KEDLESTON LOW SECURE UNIT	63.55%	91.9%	79.9%	101.6%	100.0%	Yes	we currently have reduction in patient numbers in preparation for a refurbishment of Scarsdale which means we are running at lower staffing levels. Care staff will therefore be reduced in the day

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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 (%)		
KINGSWAY CUBLEY COURT - FEMALE	73.30%	117.4%	115.7%	67.8%	152.7%	Yes	
KINGSWAY CUBLEY COURT - MALE	56.45%	73.9%	108.1%	77.4%	129.0%	Yes	we reduced our staffing numbers to reflect the reduced numbers of patients, and moved staff to other wards to support them so as not utilise bank nurses.
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	104.66%	92.5%	113.2%	100.0%	154.9%	Yes	There have been significant number of levels of observation which have required additional staff over the norm This is a stand alone unit more numbers of care staff are incurred to maintain safety especially at night Ward 1 is carrying 3 RN vacancies and Care staff There is in addition 3 WTE sickness /Mat leave
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	101.94%	93.4%	167.0%	53.2%	322.6%	Yes	Ward 33 are unable to meet the required fill rates due to significant Band 5 Registered Nurse vacancies, on nights currently only able to roster 1 substantive Registered Nurse on shift, unqualified on nights and days have been rostered with regular staff to support.
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	104.35%	94.9%	131.8%	82.3%	209.7%	Yes	Ward 34 continue to carry vacancies which is being addressed by recruitment. New roster in place to facilitate 2 registered nurse on nights.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	103.71%	83.9%	167.2%	62.9%	146.8%	Yes	All inpatient wards at the Radbourne unit remain affected by low recruitment into Registered Nursing vacancies. The current staffing establishment for Ward 35 is unable to meet the full demands for RN cover on each shift. In order to maintain safety and stability within the clinical areas, we have over recruited into HCA posts, hence the higher than required fill rates for unregistered staff. The Trust and individual ward areas continue to proactively recruit into RN vacancies and staffing/ skill mix are reviewed on an ongoing basis at ward level, operational level and Trust level.
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	100.16%	99.8%	131.1%	61.3%	254.8%	Yes	The figures reflect use of unqualified bank staff due to 3 members of staff on prolonged sickness and staff on mandatory training

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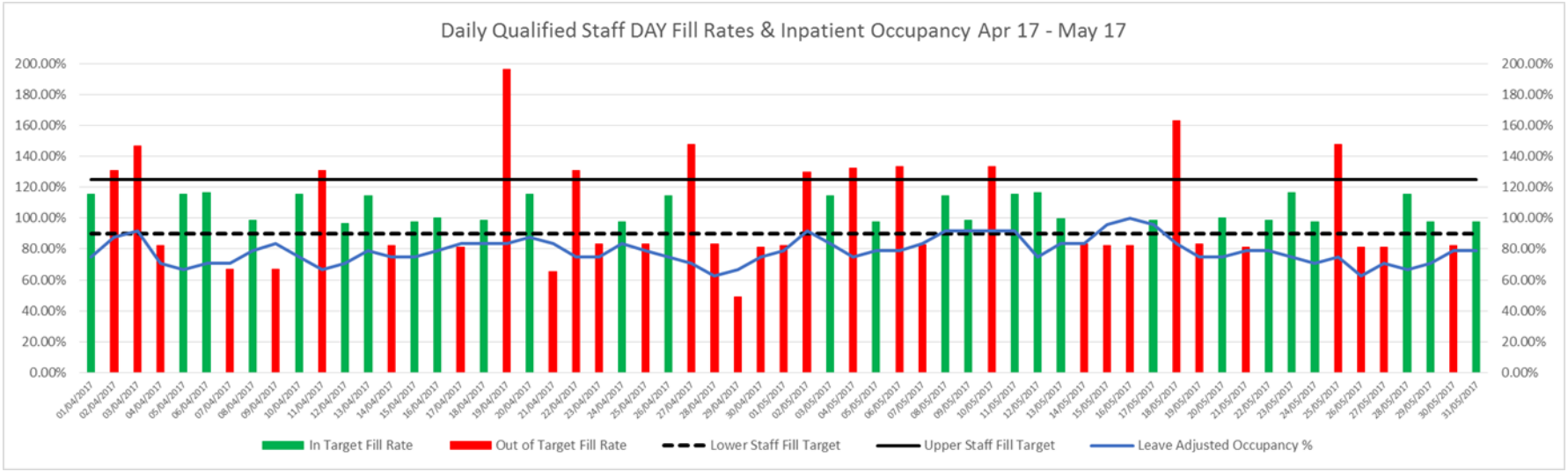
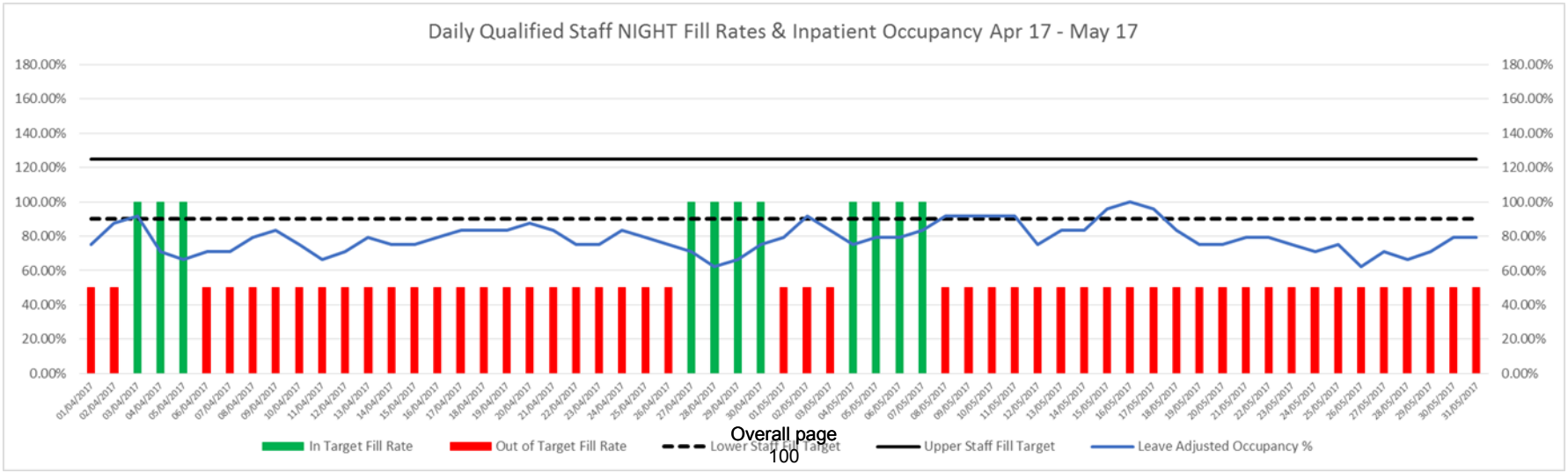
DAILY VIEW WARD STAFFING – MORTON WARD





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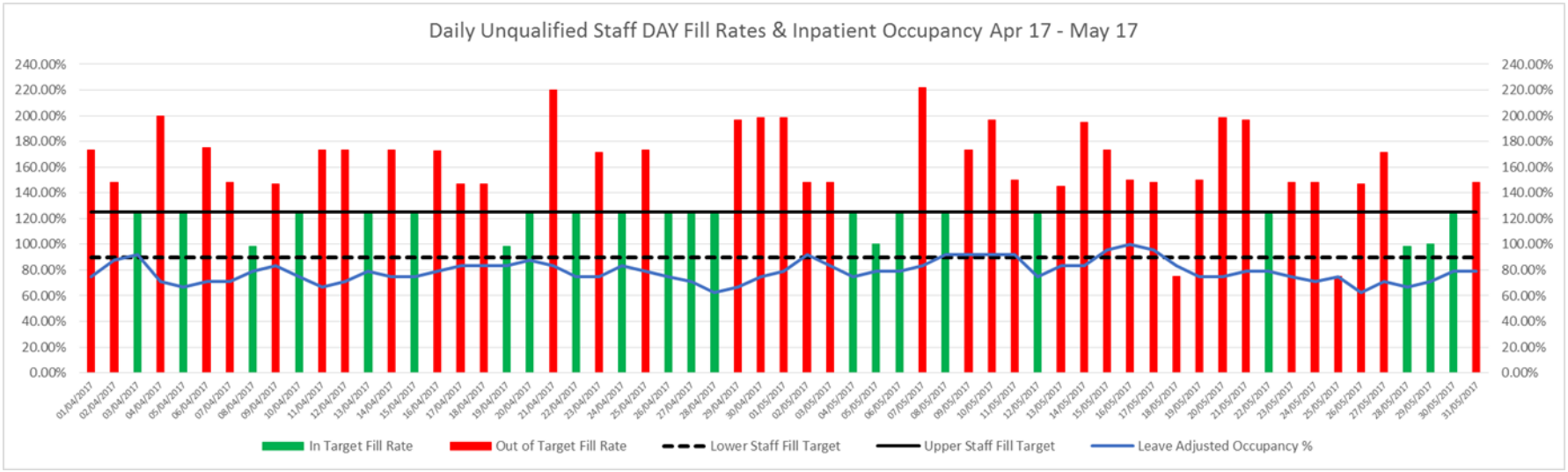
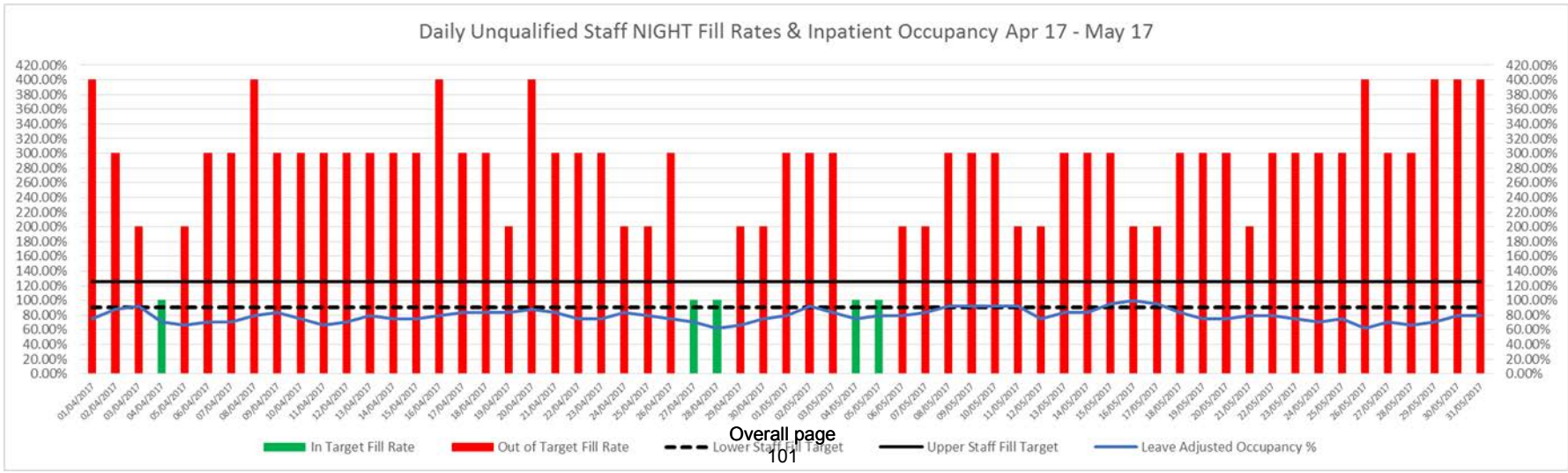
DAILY VIEW WARD STAFFING – MORTON WARD





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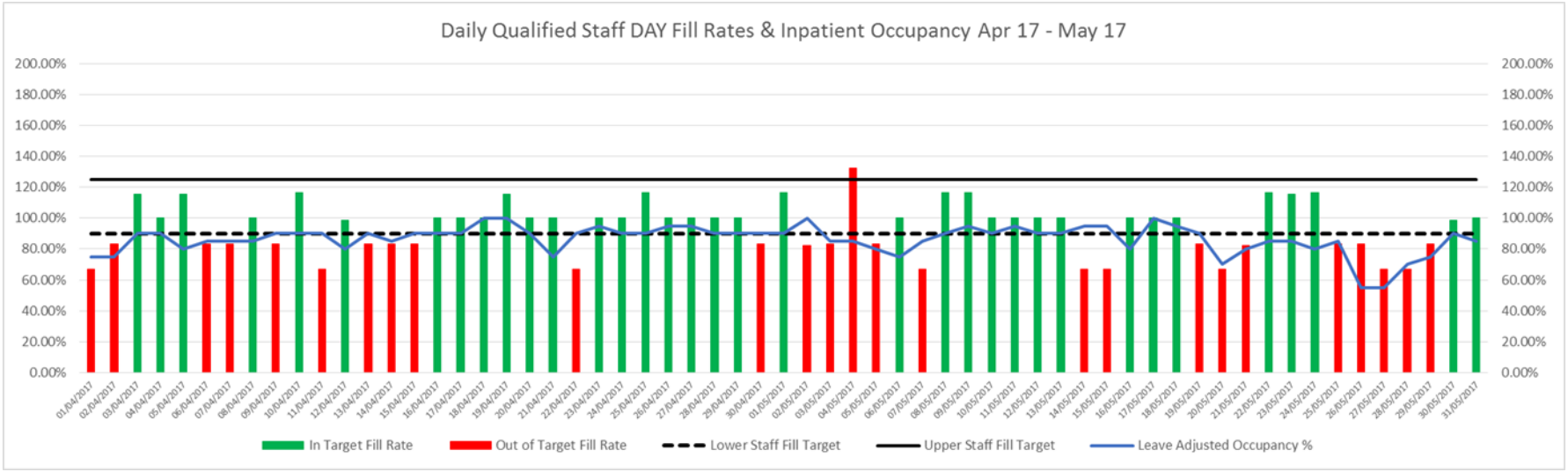
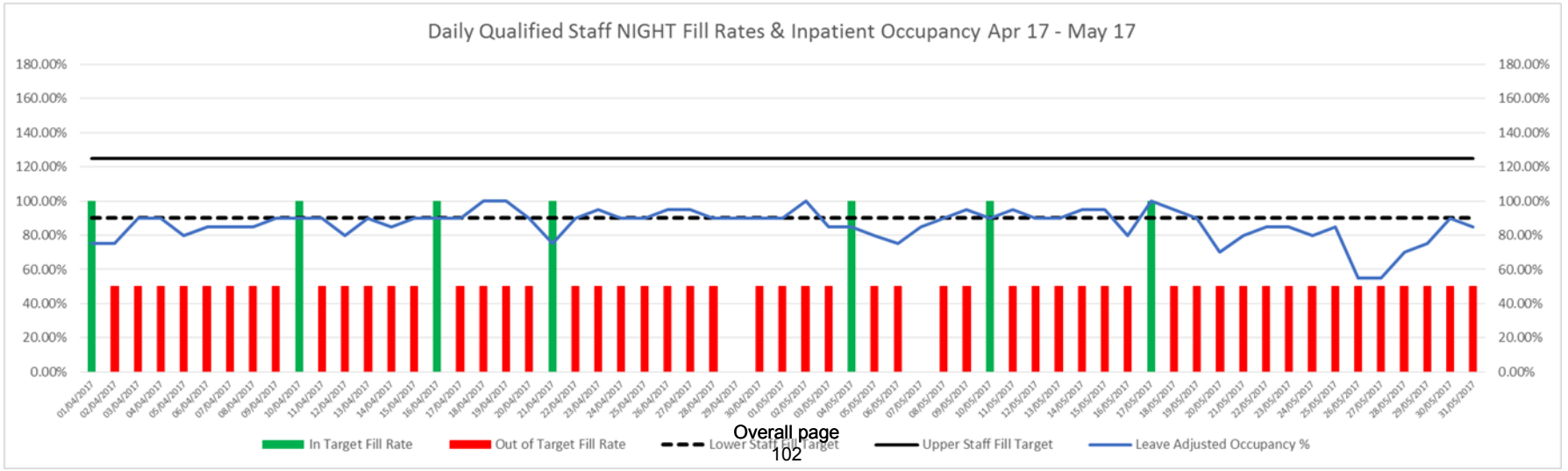
DAILY VIEW WARD STAFFING – WARD 33





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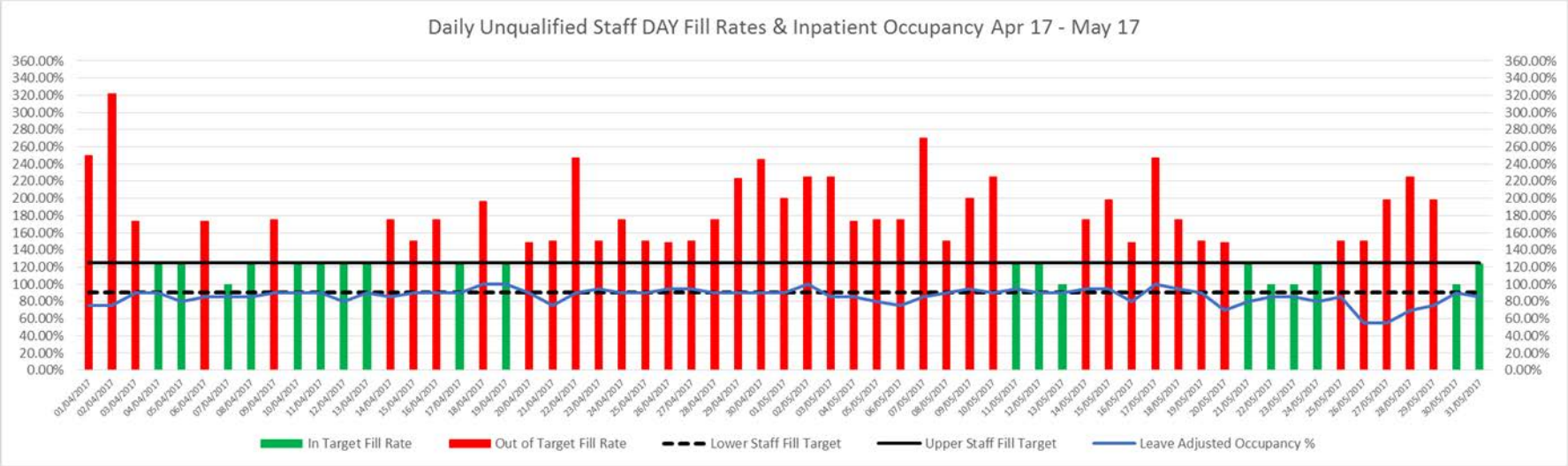
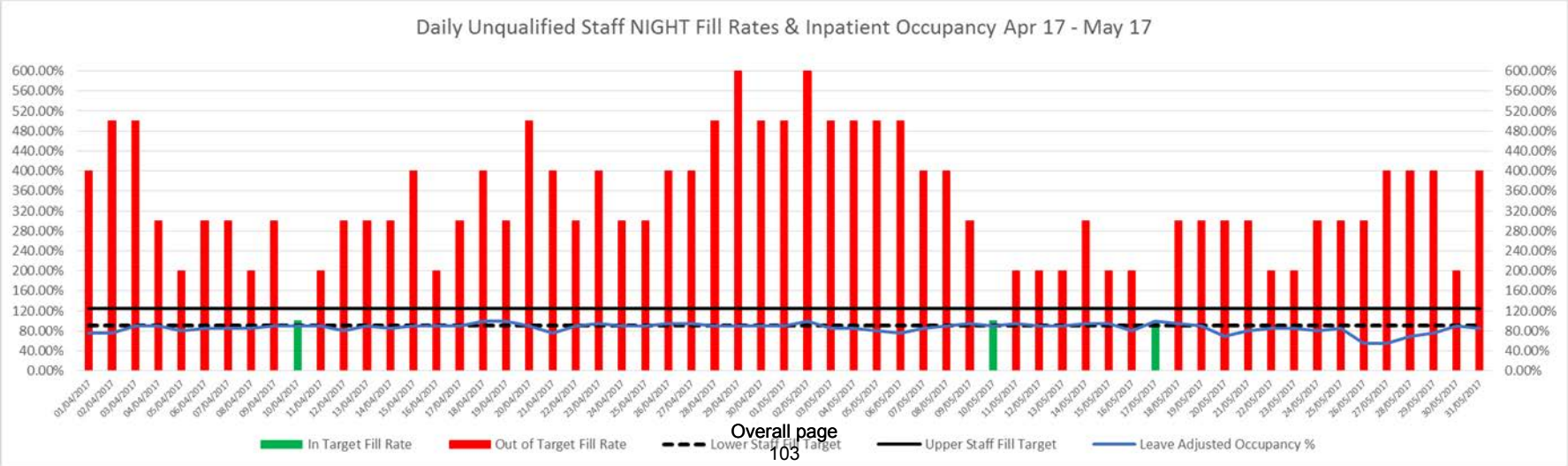
DAILY VIEW WARD STAFFING – WARD 33



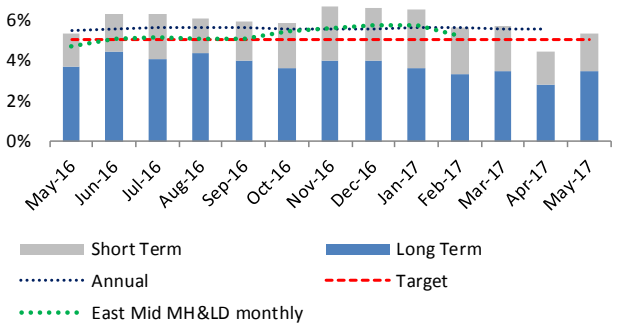


Workforce Section

WORKFORCE DASHBOARD

Sickness Absence

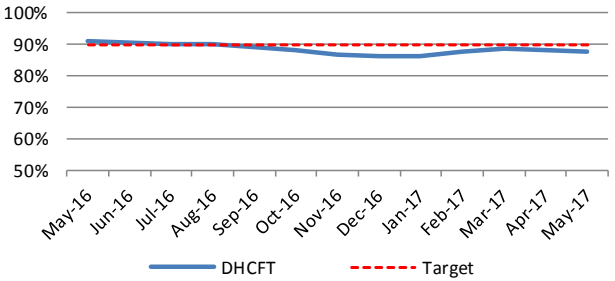
	Mar-17	Apr-17	May-17
(Monthly)	5.70%	4.45%	**5.30%** ↗
(Annual)	5.54%	5.53%	**tbc** ↘
			Target 5.04%



The monthly sickness absence rate is 0.85% higher than the previous month, however compared to the same period last year (May 2016) it is 0.02% lower. The Trust annual sickness absence rate is running at 5.53% (as at Apr 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 28.98% of all sickness absence, followed by surgery at 19.74% and other musculoskeletal problems at 8.28%. Compared to the previous month short term sickness absence has increased by 0.15% and long term sickness absence has increased by 0.70%.

Compulsory Training

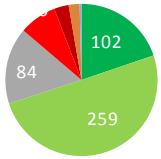
	Mar-17	Apr-17	May-17
(Staff in-date)	88.73%	88.17%	**87.73%** ↘
			Target 90%

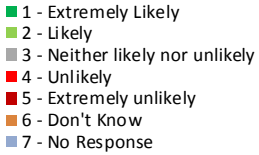


Compulsory training compliance continues to remain high running at 87.73%, which is a decrease of 0.44% compared to the previous month. Compared to the same period last year compliance rates are 3.14% lower. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target.

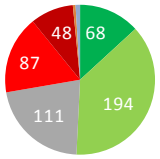
Staff FFT Q4 2016/17 (516 responses, 22.4% response rate) & Staff Survey 2016

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.



	2016	National average 2016	2015	National average 2015
Overall staff engagement:	**3.69**	3.84	3.73	3.81

WORKFORCE DASHBOARD

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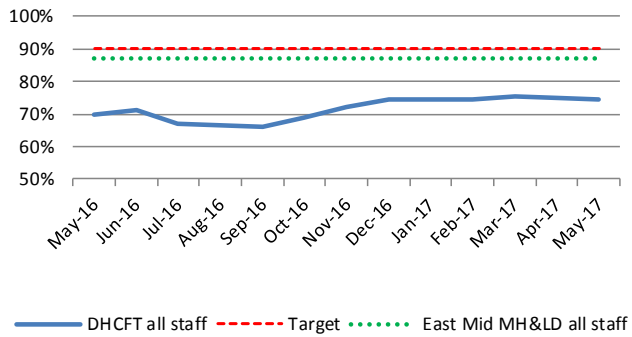
Appraisals (All staff)

	Mar-17	Apr-17	May-17
	75.14%	74.71%	**74.62%**

Target 90%

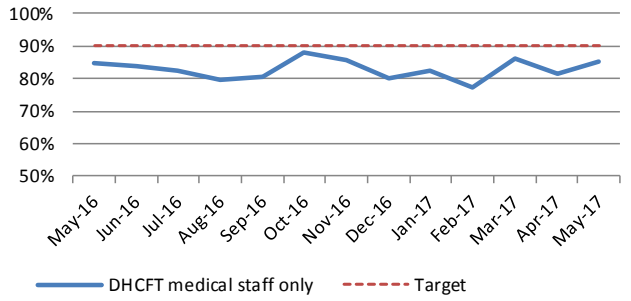


The number of employees who have received an appraisal within the last 12 months has decreased by 0.09% during May 2017 to 74.62%. Compared to the same period last year, compliance rates are 5.03% higher. According to the 2016 staff survey results, the national average for Mental Health & Learning Disability Trusts is 88.79%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 82.86%.

Appraisals (Medical staff only)

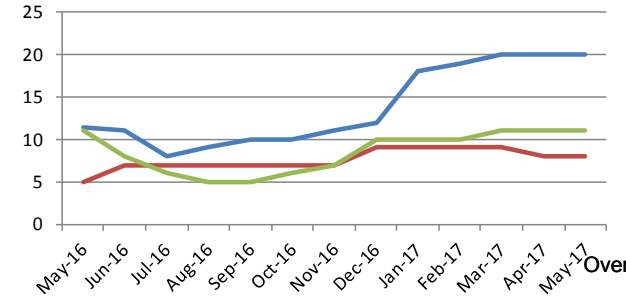
	Mar-17	Apr-17	May-17
	86.11%	81.37%	**85.29%**

Target 90%

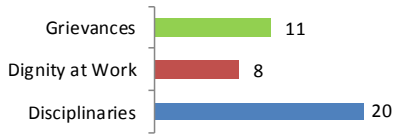


The number of Medical staff who have received an appraisal within the last 12 months has increased by 3.92% to 85.29%.

Grievances/Dignity at Work/Disciplinaries as at 31/05/2017



There continues to be eleven grievance cases lodged at the formal stage and efforts continue to resolving more grievances in the next period. Dignity at Work cases remain at 8. There are 20 Disciplinary cases, three new cases occurred in the period and three cases were resolved.



WORKFORCE DASHBOARD

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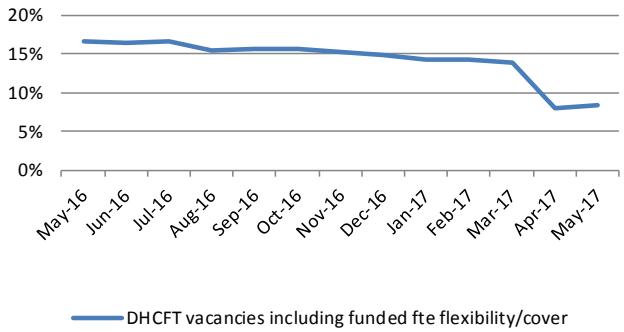
Vacancy

(Funded full time equivalent) Including funded fte flexibility/cover	Mar-17	Apr-17	**May-17**
	tbc	8.04%	**8.43%** ↗

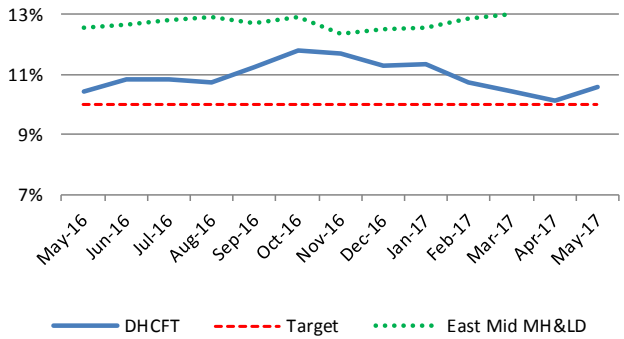


The Trust vacancy rate includes funded Fte surplus for flexibility including sickness and annual leave cover in In-Patient areas. Funded vacancy rates have increased slightly to 8.43% in May 2017. 2017/18 budget changes included a large reduction in Fte from 2016/17 investment not materialising and Cost Improvement Programmes. During the previous five months, 97 employees have left the Trust and 128 employees have joined the Trust.

Turnover

(Annual)	Mar-17	Apr-17	**May-17**
	10.44%	10.16%	**10.59%** ● ↗

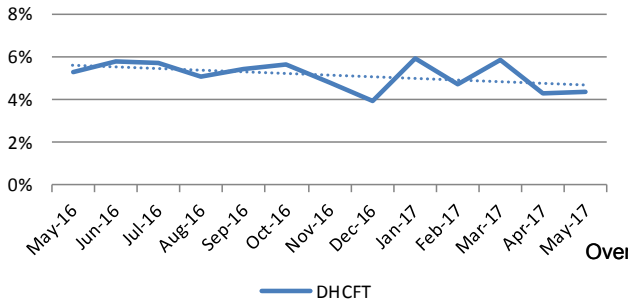
Target 10%



Annual turnover remains within Trust target parameters at 10.59% 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 by 0.94 to 21.36. During May 2017 28 employees left the Trust, an increase of 10 compared to the same period last year (May 2016). May 2017 leavers included 7 retirements.

Agency Usage

(Spend)	Mar-17	Apr-17	**May-17**
	5.86%	4.31%	**4.33%** ↗



Total agency spend in May was 4.33% (5.29% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.2%, Medical 3.1% and other agency usage 0.1%. Agency Qualified Nursing spend against total Qualified Nursing spend in May was 3.3%. Agency Medical spend against total Medical spend in May was 17.6%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £57k.

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors - 28 June 2017

Cyber-attack and lessons learned report

Purpose of Report

To inform the Board of Directors about the impact, response and actions arising from the Wanna Decryptor Ransomware attack that caused a disruption to DHcFT business continuity and to provide assurances regarding the Trust's cyber security

Executive Summary

On Friday 12th May 2017 an unconfirmed source launched a global cyber-attack by spreading a ransomware computer virus named Wanna Decryptor.

The cyber-attack was not directly targeted against the NHS, NHS organisations were affected. The Trust was able to be pro-active and protect the IT infrastructure but this caused a disruption to business continuity by significantly reducing IT functionality.

A controlled response brought IT systems back online in stages and avoided computers being infected.

This report sets out the key issues arising from the attack; lessons learned and associated actions that will be taken forward as a result of the attack.

In addition, the report sets out the Trust's position on the controls in place to limit the potential impact of any future cyber-attack.

Strategic Considerations (All applicable strategic considerations to be marked with X in end column)	
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.	

Assurances

This report should be considered in relation to the relevant risks in the Board Assurance Framework focused on business continuity.

Consultation

The majority of this report was considered by the Trust Management Team. Contributions to the report came from all relevant departments across the Trust.

Governance or Legal Issues

- Compliance with Civil Contingencies Act 2004
- NHS England Core Standards for EPRR

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

Recommendations

The Board of Directors is requested to:

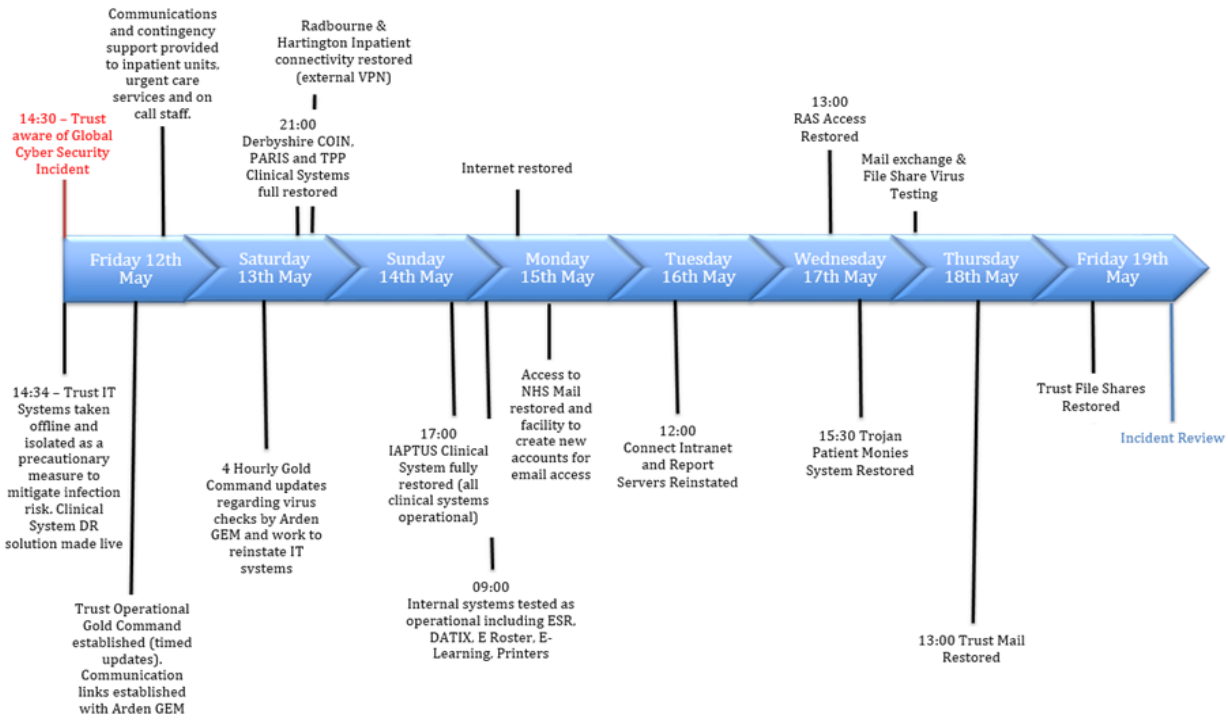
1. Discuss the content of this report
2. State its level of assurance with the response to the cyber-attack, the subsequent action plan and compliance with cyber essentials.

Report presented by: Mark Powell (Acting Chief Operating Officer)

Report prepared by: Peter Charlton (Head of IM&T)
Mark Powell (Acting Chief Operating Officer)

1. Introduction

On the 12th May 2017 a worldwide cyber-attack happened which infected computers in a number of NHS Trusts. Our Trust was not infected however; we did take action to reduce the risk when the cause was unknown and ensure no infection took place. This did result in clinical systems being unavailable for c30 hours however a business continuity solution developed locally provided access to patient records throughout the period. A timeline has been provided below.



Access to other systems was provided over the next week as they were assessed and confirmed to be at low risk of infection. Many actions already in progress within the Trust would reduce the risk of this specific virus in future, such as migration of services off windows 2003 servers, migration to NHS mail, file server migration and the ongoing rigor programme.

Since the attack took place NHS England has highlighted 39 critical CareCert bulletins which it believes all Trusts should look to implement. 30 have either been implemented or are not applicable, 9 are ongoing programmes of work which are being activity managed with our supplier Arden GEM.

2. Key Issues resulting from the attack and lessons learned for future consideration

There were a small number of issues as a result of the cyber-attack which form the basis of our ‘lessons learned’ and therefore require consideration and action to

improve our response to any future attack. Please see action plan attached in appendix 1.

2.1 Information Management and Technology (IM&T)

Our IT infrastructure consists of three elements which were impacted by the potential cyber-attack:

2.1.1 Servers

The Trust has 48 dedicated servers and a number of shared servers supporting shared systems across multiple organisations (Citrix, FS01 etc.).

The Trust has no XP computers. It has two virtual XP servers used to operate the security controlled door access system. These machines are logically isolated from the wider network to ensure that they are not susceptible to any virus and cannot spread a virus to other devices. A plan is in place to upgrade these servers to a supported operating system.

All dedicated servers automatically receive anti-virus updates every day. At the time of this attack all servers had up-to-date virus definitions in place however as this attack was an unknown virus an update to the anti-virus software had not been received to afford this protection. The update was received by GEM IT 00:30 13/05/2017. This virus definition file was loaded onto every server and a full scan was undertaken to ensure that the virus was not present.

37 of the 48 servers had the required patch applied automatically as soon as it had been released by Microsoft, and therefore would have been protected against this virus. This is the default approach for any new server deployed within the Trust. Exceptions only exist where this cannot be sustained, or there is a risk of the software failing as a result of the significant upgrade.

There were 11 servers which had not received the Microsoft patch, one does not run a Windows operating system and therefore did not require this. 4 servers form the SharePoint Server farm. SharePoint is notoriously temperamental and can fail to work if patches cause conflicts. If these patches were applied automatically, SharePoint could be down for a significant amount of time on a monthly basis whilst problems are being rectified. This would affect business continuity. An upgrade to the SharePoint Server farm had been tested and was due to be implemented on the live servers 21st/22nd May 2017. This upgrade would have made the SharePoint server farm compliant.

1 server was a print server, used to temporarily store print files until they have been streamed to the printer. The server used an old operating system (Microsoft Windows Server 2003) and was part of an ongoing project to upgrade or remove these historic unsupported systems. This server is in the process of being replaced by the secure print facility that is widely used across the Trust.

2 servers were the door controllers mentioned above which are being upgraded.

1 server provides access for c10 people to gain administration access to systems when working remotely. This server's operating system is Microsoft Windows Server 2003. The replacement of this server was also part of the upgrade project mentioned above. The issue relating to this server is the significant cost to replace a service only used by IM&T.

1 server provides support for a number of legacy systems which rely on Microsoft Windows Server 2003. These systems are Physio tools, Real Asset Management, Heritage Library and Patient Monies. These systems are owned by various teams within the Trust and plans need to be developed to address them.

1 Server provides support of two legacy systems; WebMPI and Casenote Tracker. Both were internally developed over 10 years ago and provide functionality still used within the Trust. A replacement system is in development to replace WebMPI as part of the work to support Dual Diagnosis.

Replacement of the Casenote Tracker was due to form Phase 2 of this work bringing together the functionality of both systems into a single integrated solution.

All of these issues will be resolved as part of the lessons learned action plan.

2.1.2 Laptops and Workstations

At the time of the cyber-attack the Trust technology inventory was actively monitoring 2,909 devices which were considered "deployed" within the Trust. Deployed indicates that they were considered active within the last three months and had not been flagged as decommissioned.

There were 1,567 laptops and 1,342 desktops. All 2909 had been seen on the network since April 2017, 203 in April and 2,706 in May respectively. 2,313 had been automatically patched with the Microsoft patch. By default all devices are set to automatically install Microsoft patches on a monthly basis when they are connected to a Trust network. A Trust network connection is required due to the significant size of some of the Microsoft updates.

596 did not have the appropriate patch installed. Of those devices, 477 were laptops and 119 were workstations. Anti-Virus software is installed on every device and is configured to update automatically at any time when there is a connection to the internet available. Of the 2,909 devices, 2400 had an antivirus definition file which had been updated within 5 days of the attack. 509 did not have an up-to-date virus file.

The management of mobile devices is challenging. By definition there is a balance to allow the provision for staff to work flexibly, however the management of the device needs to be controlled. The Trusts policy states that every device must be connected to the network monthly however this does not always happen.

IM&T operate a standard policy that any device not seen on the network for three months is removed from the network to prevent any potential infection.

A change was in the process of being tested to reduce this time period from three months to 45 days. This change would change the colour of the desktop to yellow after 30 days since the last connection and also display a message informing the individual it will be disconnected if it is not connected within the following 15 days. This then counts down to zero at which point the device is automatically removed from the network and the individual needs to contact the Service Desk to have their device updated and re-added to the network.

The risk the Trust ran at the time related to the 509 devices that did not have the Microsoft patch applied. The reason why these devices may not have the patch could vary but may include:

- People go on leave – this can mean that devices are not updated during their absence.
- People go on long term sick leave. This can mean that a device is either not used or only used remotely and therefore does not receive the Microsoft patches.
- People retain their old devices when new devices are deployed. This should not happen however, we are aware that a number of cases where this has occurred recently.
- People leave the Trust and teams retain the device to pass on to another member of staff or new starter. This should not happen. All devices should be returned to IM&T to be reassigned or decommissioned.
- People have multiple devices, some of which are only used when not in the office so do not connect to the network regularly.
- Devices are configured for a new starter too far in advance and not collected.
- Devices are recovered from teams and held until they can be redeployed to a new user.

We have attempted to establish an understanding of the ownership of all devices by contacting the person who last logged onto it. This has allowed a more complete understanding of the ownership of devices to be achieved. To control devices, processes will have to be put in place which heightens the responsibility of the individual concerned. This will be addressed as part of the action plan.

2.1.3 Networks

The Trust was disconnected from the internet and the N3 (private NHS network). At this point both the Hartington Unit and the Radbourne Unit became disconnected from the internal network. This was due to the fact that they were both connected via VPN tunnels over the N3 network. This meant that they could not directly access the PARIS DR solution and had to rely on other teams to relay information to them remotely.

There is a clear learning point regarding our access to N3 on other sites. Whilst we have a solution to enable access to disaster recovery for those sites via communication with Kingsway site, there is a need to review this arrangement as part of the action plan.

2.2 Business Continuity

Whilst the cyber-attack was very well managed and business continuity was maintained the attack clearly impacted upon our ability to function as effectively as we would have liked.

The Trust's Incident Response plan was utilised and essentially tested as part of this attack, which should be viewed as a positive outcome. This seemed to work well, nevertheless, it will be reviewed, particularly the action cards and amended where necessary.

More broadly there are a smaller number of low level actions that will be taken forward by the EPRR lead, alongside a review of service level business continuity plans to reflect any future cyber-attack.

2.3 Communications

As with any major business continuity disruption communication is absolutely vital to ensure that all parts of the organisation are aware of the issues and are able to adapt accordingly to continue to do their jobs. In addition, it is equally important that we are able to communicate with other stakeholder such as families, other health organisations, media etc.

In this particular incident effective communication was even more important given that the main form of communication (email) was not available for a sustained period of time.

The approach adopted therefore included all the basic forms of communication (see below), all of which worked well.

- Telephones/cascade messaging and direct face to face communication
- Posters of information
- Faxes/memos

During and following the days of disruption there were reports of benefits to having no emails, particularly from inpatient areas who felt they had more time to focus on the care that were providing and not having to respond to emails.

In contrast it became evidently clear that parts of the Trust are very reliant on the use of emails, particularly non-clinical areas.

The main lessons from this are related to the over reliance on emails and improving accessibility to alternative forms of communication (and being able to enact this immediately) both of which will be reviewed as part of the action plan.

3. Cyber Essentials

This section of the report explains how Derbyshire Healthcare NHS FT complies with the guidance issued by The National Cyber Security Centre as documented within 10 Steps to Cyber Security and seeks to provide assurance to Board members.

The diagram below provides an overview of the components they believe an organisation must put in place to limit the potential impact of a cyber-attack.

To consider each step in turn:

No.	Step	DHCFT response
1	Network security - The connections from your networks to the Internet, and other partner networks, expose your systems and technologies to attack. By creating and implementing some simple policies and appropriate architectural and technical responses, you can reduce the chances of these attacks succeeding (or causing harm to your organisation). Your organisation's networks almost certainly span many sites and the use of mobile or	Our networks are provided by Arden GEM. Firewalls are deployed to ensure an effective boundary is maintained, separating the information held inside our network from the Internet. Regular penetration tests are undertaken by organisations to simulate an unauthorised attack from both an external source and a malicious

	remote working, and cloud services, makes defining a fixed network boundary difficult. Rather than focusing purely on physical connections, think about where your data is stored and processed, and where an attacker would have the opportunity to interfere with it.	internal source. These exercises result in the production of a report which documents the key findings. These reports are then reviewed and utilised to form the basis of a work plan to ensure that any identified issues are addressed.
2	User education and awareness - Users have a critical role to play in their organisation's security and so it's important that security rules and the technology provided enable users to do their job as well as help keep the organisation secure. This can be supported by a systematic delivery of awareness programmes and training that deliver security expertise as well as helping to establish a security-conscious culture.	User education and awareness is addressed through many different interactions. Users are appraised of the cyber threats as part of the mandatory Information Governance requirements. The rational for some changes to mitigate potential threats are also discussed and reviewed at the relevant meetings within the Trust. Email communications are sent out to all staff to highlight the important issues and also to reinforce the need for vigilance when the Trust is notified of specific issues.
3	Malware prevention - Malicious software or malware is an umbrella term to cover any code or content that could have a malicious, undesirable impact on systems. Any exchange of information carries with it a degree of risk that malware might be exchanged, which could seriously impact your systems and services. The risk may be reduced by developing and implementing appropriate anti-malware policies as part of an overall "defence in depth" approach.	Malware protection is delivered via firewalls and mail filters which strip potential threats before they enter the network. Virus software is installed on every device and is updated daily when it is connect to the Trust network. The Trust also monitors and prevents unknown or unencrypted devices from being inserted into a managed device. There are also access restrictions in place to prevent the unauthorised installation of software onto Trust devices. Managed devices which are shown as not active on the Trust network for a period of three

		months are automatically removed from the network until the device is reviewed, had its antivirus updated and had the appropriate security patches applied. All services are also automatically updated with the latest virus and vendor patches unless exceptional circumstances exist. In addition monitoring is undertaken on the number of viruses that the security processes identify and clean; if any virus cannot be cleaned/removed GEM are alerted and the machine will be physically isolated from the network. These monitoring logs are also reviewed as part of the internal management meetings.
4	Removable media controls - Removable media provide a common route for the introduction of malware and the accidental or deliberate export of sensitive data. You should be clear about the business need to use removable media and apply appropriate security controls to its use.	All removable media are blocked except known “managed” devices or Trust encrypted memory sticks. Encrypted memory sticks are made available to teams to limit the impact of this control.
5	Secure configuration - Having an approach to identify baseline technology builds and processes for ensuring configuration management can greatly improve the security of systems. You should develop a strategy to remove or disable unnecessary functionality from systems, and to quickly fix known vulnerabilities, usually via patching. Failure to do so is likely to result in increased risk of compromise of systems and information.	The Trust operates a rigorous configuration model which defines what software is loaded onto each device. This allows the Trust to react quickly if vulnerability is detected.

6	Managing user privileges - If users are provided with unnecessary system privileges or data access rights, then the impact of misuse or compromise of that users account will be more severe than it need be. All users should be provided with a reasonable (but minimal) level of system privileges and rights needed for their role. The granting of highly elevated system privileges should be carefully controlled and managed. This principle is sometimes referred to as “least privilege”.	Users are only provided with limited capabilities to configure their devices. Local Administration accounts do not have the ability to access the Internet. In addition System Administrator accounts are not widely available.
7	Incident management - All organisations will experience security incidents at some point. Investment in establishing effective incident management policies and processes will help to improve resilience, support business continuity, improve customer and stakeholder confidence and potentially reduce any impact. You should identify recognised sources (internal or external) of specialist incident management expertise.	Incident management procedures are clearly documented on the Trust Intranet (Connect) and a desktop exercise is undertaken on a six monthly basis with our support provider Arden GEM.
8	Monitoring - System monitoring provides a capability that aims to detect actual or attempted attacks on systems and business services. Good monitoring is essential in order to effectively respond to attacks. In addition, monitoring allows you to ensure that systems are being used appropriately in accordance with organisational policies. Monitoring is often a key capability needed to comply with legal or regulatory requirements.	Monitoring of security incidents is undertaken at many levels. Arden GEM monitors the technical components and attempt to spot any unusual behaviour and provide statistical analysis for indications of a cyber-attack. DHCFT are in the process of introducing a monthly review of Cyber Security incidents and preventative measures. The level of incidents is currently reviewed within the IM&T&R department.
9	Home and mobile working - Mobile working and remote system access offers great benefits, but exposes new risks that need to be managed. You should	Mobile working is provided using equipment owned and managed by the Trust. This allows a level of control to be applied to the

	establish risk based policies and procedures that support mobile working or remote access to systems that are applicable to users, as well as service providers. Train users on the secure use of their mobile devices in the environments they are likely to be working in.	environment. Work is currently underway to control which websites can be visited on a mobile device when not connected via a trusted network.
10	Risk Management Regime - Embed an appropriate risk management regime across the organisation. This should be supported by an empowered governance structure, which is actively supported by the board and senior managers. Clearly communicate your approach to risk management with the development of applicable policies and practices. These should aim to ensure that all employees, contractors and suppliers are aware of the approach, how decisions are made, and any applicable risk boundaries.	DHCFT is one of the first Trusts to participate as a member of the NHS Digital CareCERT. This initiative is specifically looking at the risks associated with Cyber Security. This programme has helped the Trust to ensure that it is doing everything it can practically do to mitigate the risk of a cyber-attack.

In addition, the Trusts Auditors have made a recommendation that the cyber-security facilities within the trust are enhanced to include Intrusion Detection which is not currently provided as part of the service. A work package has been raised with Arden GEM to cost the provision of Intrusion Detection and if viable the implementation of a solution.

4. Conclusion

The Trust takes Cyber Security very seriously; it monitors the evolving cyber threats and endeavours to ensure that it maintains an appropriate level of protection. It should be noted, however, that it is impossible to fully eliminate the risk of a cyber-attack whilst maintaining a viable level of service provision. Several NHS organisations have recently been subject to attacks which have had a significant effect on their operational service. It is imperative that business continuity plans are regularly updated by services to define how they would be able to continue to operate if technology was unavailable.

The attached lesson learned action plan will be taken forward and overseen both by the EPRR Steering Group and Trust Management Team, with assurance reports provided to Quality Committee as part of routine EPRR reporting.

Derbyshire Healthcare NHS FT Wanna Decryptor Cyber-Attack Action Plan

Dept & Ref	Actions required	Target Date	Lead	Updates
IM&T				
1	Ensure routing enables Hartington and Radbourne Units to continue working if we have to disconnect in future.	31/03/2018	PC	
2	Migrate FS01 to FS102 to eliminate the risk in future.	31/07/2017	PC	
5	Replace the XP door servers with a supported solution.	30/09/2017	PC	Subject to estates
6	Replace Server providing support of two legacy systems; WebMPI and Casenote Tracker (both still used within the Trust), to provide a single integrated solution.	30/09/2017	PC	
7	Upgrade or replace Microsoft Windows 2003 server providing Physio tools, Real Asset Management, Heritage Library and Patient Monies systems.	30/09/2017	PC	subject to departments agreement
8	Replace the Microsoft Windows 2003 server providing IM&T staff with Admin access when working remotely.	30/09/2017	PC	
12	Migrate and decommission the print server and commission secure printing.	30/09/2017	PC	
13	Replace DHCFT mail service with NHS.Mail.	30/09/2017	PC	
15	Provide details of any devices that have not been recovered or registered to a member of staff following the audit of 509 devices that did not have the Microsoft patch applied.	22/06/2017	PC	
16	Review Trust Device/mobile/phone policy to consider re-defining responsibilities (embed ownership of devices into the Trust so that every asset is “owned” by someone and they feel a level of responsibility for it.)	30/09/2017	PC	
17	Require Back-up system for the Ascribe pharmacy system	31/102017	SB	
18	Review contractual arrangements with Arden GEM to esnure that they continue to meet Trust requirements	30/09/2017	PC	
Business Continuity				
18	Confirm all paper records have been transferred to EPR	31/07/2017	KL	
19	Produce a transferable business continuity guidance document for all service areas in the event of a cyber attack	30/09/2017	SMc	
20	Ensure that paper and electronic records of all staff contact details are held in the Major Incident Resource Cupboard.	31/07/2017	SMc	
21	Seek assurance staff who worked during the incident have been offered support and counsilling.	31/07/2017	SMc	
22	Review and amend Incident Response Plan following cyber attack / lessons learned process	30/09/2017	SMc	
23	Audit stock levels of log books/pens/other supplies as well as contact info in the command room and interval audit schedule.	31/07/2017	SMc	
25	Undertake a future exercise to test our recovery of backed up information – eg some of the larger financial spreadsheets?	31/12/2017	KB/Smc	
24	Produce Manager on call paper file containing most relevant out of hours procedures and information.	31/07/2017	SMc	
25	Explore alternative sitrep formats	31/07/2017	SMc	
Communications				
24	Consider need for a named lead link for each corporate team to cascade information to (eg HR, R&D, Library).	30/09/2017	SMc	
	Review use of email as a form of communciation across the Trust and explore potential solutions to reduce reliance on it	30/09/2017	ELT	
27	Scope connection of fax facility in communications team	31/07/2017	AS	
28	Establish where to deploy fax machines.	30/09/2017	SMc	
29	Obtain list of all staff work mobile phone numbers and process for contacting staff in this way	30/09/2017	NJ	
30	Seek clarity on Trust capability to do all staff mobile phone text messages.	31/07/2017	SMc	

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors - 28 June 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 – *was not brought* and Did not attend and Think Family as a Trust quality priority
2. Well led - Care Quality Commission Comprehensive and Mental Health Act Inspection – re-visits results
3. Well led – Systems leadership – Physical and Mental Health

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.

Neglect is the ongoing failure to meet a child's basic needs and is the most common form of child abuse. A child may be left hungry or dirty, without adequate clothing, shelter, supervision, medical or health care. A child may be put in danger or not protected from physical or emotional harm. They may not get the love, care and attention they need from their parents. A child who's neglected will often suffer from other abuse as well. Neglect is dangerous and can cause serious, long-term damage and death. The case outlined is a neglect case and the Nottingham serious review case learning is key to future prevention.

There is an over representation or / higher prevalence of women in eating disorder care and access to care for males is a consideration for equal and inclusive service and access.

Recommendations

The Board of Directors is requested to:

1) Receive this quality position statement
2) Gain assurance; be advised on safety, children’s service learning, to be adopted in the trust, systems leadership initiatives to improve quality and the patient experience. The trust Board is asked to review its content and seek clarity or challenge on any aspect of the report

Report prepared by: **John Sykes Medical Director and Carolyn Green Executive Director of Nursing & Patient Experience**

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

QUALITY POSITION STATEMENT

1.1 **Safety** - **Was not brought and Think Family strategy**

Nottingham City Council, NHS Nottingham City CCG and the NCSCB have jointly commissioned a video animation to encourage practitioners to identify children as 'Was Not Brought' as opposed to 'Did Not Attend' when referring to them not being presented at medical appointments.

The animation is a powerful reminder that children do not take themselves to appointments; they have to be taken by parents or carers. The animation therefore encourages practitioners to reflect on the impact that missed appointments have on a child's wellbeing and to consider whether this is a sign of neglect.

To watch the animation
https://www.youtube.com/watch?v=dAdNL6d4lpk

For more information about Nottingham City Safeguarding Children Board please visit www.nottinghamcity.gov.uk/ncscb, which includes the learning form the death of a Nottinghamshire Child. The Trust is currently working on quality issues in the Trust that help our staff, spot the signs of neglect.

The Director of Nursing and patient experience presented our work on Think Family over the last three years and new developments that have been put in place to embed a Think family and family inclusive approach to the organisation.

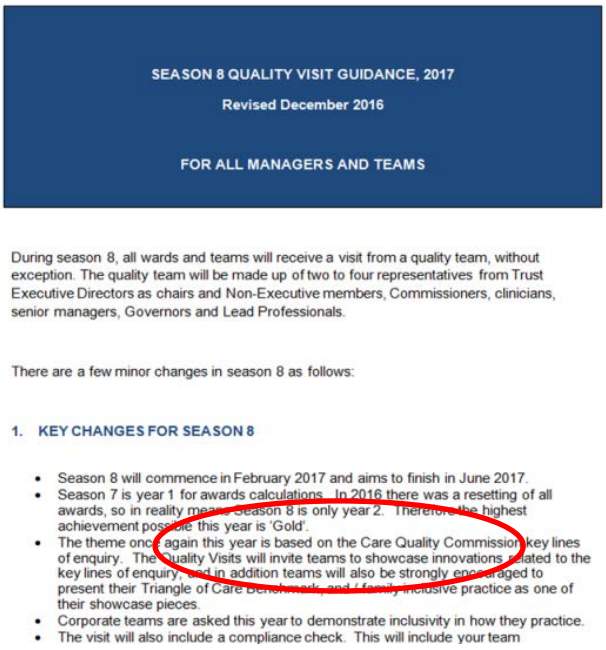
We have learning to put in place from serious case reviews involving parents with mental health conditions that may impact on their parenting style ; our strength is that we are a learning organisation.

Where are we now?
We have a Board level Safeguarding committee with direct links to the Board and a Non executive Director as chair, with external representatives

We have trained 85% of our organisation in Think Family
Over 1400 staff have been trained. Follow up audits and practice and since you have done this training- What's different in your practice?

Our Level 3 safeguarding training at year end was 85% with a recent dip with new staff at 82%. We have trained over a 1000 staff and we continue to train all of our clinically qualified staff in all clinical areas (not just Children's and Camhs)
Action: This learning and strategy has been put in place across the organisation, we adapt our performance reporting and ensure that all Children and CAMHS service reports are considered as was not brought and will be continually review and embed this practice.

Developments in 2016 and this year, focusing upon Carers and Family inclusive practice



SEASON 8 QUALITY VISIT GUIDANCE, 2017

Revised December 2016

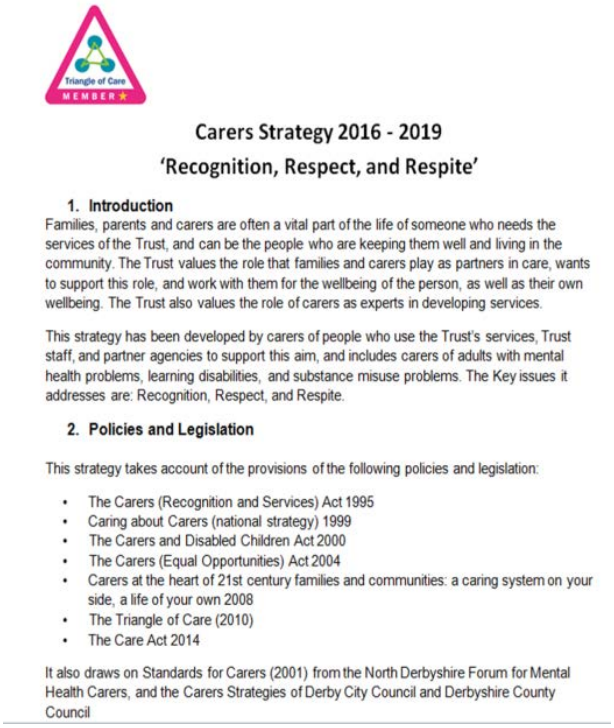
FOR ALL MANAGERS AND TEAMS

During season 8, all wards and teams will receive a visit from a quality team, without exception. The quality team will be made up of two to four representatives from Trust Executive Directors as chairs and Non-Executive members, Commissioners, clinicians, senior managers, Governors and Lead Professionals.

There are a few minor changes in season 8 as follows:

1. KEY CHANGES FOR SEASON 8

- Season 8 will commence in February 2017 and aims to finish in June 2017.
- Season 7 is year 1 for awards calculations. In 2016 there was a resetting of all awards, so in reality means Season 8 is only year 2. Therefore the highest achievement possible this year is 'Gold'.
- The theme once again this year is based on the Care Quality Commission key lines of enquiry. The Quality Visits will invite teams to showcase innovations related to the key lines of enquiry, and in addition teams will also be strongly encouraged to present their Triangle of Care benchmark, and / family inclusive practice as one of their showcase pieces.
- Corporate teams are asked this year to demonstrate inclusivity in how they practice.
- The visit will also include a compliance check. This will include your team



Carers Strategy 2016 - 2019

'Recognition, Respect, and Respite'

1. Introduction

Families, parents and carers are often a vital part of the life of someone who needs the services of the Trust, and can be the people who are keeping them well and living in the community. The Trust values the role that families and carers play as partners in care, wants to support this role, and work with them for the wellbeing of the person, as well as their own wellbeing. The Trust also values the role of carers as experts in developing services.

This strategy has been developed by carers of people who use the Trust's services, Trust staff, and partner agencies to support this aim, and includes carers of adults with mental health problems, learning disabilities, and substance misuse problems. The Key issues it addresses are: Recognition, Respect, and Respite.

2. Policies and Legislation

This strategy takes account of the provisions of the following policies and legislation:

- The Carers (Recognition and Services) Act 1995
- Caring about Carers (national strategy) 1999
- The Carers and Disabled Children Act 2000
- The Carers (Equal Opportunities) Act 2004
- Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own 2008
- The Triangle of Care (2010)
- The Care Act 2014

It also draws on Standards for Carers (2001) from the North Derbyshire Forum for Mental Health Carers, and the Carers Strategies of Derby City Council and Derbyshire County Council

In June we celebrated Carers Week 2017 - Building Carer Friendly Communities

We further expanded on its efforts in promoting the Triangle of Care – a set of standards for how mental health services should identify – once again this year, Derbyshire Healthcare will be seizing the opportunity of Carers Week (12-18 June 2017) to improve understanding and recognition of the vital contributions thousands of life-changing individuals are bringing to the lives of their friends and relatives.

Carers, often unpaid family members or friends, are the backbone of support for many vulnerable people and, for some, the carer is their lifeline without whom they would not be able to cope. Yet for many carers the decision to care can mean a commitment to future poverty and

deterioration in their own physical and mental health. Some give up an income, future employment prospects and pension rights to become a carer.

Derbyshire Healthcare aims to support the work of these unsung heroes and, recognising to the Trust's determination to ensure that all carers are fully included and supported when the person they care for is using a Derbyshire Healthcare services, the organisation was awarded a Triangle of Care gold star in 2015.

Carers Week: Building carer friendly communities

This year's annual Carers Week campaign has a nationwide focus on building communities which support carers to look after their loved ones well, while recognising that they are individuals with needs of their own.

During the week, health professionals from Derbyshire Healthcare will be hosting a number of activities and events to celebrate the important role carers play across Derbyshire and the rest of the UK. Additionally, the Trust's learning disability service staff will also be sharing best practice information about caring for someone with a learning disability with all 119 Derbyshire GP practices and reminding them to register learning disability carers.

Derbyshire Healthcare's activities and event for Carers Week include Ward and community based events to support our Family and Carers

We would like to pass on our thanks to Lynn Dunham for her extensive work in this area.

Actions:

1. To fully implement the *was not brought* model rather than *a did not attend* policy and consider for other care settings, where a carer is leading the attendance of a person at a health appointment.
2. Next steps in 2017 we will complete a full revision of the CPA policy to include Family and carer new standards, put the policy in place, redesign the training and audit the compliance of this revised policy. This work has commenced by the CPA manager
3. To enable staff to always keep the family in mind, we are developing systems checks on family and carer details on assessment appointments.
4. We will launch and put in place clinical systems that share information on colocation, and being open to more than one service in the Trust's portfolio through clinical systems interoperability- in line with the Safeguarding family strategy so we are aware who is connected to the family?

2 Well led- Leadership

2.1 Care Quality Commission Comprehensive and Mental Health Act Inspection – re-visits results

The learning from the Care Quality Commission Comprehensive visit continues and this is closely monitored by the Quality committee.

There has been overall improvement in the status of the **2016** actions. The comparison to previous reviews is shown below:

	Current 2016 Action Status			
Portal Review	At Risk of Not Delivering	Concerns	In Progress and on Target	Completed
October 2016	0	34	136	20
December 2016	0	22	128	40
January 2017	0	24	96	70
February 2017	0	12	81	97
March 2017	0	5	76	109
April 2017	0	4	65	121
May 2017	0	4	60	126
Comparison To Previous Month (% of all actions)	The Same	The Same	3% Decrease	3% Increase

Better together

In May the Trust briefed the Board that two further Mental Health specialist visits to the Trust. In June to review Community Treatment orders practice; this is an additional visit which can be planned at two yearly intervals and in July. A visit monitoring under Section 120 of the Mental Health Act 1983: Assessment and Application for Detention and Admission visit. Both visits were cancelled by the CQC due to internal requirements. We would like to offer our apologies to the Patients, Carers and staff who planned to give their time to this visit. We are really sorry that you were unable to share your experiences with the CQC. Our staff team are very happy to listen and feed in your experiences.

2.2 Systems Leadership

Physical health and Mental health.

The Costs of Eating Disorders - Social, Health and Economic Impacts report, commissioned by Beat (Third sector- Beating eating disorders) and produced by PwC in February 2015, estimates that more than 725,000 people in the UK are affected by an eating disorder - using a more robust methodology than previous studies.

The National Institute of Health and Clinical Excellence estimates around 11% of those affected by an eating disorder are male.

Recent research from the NHS information centre showed that up to 6.4% of adults displayed signs of an eating disorder (Adult Psychiatric Morbidity Survey, 2007). This research suggested that up to 25% of those showing signs of an eating disorder were male.

The Health and Care Information Centre published figures in February 2014 showed an 8% rise in the number of inpatient hospital admissions in the 12 months previous to October 2013.
Anorexia has the highest mortality rate of any psychiatric disorder, from medical complications associated with the illness as well as suicide. Research has found that 20% of anorexia sufferers will die prematurely from their illness. In every case, eating disorders severely affect the quality of life of the sufferer and those that care for them.

Physical health and Eating disorders safe management are key to ensuring that we meet the needs of individuals across all of our Derbyshire organisations.

Actions: Our Trust working with other health partners are planning a conference for the autumn on working together on physical healthcare, which will include , our collective best practice in working in physical health in a psychologically minded practice and Eating disorders care will be a key showcase, of our joint efforts. This will be led by our Chief Nurse and Medical Director.

Report prepared by: **Carolyn Green, Executive Director of Nursing and Patient Experience and John Sykes Medical Director**

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

Board Committee Summary Report to Public Trust Board
Audit & Risk Committee
25 May 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/Apologies Draft Minutes Audit & Risk Committee meeting held 27 April Action Matrix and Matters Arising:	Caroline Maley and Ifti Majid were welcomed to the meeting. Minutes of the last meeting were approved. Updates were agreed and added to the actions matrix. Matters arising – Sam Harrison to review Committee objectives for 2017/18 and circulate to members.	Full assurance was received that completed actions were fully actioned and that these could be archived.	None	Actions agreed as completed as noted.	None
Updated Conflicts of Interest policy for approval	The proposed revised policy was presented and action plan to ensure effective implementation was discussed	Significant assurance was received on the policy which followed the national model and had been developed in liaison with internal audit. It was noted that dissemination to staff would take place for the June implementation date.	None	The policy was agreed subject to amendments as raised. Progress on the action plan is to be reviewed at the October Committee meeting.	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Summary of key changes from draft to final Annual Accounts 2016/17	Stacey Forbes updated on updates to the annual accounts made since the last meeting and following auditor comments.	Full assurance was received that the required amendments had been made to the final accounts	None	Amendments were noted and final accounts agreed.	None
Review audited Annual Report 2016/17 (including Quality Report and Annual Governance Statement)	Anna Shaw presented amendments to the annual report and quality account including updates to reflect licence compliance as notified by NHSI in the morning of the meeting.	Significant assurance was received on the annual report/quality account and these were agreed for signature.	None	Annual report/quality account to be signed as per submission requirements.	None
Management Letters of Representation	The letter of representation relating to the financial statements was outlined by Claire Wright The letter of representation relating to the quality account was outlined.	Committee members received full assurance on the management letters of representation.	None	The letters of representation from the Trust were agreed for signature. .	None
External Audit Findings Report and Associated Opinion	Mark Stocks noted that this was a good audit with good quality papers. The impact of the cyber attack in finalising the accounts was noted. There was no change to	Everyone was thanked for their work to overcome the issues related to the cyber attack. It was noted that there was work required to	None	The Audit findings were noted.	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	the surplus stated in the draft findings. **Audit findings** Key audit findings were outlined. Regarding the qualified opinion on value for money it was noted that the GIAP comments had now been updated to acknowledge that licence conditions have now been withdrawn. Thanks were given from external auditors to finance and the wider team involved in production of the annual report and accounts. **Audit opinion** The unqualified opinion was noted to have been updated to reflect removed licence conditions. **Quality report –** this was noted to be a clean report. Consistency of information and quality of indicators within the report was noted.	rectify issues on Property, Plant and Equipment and depreciation. Claire Wright is to take forwards. Significant assurance was received on the Annual Governance Statement and the annual report. No control weaknesses were identified and good progress had been made with the GIAP. It was requested that the planned Board paper covering the cyber incident needs to include recommendations relating to the intrusion detection system			

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Physical sign off of Annual Report and Accounts 2016/17	Final documents of the annual report and accounts were presented for signature by Trust officers	Full assurance was received that the annual report and accounts were fully accurate and complete	None	It was agreed that the annual reports be signed off and submitted to Parliament as per required process	None
Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework	It was explained that now that external assurance had been received on implementation of the GIAP the risk identifying this issue should be reviewed and reduced.	Significant assurance was received on implementation of the GIAP following external review and confirmation of compliance with licence undertakings as advised by NHSI on 25/6/17	None	It was agreed that the relevant BAF risk should be reviewed and reduced.	None
2017/18 Forward Plan	Noted	None	None	The forward plan was noted.	None
Meeting effectiveness	The responsiveness from Trust officers and external auditors was applauded with respect to incorporating the licence compliance received during the morning of the meeting. Thanks were extended to all involved.	None	None	None	None

Board Committee Summary Report to Public Trust Board
Mental Health Act Committee
9 June 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 from Mental Health Act Committee held 3 March** **Matters Arising – Actions Matrix**	It was noted that a business case for S136 suite staffing/risk assessment was now part of STP process but unlikely to be resolved with alacrity. The consequence of this could impact nursing numbers on wards. An exception report on this possible effect was requested.	Limited assurance. Tracey Holtom to include in S136 group reports for MHAC sub group July 2017.	Bleepholder on Unit is often drawn down to cover S136 assessments potential compromising senior nursing cover of inpatient units. Danger of every risk being held in STP workstream.	To quantify effect of not achieving cover of S136 suite in nursing provision.	None
Matters Arising – Location of LD beds in times of bed shortage	There is no agreed process of accessing LD beds when none are immediately available at Ashgreen despite the statutory need for Community Treatment Reviews at such times. DHCFT and DCHS have declined to accept responsibility and commissioners have not resolved the issue. MD to MD discussions over a period of 2 years have failed to bring a resolution.	Joe Wileman is producing an options appraisal. No assurance at the MHAC prior to this.	Failure to locate a bed at a time of crisis could result in a catastrophic serious incident.	MD to approach commissioners directly – superseded by stop press.	None

Actions Matrix					
Review Policy Matrix	It was noted that all policies were in date.	Commentary requested by Rachel Kempster for next report to MHAC August 2017. Full assurance.	None	None	None
Mental Health Act Manager's Report including CQC visit reports to Ward 35 and Tansley Ward	It was noted that 6 seclusion reports remained outstanding.	Escalated to Richard Morrow who confirmed later in the meeting that these had been received. Full report to Quality Committee and then to MHAC sub group consequently limited assurance.	None	Stop dual reporting to Quality Committee as exceptions process now established.	None
	Good overall compliance except: • CTO rights form at 3 months only 63%	Claire Biernacki to address performance management in neighbourhoods – limited assurance.	Non complaint with legislation	Report to be scrutinised in MHAC sub group and actions identified.	None
	• 8 patients given forced injections not covered by Section	Rachel Kempster to pull Datix reports for SI Group – no assurance.			
	• Record of Consent compliance falling to 85%	John Sykes to address performance management with CDs/Deputy MD – limited assurance.			
	• Consultants not using EPR to log SOAD requests	John Sykes to manage performance through Deputy MD/CDs – limited assurance.	Unable to determine appropriate use of S62 without this information.	Action identified.	None

	Unannounced CQC visits to Tansley Ward and Ward 35. Familiar themes re patient rights and consent.	Action plans to be developed by ward managers which need to be SMART and highlight challenges. To be reviewed at MHAC sub group – limited assurance.	Non compliance with statutory duties.	None	None
Report from CQC Ward Visit to Kedleston Unit	A comprehensive work plan is in play developing clinical approaches, plus improving security and a full refurbishment. The ward will close for 12 weeks.	Fully engaged with Workforce and OD and Unions. Supports ligature reduction programme. Reducing restrictive practice. Tracey Holtom.	Issues identified by NHS England and CQC are being addressed and significant progress made.	None	None
CQC Actions – overall update on Inspection Summer 2016	Multiple actions were harvested during and after the visit which populate the 190 item plan logged in the CQC portal. 12/21 MHA/MCA actions all completed with others in progress and on track.	Work recently completed by the Mental Capacity Lead, Ed Komocki, should facilitate closure of remaining actions and will be the subject of a "deep dive" at the Quality Committee. Likewise progress has been made with training – limited assurance. John Sykes to work with action leads to close actions. Stop press – Quality Committee require high level of assurance to close actions eg serial improvement in compliance rates. It may not be possible therefore to close all actions this summer. John Sykes to clarify.	Actions need to be closed ASAP in order to conserve capacity for subsequent CQC reports and actions.	To aim for completion this summer if possible.	None

	Actions from routine CQC inspections need to be owned by team concerned.	Reallocation of "lead" back to clinical team to develop SMART action plans. Overall action plan is overseen by Darryl Thompson, deputy chief nurse, with John Sykes being executive lead.	Action plans need accountability at team level.	To reallocate action plans and review at MHAC sub group.	None
Seclusion Update	Verbal assurance given that all episodes are being reported and exceptions identified for scrutiny. EPR is helping process.	Limited assurance. Full report to MHAC sub group - Richard Morrow.	None	None	None
Rapid Tranquilisation Audit(s)	A series of audits has improved prescribing in line with NICE guidelines (now 100%) and the end to pre-emptive prescribing (now 75%) but circa 50% compliance with other aspects.	CDs to review performance with Senior Pharmacist overseen by deputy MD. Likewise review of effectiveness of tranquillisation to be reviewed by Heads of Nursing overseen by deputy chief nurse – limited assurance.	8 patients given IM injections not covered by Sections as described earlier.	Further audits required. Action plan reviewed and accepted.	None
S12 Pilot - final report	AMHPs often experience delays in obtaining two S12 doctors for an assessment particularly as GPs are usually no longer available. The pilot of having one S12 doctor with the AMHP team showed this was an advantage for the	John Sykes to report progress to Director of Strategic Development with view to commissioner support.	None	None	None

	county but not for the city. A further pilot is underway to ascertain the feasibility of combined rotas and dedicated S12 availability during the day.				
Mental Capacity Act Manual	System, process and training have been significantly developed by Mental Capacity Lead working with IT and training department.	Work to continue part funded by MD "backfill" agreed at Remuneration Committee. CEO to report to RC. Full assurance re quality of tools to support training/clinical practice.	Variable compliance with statutory requirements remains a risk.	Manuals agreed. To form the basis of further training and audit.	None
Training Needs Analysis	Training needs analysis gives full assurance informed by Mental Capacity Manuals for adult and old age services. Further work is required for children's and LD services.	Medical Capacity Lead is doing further work with children's and LD services.	None	To include MHA and DoLS training in 3 yearly cycle with MCA.	None
Training Compliance Report	Once only training is satisfactory but new 3 yearly cycle is slow to build.	To develop trajectory and milestones for training – Tracy Shaw, training manager. To review medical training passport – John Sykes. To launch manuals – Tracy Shaw and Ed	Training required to improve compliance with statutory requirements around MHA/MCA.	To have all relevant training on a 3 year cycle. To prioritise registered clinicians. To continue reporting once only and 3 yearly compliances.	None

		Komocki.			
S136 Group Report and action plan including response to Police and Crime Bill 2017	The forward work plan was noted.	Limited assurance pending progress of work plan. Tracey Holtom to report to MHAC sub group.	Police and Crime Bill could increase S136 activity. Previous staffing concerns noted as above.	Data on activity/staffing to be fed into STP workstream.	None
Update from Hospital Managers	Verbal report received. No issues raised.	N/A	None	None	None
Medical Tribunal Audit and action plan	Essential criteria (but not all) were met for legal requirement in all cases but reports not person centred. Recent case law changes unlikely to have significant effect on discharge rates.	Action plan authored by Dr Joanne Carley accepted. Template to be shard by John Sykes.	Patients not supported by person centred reports.	To add template to action plan.	None
Revised Terms of Reference	MHAC sub group to be reflected in Terms of Reference. Sub group to scrutinise, delegate, hold to account.	To expand ToR – John Sykes.	None	None	None
Feedback regarding to LD bed finding responsibilities	See previous				
Confirmation of actions completed from PwC Audits **- Mental Capacity Act** **- S132**	All actions completed.	Full assurance	None	None	None

Derby City AMHP Update including quarterly DOLS report Derbyshire County Council AMHP Update	Report received.	Data needs interpretation at MHAC sub group.	DoLS assessment breaching time thresholds.	To cross check LA DoLS data with Trust internal report.	None
Recommendations from Deloitte Report for Mental Health Act Committee	Recommendations noted.	To form MHAC sub group to meet 4 weeks before MHAC.	None	None	None
Any Other Business	None	None	None	None	None
MHAC BAF risks – review of discussions that could affect the risk rating of the Committee's risks	To be updated in next week by John Sykes.	N/A	None	None	None
2017/18 Forward Plan	Noted	N/A	None	None	None
Issues escalated to Board, Audit & Risk Committee or other Board Committees					None
Meeting effectiveness	Improvement n preparation noted but still some outliers re papers. Sub group should shorten MHAC and improve assurance levels.	N/A	None	None	None
S117 Audit – for information	Action plan previously agreed by MD under executive action.	N/A	None	None	None

Board Committee Summary Report to Public Trust Board
Mental Health Act Committee
9 June 2017

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	for children's and LD services.				
Training Compliance Report	Once only training is satisfactory but new 3 yearly cycle is slow to build.	To develop trajectory and milestones for training – Tracy Shaw, training manager. To review medical training passport – John Sykes. To launch manuals – Tracy Shaw and Ed Komocki.	Training required to improve compliance with statutory requirements around MHA/MCA.	To have all relevant training on a 3 year cycle. To prioritise registered clinicians. To continue reporting once only and 3 yearly compliances.	None
S136 Group Report and action plan including response to Police and Crime Bill 2017	The forward work plan was noted.	Limited assurance pending progress of work plan. Tracey Holtom to report to MHAC sub group.	Police and Crime Bill could increase S136 activity. Previous staffing concerns noted as above.	Data on activity/staffing to be fed into STP workstream.	None
Update from Hospital Managers	Verbal report received. No issues raised.	N/A	None	None	None
Medical Tribunal Audit and action plan	Essential criteria (but not all) were met for legal requirement in all cases but reports not person centred. Recent case law changes unlikely to have significant effect on discharge rates.	Action plan authored by Dr Joanne Carley accepted. Template to be shard by John Sykes.	Patients not supported by person centred reports.	To add template to action plan.	None

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Feedback regarding to LD bed finding responsibilities	See previous				
Confirmation of actions completed from PwC Audits **- Mental Capacity Act** **- S132**	All actions completed.	Full assurance	None	None	None
Derby City AMHP Update including quarterly DOLS report Derbyshire County Council AMHP Update	Report received.	Data needs interpretation at MHAC sub group.	DoLS assessment breaching time thresholds.	To cross check LA DoLS data with Trust internal report.	None
Recommendations from Deloitte Report for Mental Health Act Committee	Recommendations noted.	To form MHAC sub group to meet 4 weeks before MHAC.	None	None	None
Any Other Business	None	None	None	None	None
MHAC BAF risks – review of discussions that could affect the risk rating of the Committee's risks	To be updated in next week by John Sykes.	N/A	None	None	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
2017/18 Forward Plan	Noted	N/A	None	None	None
Issues escalated to Board, Audit & Risk Committee or other Board Committees					None
Meeting effectiveness	Improvement n preparation noted but still some outliers re papers. Sub group should shorten MHAC and improve assurance levels.	N/A	None	None	None
S117 Audit – for information	Action plan previously agreed by MD under executive action.	N/A	None	None	None

Enc I

Derbyshire Healthcare
NHS Foundation Trust

Substance Misuse Services

Report to Trust Board – 28th June 2017

David Hurn
Dr Senthil Mahalingam

Better together

Enc I

Derbyshire Healthcare NHS Foundation Trust provides a range of drug and alcohol services offering support adults of all ages in our local communities.

NHS
Derbyshire Healthcare
NHS Foundation Trust

Derby drug and alcohol service

Derby drug and alcohol service (DDAS) is a partnership between Derbyshire Healthcare NHS Foundation Trust, Phoenix Futures and Aquarius. The service is based at St Andrews House and St Peters Churchyard in Derby. The service is for any adult (18 years +) who wishes to address any issues they have caused by the use of drugs or alcohol. DDAS only accepts referrals via the Single Point of Entry Assessment and Recovery (SPEAR) for drug and alcohol treatment provided by Phoenix Futures. This is an open access (Monday to Friday, 9.00am - 4.00pm) assessment service with no appointment required.

Derbyshire Recovery Partnership

From 1st April 2017 Derbyshire Recovery Partnership (DRP) is a DHcFT led partnership with Phoenix Futures, Derbyshire Alcohol Advice Service and Intuitive Thinking Skills providing services to meet the health and harm reduction needs of those in Derbyshire with a drug and/or alcohol problems. The teams offer different levels of support from brief advice and harm reduction to prescribing, structured 1-to-1s and group work. Services are based at 4 main sites across Derbyshire and via satellite bases and clinics.

DHCFT @derbyshcft

www.derbyshirehealthcareft.nhs.uk

Better together

Key Achievements

Derbyshire Healthcare NHS Foundation Trust

Derbyshire Recovery Partnership

- Recovery Partnership implementation project completed
- Successful transfer of service users and TUPE of staff from DAAS and Addaction across to new Derbyshire Recovery Partnership Derbyshire

Derby Drug and Alcohol Service

- PIED (Performance & Image Enhancing Drugs) Outreach pilot
- ECG pilot project started in December 2016

Both Derby and Derbyshire services

- Naloxone (anti-overdose medication) projects ongoing
- Fully paperless system and archiving undertaken from October 2016
- Analysis of high risk service users and drug related deaths
- New IT links between SystmOne and Paris

Key Challenges

Derbyshire Healthcare NHS Foundation Trust

- New partnership with Derbyshire Alcohol Advice Service (DAAS) to provide SPoA for Derbyshire Recovery Partnership
- Performance in terms of 'successful discharges' have been low in county over past 12 months and variable in city.
- Notice served and new tender for Derby integrated service (+ new lots) scheduled for Sept 2017 for April 2018 start*
- Deaths within substance misuse are frequent and on increase in-line with national trends. Impact Trust figures and resource commitment significant for investigations and external oversight via Public Health.
- Targeted CQC inspection due in 2017 – date TBC

CQC Targeted Inspection

Derbyshire Healthcare NHS Foundation Trust

Strengths

- Integrated operational and clinical leadership
- Fully electronic patient record implemented
- Multi-disciplinary services/teams
- Clinical pilot projects
- Learning from drug related deaths
- Integrated governance

Challenges

- Lack of detail from other targeted inspections
- Two separate contracts/services
- Supervision (clinical and managerial)
- MHA/Capacity standards
- Mixed quality of care plans across providers
- Historic NDTMS data quality

Derbyshire Healthcare NHS Foundation Trust

Plans for future improvement

- Implementation of Health Improvement Team (HIT) within DRP model to focus on wider and co-morbid health issues
- ECG pilot to go into county
- Hepatology in-reach in north Derbyshire via Sheffield ODN
- Capacity implementation (inc audit) based on new model and MCA training across all providers
- Paris IT training across Phoenix and Aquarius staff to build on new IT links and Mental Health Homicide Review findings.
- Further ‘mystery shopper’ input from Phoenix national service user team to check/challenge model and delivery

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors - 28 June 2017

Equality, Diversity & Inclusion Update June 2017

Purpose of Report

The purpose of this paper is to present to the Board an update relating to equality, diversity and inclusion (ED & I) including Draft Public Sector Equality Duties & EDS2 Implementation Plan 2017/18 setting out our plans for annual grading process, Draft Board Equality Action Plan 2017-2020 (top six priorities) and Board ED& I Development Session 12th April, 2017 Evaluation Report. The aforementioned documents can be found at Appendices 1 – 3.

Executive Summary

EDS2 17/18 forward planning and risk management - ensuring Trust operates inclusively and demonstrating compliance with Equality Act 2010.

This report is presented in a format and context that is aligned to the EDS2 Goals and evidence, particularly with reference to EDS2 Goal 4: Inclusive Leadership *(leaders engaging and responding to the needs of the diverse REGARDS groups)* and EDS2 Goal 3: Empowered, engaged and well supported staff *(a good and fair employer for all REGARDS groups).*

It presents an update on our journey to reaffirm and demonstrate our commitment to equality, diversity and inclusion (ED&I). The Trust is committed to ensuring ED & I and human rights are central to the way we deliver healthcare services to our service-users and how we support our staff. We want to be known as a caring and progressive organisation that promotes equality, values and celebrates diversity and has created an inclusive and compassionate environment for receiving care and for employment. This means that we work to ensure that our staff provide inclusive services that are equally good to all service users, which meet their needs and are delivered with kindness, dignity and respect, . We also want to ensure that all our staff are engaged, valued and treated equally with kindness, dignity and respect.

We are committed to ensuring an environment where harassment, bullying and discrimination are not tolerated and where our culture ensures that all people including those who are often left behind or traditionally excluded, for example, and vulnerable people or living in poverty are treated fairly and compassionately.

EDS2 Outcome 4:1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.

- Draft Public Sector Equality Duties & Equality Delivery System2 (EDS2) implementation plan 17-18 sets out the specific actions and leads to undertake our annual EDS2 grading by stakeholders and communities of interest. This will be discussed in detail at the Trust Equalities Forum on the 10th July 2017 and is part of quality assurance reporting to commissioners (QAG). Appendix 1.

- Draft Board Equality Action Plan 2017-2020 (top six priorities), including measureable targets and accountable leads. Appendix 2

- Board Equality, Diversity and Inclusion Development Session 12th April, 2017 Evaluation Report is presented at Appendix 3.

- Embedding British Sign Language Charter Standards – Health Information event for Deaf people, held on the 17th May, 2017 at Derby Deaf Club. This was delivered in partnership with Robyn Ash, British Deaf Association and clinical staff. The session was opened by Ifti Majid, Chief Executive and interactive stalls and workshops delivered by Kath Lane, Deputy Director of Operations and team. Building on the success of this event, it has been agreed to make this an annual event, taking place next year on Saturday 19th May, 2018. BSL Interpreting reviewing service experience and quality to take place on the 27th September 2017 at Derby Deaf Club. The purpose is gain feedback from deaf people to ensure quality provision of trained BSL Interpreters used by our new Interpreting provider Captia and Communication Unlimited (NRCPD qualified and registered interpreting agency).

EDS2 Outcome 4.2: Papers that come before the Board and other major committees identify equality –related impacts including risks, and say how these risks are to be managed.

- This will be audited in February, 2017, as set out in Draft Public Sector Equality Duties & EDS2 implementation plan. The Board took the opportuntiy during ED& I development session 12th April, 2017 to refine the Board and key committees front summary sheet as follows :

Public Sector Equality Duty & Equality Impact Risk Analysis The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people).	
There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	
Actions to Mitigate/Minimise Identified Risks	

EDS2 Outcome 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination. Evidence for this will be drawn from new engagement group, work streams, workforce data, surveys, Workforce Race Equality Standard analysis and BME Staff Support Network.

EDS2 Goal 4 and EDS2 Goal 3: Empowered, engaged and well supported staff and Workforce Race Equality Standard *(Is the Trust a good and fair employer for all REGARDS groups)*

- Reverse Mentoring for Diversity and Inclusion (ReMeDy) pilot in partnership

with Stacy Johnson, Associate Professor, and University of Nottingham proposal. A joint introductory and scoping meeting was held on the 7th June, 2017 with Executives and Black and Minority Ethnic (BME) staff network to consider adopting the pilot, with plans to cascade it across bands/professions alongside traditional leadership programmes and mentoring opportunities. The BME Staff Support network and Reverse Mentoring pilot is championed by Ifti Majid Trust, Acting Chief Executive. This intervention will enable senior leaders (initially Executives as mentees) to gain insight into the lived experience of BME staff and support development of cultural competence, inclusive culture and environment. Moreover, support the delivery of People Plan and DHCFT Workforce Race Equality Standard action plan to address variations across the 9 indicators, in terms of growing BME leadership pool through existing and new development and talent management approaches. As a learning organisation we are keen to support this research and generate new evidence based practice. This work and evaluation will include liaising with Rubina Reza, Research Manager in relation to linking into Trust Research and Assurance Group. The session objectives:

- To explore mechanisms, training and organisational development required to set up effective and successful reverse mentoring schemes
- To Introduce the RACE and gRACE Frameworks (Johnson 2017) for reverse mentoring
- To discuss the merits and risks of reverse mentoring as a strategy for improving the capacity and capability of leaders in the UK health sector to be truly inclusive
- To explore the potential for reverse mentoring to raise the confidence and profile of BME staff in organisations and consider the contribution this might make to increasing the diversity of the leadership of the UK health sector

The next meeting to start to take this forward is taking place on 13th July, 2017.

Forward planning – 17/18

Workforce Race Equality Standard (WRES) 17/18 submission – to be submitted centrally through Unify 2 system (via IM & T) August 2017 and published on website annually along with Board statement. WRES action plan to be developed and tabled at key committees as part of reporting schedule, including Board 27th September, 2017. In line with the WRES Technical guidance, it is recommended that the Board consider WRES submission and findings at the July Board for sign off and Board statement.

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

Assurances

The Equality Forum together with Quality Assurance and People and Culture (PCC) Committees will ensure the Trust meets its statutory duties under the Human Rights Act (1998). Equality Act (2010) and Public Sector Equality Duty

- EDS2 16/17 – completed and You said, we did feedback by General Manager in September 2017.
- Draft Public Sector Equalities Duty & EDS2 17/18 implementation and work plan tabled at Equality Forum 10th July, 2017 and Board update due 27th September, 2017.
- Board Assurance Framework risk 3d is regularly presented to Equality Forum and PPC to discuss control. Controls to ensure data completion (85% target) and stakeholder capacity – discussed at Equality Forum 10th April, Board Development 12th April, and PCC on the 20th April, 2017.
- Meets statutory duties under the Human Rights Act (1998). Equality Act (2010) and Public Sector Equality Duty.
- Quality Assurance Schedule 4 2017/18 reporting e.g. EDS2, WRES, publishing equality information on website.
- Tackling potential inequalities in our services and employment and thus helping to deliver our corporate vision and strategy.
- Informs better decision making based on evidence based working.
- Information is being collected and acted on to ensure learning informs changes in practice.
- More effective targeting of policy and resources.
- More effective use of talent and networks in the workforce.

Consultation

Involve engagement with service users, carers, community, health watch, governors and workforce, including BME Network and University of Nottingham.

Governance or Legal Issues

Equality Act 2010 - the legal duty to comply with the Public Sector Equality Duty (PSED) The Equality Act provides legal protections for 9 characteristics: age; gender; ethnicity; disability; religion; sexual orientation; gender-reassignment; marriage & civil partnership, and pregnancy & maternity. These are referred to as protected characteristics or protected groups. Under the Equality Act, public sector bodies have a duty to publish evidence on how they have: eliminated discrimination against protected groups, advanced equal opportunities for protected groups, and fostered good relations between those in protected groups and those outside of them. There is also a duty to set equality objectives every 4 years.

From April 2015, EDS2 implementation by NHS provider organisations was made mandatory in the NHS standard contract. EDS2 implementation is explicitly cited within the CCG Assurance Framework and embedded within the CQC new inspection regime for hospitals Care Quality Commission's key inspection - are

services - well led, safe, caring, effective and responsive.

Equality Impact Risk Analysis The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people).	
There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential gaps/inequalities are outlined below, with the appropriate action to mitigate or minimise those risks.	x

Actions to Mitigate/Minimise Identified Risks

Reverse Mentoring intervention will help to us to understand the reported variations in BME staff lived experience in the work place. This will inform the People Plan, Board Equality Action Plan priorities and WRES Action Plan with regards to addressing potential workforce and employment journey differences between white and BME staff. WRES 17/18 report, finding and outcomes to be presented as a separate report and action plan. (See recommendations).

WRES 2016 via staff survey :

- Indicator 5: KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months – white 27% (32.42% 2015) and BME 29% (40.91% 2015)
- Indicator 6 : KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. – White 22% (22.53% 2015) and BME 21% (18.8% 2015).
- Indicator 7 : KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion - White 75% (83.57% 2015) compared to BME 73% (80,0% 2015)
- Indicator 8: Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues. White 6% (6.85 % 2015) and BME 10% (13.64% 2015)

http://www.nhsstaffsurveyresults.com/workforce-race-equality-standard-wres/

Recommendations

The Board is requested to:

1) Approve Draft Public Sector Equality Duties & EDS2 Implementation Plan 2017/18 setting out our plans for annual grading process.

2) Note EDS2 Outcome 4:2 10 Board/key committee papers to be audited in February, 2017, as set out in EDS2 implementation, 2017/18

3) Approve Draft Board Equality Action Plan 2017-2020 (top six priorities)

4) Note Board ED& I Development Session 12th April, 2017 Evaluation Report and consider additional session to achieve 90% attendance.

5) Note and support Reverse Mentoring for Diversity and Inclusion (ReMeDy) pilot in Partnership University of Nottingham. The initial pilot

	will include Executive mentees paired with BME staff (Mentors)
6)	Consider scheduling WRES 17/18 submission and findings, including board statement at July, 2017 board prior to submission to NHS England National WRES team 1st August, 2017 (in line with WRES technical guidance)

Report presented by: Harinder Dhaliwal, Assistant Director for Engagement & Inclusion

Report prepared by: Harinder Dhaliwal, Assistant Director for Engagement & Inclusion

Appendix 1: Draft Public Sector Equality Duties & EDS2 Implementation Plan 2017/18 setting out our plans for annual grading process,
Appendix 2: Draft Board Equality Action Plan 2017-2020 (top six priorities)
Appendix 3: Board ED& I Development Session 12th April, 2017 Evaluation Report

Appendix 1: DRAFT Equality public sector duties & Equality Delivery System2 (EDS2) Implementation Plan 2017/18

2017					2018
April – May 2017	June 2014	July to October Goals 1 & 2 Service delivery & experience Goal 3 workforce		September 2017	November 2017 Goals 1 & 2 Service delivery & experience	January 2018 EDS2 Goals 3 & 4 Workforce & leadership
Equality, Diversity & inclusion EDS2 Board Development session held 12th April, 2017 Equality objectives reviewed and Top 6 Board equality priorities identified and action plan developed 28th June, 2017 Inform Board Governance arrangements and leadership commitment (1) WRES populated via ESR and UNIFY2 system (Workforce &		Assemble EDS2 9PCs/REGARDS evidence including active consideration of any gaps in evidence* for both services and workforce. Identify service and corporate KPIs for this year's EDS2 grading cycle (to gradually focus on all services/neighbourhoods over next 5 years) Develop service & corporate evidence base to inform stakeholder engagement and EDS2 grading documents. *REGARDS equality monitoring data, CQC registration evidence, surveys of patient and staff experience, workforce data	Engagement activities Identify local interests and stakeholders including 4Es Stakeholder Alliance, HW, carers, governors, staff side, staff networks Launch EDS2 consultation and evidence. WRES analysis action plan 17/18 developed through –	EDS2 2016/17 Equality objectives and priority actions identified on the 22/3/2016. Update and feedback to local interests and stakeholders 'You said, we did' report for neighbourhoods and Perinatal. Publish grades and update against priority actions on website Lead: Deputy Director Operations and General Managers.	EDS2 17/18 stakeholder grading event. Present self-assessment and evidence. The Trust has analysed its performance on each EDS2 outcome, through various engagement activities during July – October 2017 Review annual equality objectives and identify priority actions. Lead: Deputy Director Operations	Provide preliminary report to stakeholders Board EDS2 Goals 3 & 4 Grading events with workforce community including staff networks. WRES data and priority actions. Lead: Director of People & Organisational

IT)	and reports, WRES, demographic data, local Health watch insight, and complaints and PALS data. Review Equality objectives Populate using EDS Summary Report** WRES data submitted to NHS England WRES team - deadline 1st August 2017 – sign off by People & Culture Committee/Board prior to publishing on Trust website.	engagement with BME Staff Support Network. People & Culture committee/Board sign off prior to publishing on website.		and General Managers. Director of Nursing & Patient Experience. .	Effectiveness CEOs/Board Members.

2018	
February 2018	March – April 2018
Audit 10 Board & key committee papers (EDS2 Goal 4 –outcome 4: 2) Review Feedback and revise equality objectives Lead : CEOs/Board members as per Board Equality Action Plan	Board update and sign off Revised/updated equality objectives and priority actions following EDs2 grading Annual Public Sector Equality Duty Report (REGARDS data and analysis of compliance against equality duties) The Trust's EDS summary report and dashboard documents published on the Trust website

*REGARDS & Protected Characteristics - taking into account of each relevant protected group, i.e. ; Race; Gender; Gender ; Reassignment, Age, Religion & Belief; Disability; Sexual Orientation; Marriage & Civil Partnership; Pregnancy & Maternity. Other disadvantaged groups to be considered i.e. people who are homeless, people who live in poverty, people who are long-term unemployed, people in stigmatised occupations, people who misuse drugs, people with limited family or social networks and people who are geographically isolated.

** The *EDS2 Summary Report* enables organisations to outline their EDS2 grades, summary of engagement activity, and the evidence that sits behind the grades, as well as the organisation's equality objectives and headlines of good practice outcomes emerging from EDS2 use.

Appendix 2: Draft Board Equality Action Plan 2017-2020 (top six priorities)

(DRAFT) BOARD EQUALITY ACTION PLAN 2017-2019

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

	Priority	Target (KPI) & by when	Responsible Executive Lead	Actions	RAG Rating	Outcome & sources of evidence (crossed reference to equality duties, EDS2 outcomes and WRES)
1 a	Completion of data (*across the nine protected characteristics/PCs/REGARDS) for a) services and b) workforce	a) Service 85 % (Ethnicity 90% MHMDS)	Mark Powell Acting Chief Operating Officer Carolyn Green Director Nursing & Patient Expereince	1. Embedding and putting in place a tracking system to measure compliance - 9PCs/REGARDS baseline report monitored via Integrated Performance Report 2. Annual statutory REGARDS/9PCs performance report by service areas and employment cycle (gaining assurance of fairness processes)		• Continuous improvement and steps taken to improve recording across all 9PCs/REGARDS. • EDS2 grading progressing (triangulation of evidence to support independent EDS2 grading by stakeholders). • Service and workforce REGARDS/9Pcs information/profiles published (evidence for Local Quality Requirement 17/18 Schedule 4 ref 43, Equality Act 2010 and support annual EDS2 positive progress and grading. Statutory information published on DHCFT external website)
1 b		b) Workforce 85% By March 2018				
2	Developing engaging and inclusive leadership	c) 100% executives participate in Reverse		3. Adoption of Reverse mentoring pilot programme in partnership with University of Nottingham. Introductory and action planning	Amber	• Inclusive culture, work environment and statutory compliance. Enhanced senior leadership cultural

		Mentoring Pilot - mentored by BME Mentee d) 90% Board members have undertaken Board Equality& Inclusive leadership & Equality Impact Risk Analysis training. e) 10 instances or examples when Board members & senior leaders demonstrate their commitment to equality in past year. f) Board representative of local community		session with Associate Professor Stacy Johnson, executives and BME Staff Network took place on 7th June, 2017. 4. Board development attendance and evaluation. Board E, D & I training 8 attendees (57%) of 14 Board members completed 5. Board members and senior leaders' appraisals include equality and inclusion objectives (proactive steps to embed REGARDS, address under-representation and variations in equitable and fair access to development opportunities and services e.g. traditional mentoring and development opportunities) 6. Workforce Race Equality Standard tracking system to close any disproportion across the 9 indicators and demonstrate significant shift in distribution of BME across the bands and senior leadership pool.(Integrated Performance report, People Plan and People & Culture Committee)	Amber	competence and capability. • Equality is advanced and good relations are fostered. • Progressive organisation & best practice. Positive impact on culture and behaviours (understanding and learning from lived experience of BME staff, reduce potential systemic barriers and biases). • Portfolio of tangible examples of regular communication, blogs, reports, presentations, speeches, including quality visits and corporate messages demonstrating commitment & making a difference to REGARDS, Equality, Diversity and Inclusion by Board members and senior leaders to various committees and audiences (EDS2 outcome 4:1 & 4:3) • Positive feedback from stakeholders (including workforce). Staff Survey, WRES, FFT.(EDS2

		g) The chairs appraisal of directors and board includes equality & inclusion objectives and recruitment opportunities to retain and attract board members & senior leaders from diverse backgrounds. h) Workforce Race Equality Standard Indicators are tracked and disproportion closed across the 9 indicators. (year on year improvement from baseline				outcome 2:4 & 3.6) • WRES standards –positive experience and shift in representative workforce and distribution pattern between white and BME people across the bands including senior leadership positions. Equal and fair access to recruitment, promotion and development (so talented BME people can thrive and robust BME talent pipeline/ succession planning for potential BME senior leaders).(Equality Act 2010 duties, WRES indicators 1-9) & EDS outcome 3:1 - 3:6)

		2017)				
3	Allocate corporate resources to progress the equality and inclusion agenda within DCHFT	i) Budget and cost centre by June 2017	Ifti Majid, Acting Chief Executive	7. Equality budget set up and resources allocated -(completed) 8. Programme of diversity events (internal and external) to progress equality and inclusion. 4Es/targeted focus groups to help analysis of EDS2 grading with stakeholders. Support for staff diversity networks, annual conference and talent management programmes. Reverse mentoring pilot costs. BSL Charter implementation and engagement events.	Green	• Equality & inclusion is advanced and good relations are fostered. • Budget agreed.
4	Demonstration of 'due REGARDS' relating to strategy, policy and decision-making	j) Ten substantive papers that came to the Board and other major committees in the past year demonstrate Equality Impact Risk Analysis (EIRA) taken into consideration and risk		9. Evidence based decision making: tangible examples of REGARDS wheel prompts and EIRA data used to proactively discuss and tackle variations and inequalities presented at the Board. 10. EIRA Board & key committee papers Audit - equality-related impacts including risks, and said how risks will be managed. Impacts and (EDS outcome 4:2)		• Board paper audit as part of evidence in meeting EDS2 Outcome 4:2 • Equality is advanced and good relations are fostered. • Embedding equality and evidence based decision making.

		managed (related to the three elements of the general duty of the public sector Equality Duty & Brown Principles). By April 2018				
5	Develop refined community engagement mechanisms (particularly reaching out to seldom heard/traditionally excluded groups)	k) Targeted outreach engagement – 9 PCs seldom heard groups. Each Board member/ Executive aligned to REGARDS strand & visits one group (e.g. LGBT), and feeds issues and needs into Board- 90% By April 2018 l) Review of 4Es Stakeholder Alliance in		11. Review 4Es Stakeholder Alliance to support long term sustainable relationships and annual EDS2 grading. 12. Targeted outreach plan with traditionally excluded/seldom heard groups of people fed in Board and EDS2 assessment process.		• Executive REGARDS visits and evidence of Board discussion and feedback from stakeholders (including workforce). . • Equality is advanced and good relations are fostered. • Engagement is an intrinsic part of the NHS Equality Delivery System.

		partnership with members of alliance by November 2017 m) % Executives attending established engagement with existing groups e.g. Carers Forums. By April 2018				
6	EDS2 assessment – continuous improvement across the 4 Goals/18 outcomes	n) No red rating (undeveloped) by 31st March 2018. 70% green (achieving grade) by 2019 and 100% by 2020.		13. Integrate into performance reporting.		• Annual EDS2 Plan and grading by stakeholders (including workforce). • BSL Charter championed and standards embedded. • WRES action plan.

Appendix 3: Board ED& I Development Session 12th April, 2017 Evaluation Report

Evaluation: Board Development Equality, Diversity & Inclusion (ED&I) Development session
Wednesday 12th April, 2017 from 9.30 am to 1.00pm at the Centre for Research & Development, Kingsway Site.

Introduction

This report summarises the evaluation from Board Development Equality, Diversity & Inclusion (ED&I) session held on Wednesday 12th April, 2017 coupled with key top six actions and Board Equality action plan.

This was a focused half day equality Board development session, facilitated by Amanda Rawlings, Director of People and Organisational Effectiveness and Harinder Dhaliwal, Assistant Director for Engagement & Inclusion (Trust equality lead). It provided protected time to reflect and take stock of our current position and our aspirations for equality and inclusion. We use the opportunity to review our corporate Equality Objectives and identify specific Board actions to drive a strategic approach to improve our culture, equality performance and proactively leverage the benefits of inclusion and engagement. This is about living our values as a progressive, compassionate and inclusive organisation. We want to provide the best possible care and be the preferred employer and best place to work.

Board members have drafted a set of top six focused actions that can make a major impact, drive inclusive behaviours, and ensure compliance, innovation, and continuous improvement and delivery of our corporate priorities. The draft actions have been refined into a measureable action plan, which has been developed to be included in the current business planning period. This is being presented in more detail at the June 2017 Board meeting.

Aims of the session:

- This session will help to support the Board in developing the strategic connections between Equality, Diversity & Inclusion (ED&I) and see it as part of everyday core business and a fundamental part of the organization's culture.

- Opportunity for the leadership to focus on diversity's strategic potential to contribute to the e-quality agenda and creating an inclusive environment to ensure services and employment are equally good and working well for everyone.

- Overall this session is to help encourage the Board to make a commitment to do things differently, learn from past challenges and become a beacon of best practice in relation to staff and patient experience and outcomes.

Outcomes of the session to:

1. Increase Board assurance, governance and culture of equality, diversity & inclusion by ensuring the Board has an understanding of their responsibilities with regards to regulatory and equality legislation and how Trust compliance is proactively integrated, operationalized and maintained.

2. To understand how equality, diversity & inclusion makes as a positive and strategic contribution to the successful operation of an organization and most importantly the quality of patient care and progressive employment.

3. Creating a shared vision of equality, diversity & inclusion and identifying actions that will make a major impact on the lived experiences and improvement of outcomes for people from protected characteristics

4. Building Equality, Diversity & Inclusion into how the Board operates.

DHCFT Equality Objectives 2017-2019

1. Consider the impact of what we do (or are planning to do) on all sections of the community / protected characteristics).
2. Increase and improve DHCFT' awareness and understanding of equality, fairness, diversity, inclusion and Human Rights issues – improve organisational culture.
3. Better understand, and more effectively meet, the needs of all our service users / patients.
4. Better understand the profile and experiences of our employees and achieve a diverse workforce.
5. Progress the equalities agenda within DHCFT.

Attendees:

This half day session included 8 attendees (57%) out of 14 board members participated:

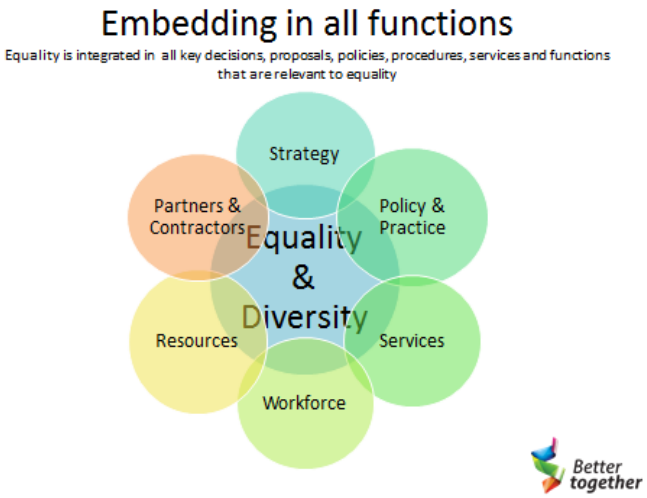
- Ifti Majid, Acting Chief Executive
- Amanda Rawlings, Interim Director People & Organisational Effectiveness
- Carolyn Green, Executive Director of Nursing & Patient Experience
- Samantha Harrison, Director of Corporate Affairs/Trust Secretary
- Caroline Maley, Acting Chair
- Dr Julia Tabreham, Deputy Chair & Non-Executive Director

- Margaret Gildea, Non-Executive Director & Senior Independent Director
- Richard Wright, Non-Executive Director

Apologies received from:

- Mark Powell, Acting Chief Operating Officer
- Claire Wright, Deputy Chief Executive & Executive Director of Finance
- Dr John Sykes, Medical Director
- Lynn Wilmott-Shepherd, Interim Director of Strategic Development
- Barry Mellor, Non-Executive Director
- Dr Anne Wright, Non-Executive Director

Discussion and key messages



Equal quality –Equitable - **Access - Experience - Outcomes**

Our context, approach and the why ED&I is critical to our success (business Case) was discussed: a survey of the academic literature was considered. Four key conclusions from the research are that:

- Diversity, if appropriately managed, can result in business benefits. However, if poorly managed, it can also increase business cost.

- The firm's economic and organisational context is crucial in determining the way in which equality and diversity brings about business benefits.

- There is no single approach that businesses can adopt to ensure equality and diversity are beneficial.

- Strategic approaches are likely to be more successful: equality and diversity need to be embedded in the business organisational strategy, not ad-hoc additions to the business.

Source: Government Equalities Office: The Department for Business Innovation and skills (January 2013)

Key points of discussion included :

- Doing inclusion right is part of running a inclusive, compassionate, efficient, ethical and socially responsible organisation.
- Making a difference to peoples life chances, so they can be the best they can be.
- Making a difference - tackle health inequalities, social exclusion and stigma.
- Organization that has an inclusive mindset and behaviours to excel at providing a high quality service and employment to diverse people
- Not just a must do (not just legislation) but about a desire to create culture /environment that is inclusive (good for everyone) and where people can be themselves. A 'must-have' to manage it as a strategic lever to leverage the potential and commitment of staff.
- The diversity of our workforce and service uses enriches us all and allows us to deliver best-in-class services and employment.

Our collective mission....

Action planning: how can the Board demonstrate a strong and sustainable commitment to promoting equality and inclusion within and beyond the organisation?

Board - creating a shared equality vision and objectives

Working with due REGARDS and respect in Derbyshire Healthcare NHS Foundation Trust so that everyone can be the best they can be.

REGARDS diversity wheel and understanding equality terminology and definitions

How our diversity adds value - ice-breaker: learning and connecting with each other and leveraging the benefits of diversity. Our collective talents and skills benefit our Trust and people. We are the same but different, basic human rights, compassion &fairness.

Everyone has a responsibility to promote equality and inclusion. What are you personally going to do to progress the agenda forward?

Our top 6 priority actions

Board equality action plan -provisional draft top six actions for further discussion and refinement:

- Completion of data (across the nine protected characteristics) for services and workforce – target 85% by March 2018
- Developing engaging and inclusive leadership
- Allocate corporate resources to progress the equality and inclusion agenda within DCHFT
- Demonstration of 'due REGARDS' relating to strategy, policy and decision-making
- Develop refined community engagement mechanisms.
- EDS2 assessment – no red (undeveloped) rated by 31st March 2018 and 70% green (achieving grade) by 2019 and 100% by 2020

Feedback, expectations and learning.

Participants rated aspects of the session as follows:

1. How did you rate today's workshop on a scale of 1 = poor / 5 = very good. Very Good = 8 (100%)

2. How effective was the style and approach of training in supporting your learning – Excellent = 8 (100%)
3. As a result of this workshop please indicate how you would assess the improvement in your understanding against each of the following:

	Satisfactory	Good	Very good
REGARDS & Protected Characteristics	1 (12%)	1 (12%)	6 (76%)
The business case for equality, diversity and creating an inclusive culture (must do, to must have)		4 (50%)	4 (50%)
Your personal responsibilities with regards to regulatory compliance and equality legislation	1 (12%)	3 (38%)	4 (50%)
Equality Act 2010 and Public Sector Equality Duties		4 (50%)	4 (50%)
Equality Impact Risk Analysis & Brown Case Law principles	2 (28%)	3 (44%)	2 (22%)
Equality Delivery System2 and how it can be used as an enabler to embed and drive inclusion.		5 (62%)	3 (38%)
Workforce Race Equality Standard & other standards		7 (87%)	1 (13%)

4. What was the most useful part of the session?

- Bringing equalities to life and supporting shared examples.
- Listening and understanding.
- The ice-breaker -great team building.
- This session absolutely improved my awareness. I still feel I need to do more work to say my understanding is excellent.
- REGARDS when sharing and setting Board Priorities.
- Ice breaker, brilliant!
- Shared experience
- Loved the ice-breaker and getting the 6 objectives.

5. Did the session meet your expectations and any further comments? Are there any areas you would like to explore further?

- Excellent session – covered detail, strategic issues, and opportunity to share experiences and to understand colleague's perspectives and impact of REGARDS groups.
- Brilliant morning, thank you.
- Yes – exceeded them.
- Very good, Harinder
- Expectations were met
- Yes, further exploration of this work into practice.

6. Would you recommend this workshop to other colleagues?

- Without doubt. Good to think about how we can use of the session with middle managers.
- Yes(5)
- Absolutely, tremendous use of Board time.
- Yes excellent. Thank you for a very helpful session.
- Absolutely.

7. Other comments

- Excellent facilitation and superb handling of the logistics as we shaped the agenda on an on-going basis. Thank you Harinder!
- One of the best Board Development sessions I have ever attended. Thank you ☺
- Thank you Harinder, for the information and challenges.

Report prepared by :

Amanda Rawlings, Director of People and Organisational Effectiveness
Harinder Dhaliwal, Assistant Director for Engagement & Inclusion
14th June, 2017

Derbyshire Healthcare NHS Foundation Trust
Report to the Board Committee – 28 June 2017

Workforce Strategy and Plan 2017 - 2022

Purpose of Report

To provide the Board with the Trust's Workforce Strategy for 2017 – 2022 and a first year costed implementation plan to enable the Trust to proactively mitigate its workforce supply challenges, reduce reliance on agency and locum staff and retain staff by providing enhanced career pathways.

We have captured our five-year plan in line with the Health Education England (HEE) Mental Health Workforce Strategy (2017). Prioritisation for affordability and implementation has been given to Year 1 of the Plan. A review of cost for implementation and affordability will need to take place year on year in line with local and national developments. Although we have highlighted numbers for recruitment plans in mental health nursing, we will over-recruit in readiness for staff who may retire.

Executive Summary

The supply and demand gap for skilled staff in the NHS has never been more challenging than now. At the time of preparing this strategy we are have just triggered Article 50 to leave the European Union adding further challenges and a period of uncertainty with future workforce supply and retention. We are also experiencing the changes to national workforce funding models which is leading to new working arrangements between trusts, colleges and universities.

We have developed this strategy to scope out the challenges that we face as a trust and the steps we plan to take to address these. It is a living document and will evolve at some pace. We are testing new roles and workforce models and will look at adoption and spread across our trust. We aim to be an employer of choice and to build strong relationships with schools, colleges and universities and to ensure all students that come to us on placement have a positive and enriching placement that they want to return.

The organisation has now caught sight of the HEE Mental Health Workforce Strategy which sets out the Five Year Forward View for Mental Health, it is reassuring to see that the Vision highlighted by HEE mirrors the developments highlighted in our Strategy.

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

Assurances

The Trust's financial state has been taken into account in the development of this plan.

Consultation

Consultation has now taken place Trust wide and services have contributed to the development of this Strategy and costings.

Governance or Legal Issues

Progress of implementation will be monitored via the People and Culture Committee, Executive Leadership Team and TMT.

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

Actions to Mitigate/Minimise Identified Risks

We will ensure that all staff across all AFC pay bands have fair access to all developmental and training and opportunities identified in this document.

Recommendations

The Board Committee is requested to:

1. Sign off this document as the DHCFT WorkForce Strategy and Plan
2. Acknowledge that this Strategy and Plan will remain a live document and will be amended in line with local and national developments.
3. Acknowledge the need to fund the developments identified in this document and acknowledge the cost pressure identified in year 1.

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

Report prepared by: **Faith Sango**
Head of Education

Derbyshire Healthcare
NHS Foundation Trust

Workforce Strategy and Plan

2017-2022

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Executive Summary

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We have developed this strategy to scope out the challenges that we face as a trust and the steps we plan to take to address these. It is a living document and will evolve at some pace. We are testing new roles and workforce models and will look at adoption and spread across our trust. We aim to be an employer of choice and to build strong relationships with schools, colleges and universities and to ensure all students that come to us on placement have a positive and enriching placement that they want to return.

Our Vision, Values and Strategic Objectives

"To provide services that meet the needs of the individuals and communities we serve, working with our people and partners to achieve a collaborative approach."

We are proud of the services we offer and these need to be underpinned by our values. We need to ensure that we live our values and that they underpin everything we do. The values we will live by are:

- We put our service receiver at the centre of everything that we do – we are **respectful** and **responsive**
- We focus on our people – we work with **integrity** and **trust**
- We involve our people in making decisions – we encourage a culture of **honesty** and **openness**
- We will aspire to deliver excellence – we work in **partnership** with service receivers and stakeholders. We will enable teams to be **effective** and **efficient**.

1. We will deliver **quality** in everything we do providing safe, effective and person 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.

.

National Drivers

The DHCFT Workforce Strategy takes into account NHS national policy that is currently shaping the future of NHS services. As a result, ensuring the adequate supply of staff with the right skills, values and behaviours in the right numbers to deliver safe, effective high quality care is of the most significant importance to the organisation**.**

The Derbyshire Sustainability and Transformation Plans (STPs) will drive a realistic and sustainable transformation in health and care outcomes between 2016 and 2021. Partners across Derbyshire including commissioners and providers, from health and social care have been working on developing our service priorities. It is known in Derbyshire that people are living longer with long term conditions and that this increasing life expectancy and decreasing health puts added pressure onto health and care services. The STP approach to deliver these services is to provide a more holistic model of care which supports the maintenance of independence, is safe, promotes health, and is delivered closer to home.

DHCFT will deliver change aligned to the Derbyshire STP workforce priorities:

- Delivering, where possible, in the “place” where people live by local teams
- Preventing and delaying the onset of deterioration with existing health and care conditions
- Addressing the Urgent care needs of our population
- Ensuring there is a workforce available to provide the care defined in the STP

To enable us to achieve this we will develop our existing workforce and attract new people to address the key areas:

1. Increase the number of people who enter into our care workforce, be that in private, voluntary, Local Authority or Health provision. Building on our talent for care academy approach for Derbyshire.
2. Increase the number of Advanced Clinical Practitioners, drawing this workforce from not only nursing but Allied Health Professionals, Paramedic and Pharmacy workforce.
3. Continuing to introduce new roles and new ways of working where appropriate.
4. Ensure the supply of a future medical, nursing and therapy workforce by being a place where learners thrive and wish to stay on following completion of their professional study.
5. Developing our attraction and retention strategies for key workforce roles.

Health Education England (HEE) is responsible for ensuring that our future workforce has the right numbers, skills, values, cultural sensitivities and behaviours to meet patients' needs and deliver high quality care.

The need to support the development of a workforce which will deliver high quality patient care with staff working in extended roles across a variety of settings has been further emphasised with the publication of The NHS Five Year Forward View (DH, 2014). The Five Year Forward View sets out a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

In February (2016) NHS Improvement announced that Lord Carter's recommendations on acute hospital efficiency were to be extended to more sectors including mental health. Lord Carter's review identified significant savings which can be made through better use of clinical staff, reducing agency spend, absenteeism and adopting good people management practices. As such, the Trust has initiatives working on reducing absences, managing the need for bank and agency staff and reviewing new nursing roles. Details of the above work streams are referenced throughout our strategy.

Overview of our Current Workforce

For the first time in history there are 4 generations in the workplace, Baby Boomers, Generation X, Generation Y and Generation Z. Workforce statistics confirm that Baby Boomers are already starting to retire and will continue to do so over the next decade, Generation X and Y dominate the workforce, whilst Generation Z are beginning to graduate. Generations4Change, a project hosted by Health Education England aimed at supporting a multi-generational workforce for Derbyshire Health and Social care organisations aimed at improving attraction, engagement and retention across 4 generations was led by Derbyshire healthcare NHS Foundation Trust.

Generations4Change created an opportunity to explore the motivations of early career professionals to enable us to design workplace support and career opportunities that better address their needs. Local and national research shows that typically, the highest proportion of employees fall into Generation X. Younger workers are underrepresented at 10.92% of the overall workforce, compared to the population of Derbyshire at 21.82% and are most likely to leave with the highest leaving rate percentage compared to the other age profiles. Generation Y are less likely to be shortlisted and Baby Boomers are less likely to be appointed compared to those in Generation X. For organisations, this means Generation X is the largest and most stable cohort of the workforce, and as we continue to lose Baby Boomers due to retirement we rapidly need to address how we retain those workers considering retirement, meanwhile ensuring we meet the needs of generation Y and forward planning for generation Z.

Generations4Change built on the earlier findings from Birmingham's Mind the Gap report and created the opportunity to consider national research and for organisations to share experiences, knowledge and expertise with the aim of developing workforce strategies that reflect and respond to the age profiles of the workforce and future supply.

The project provided opportunities for employers across the system to support different generations to work in more integrated approach to support the overall delivery of the Sustainability and Transformation Plans (STP's) as described within the Derbyshire Workforce Strategy. The report identified 3 key system wide workforce objectives underpinned by a number of recommended opportunities for Derbyshire.

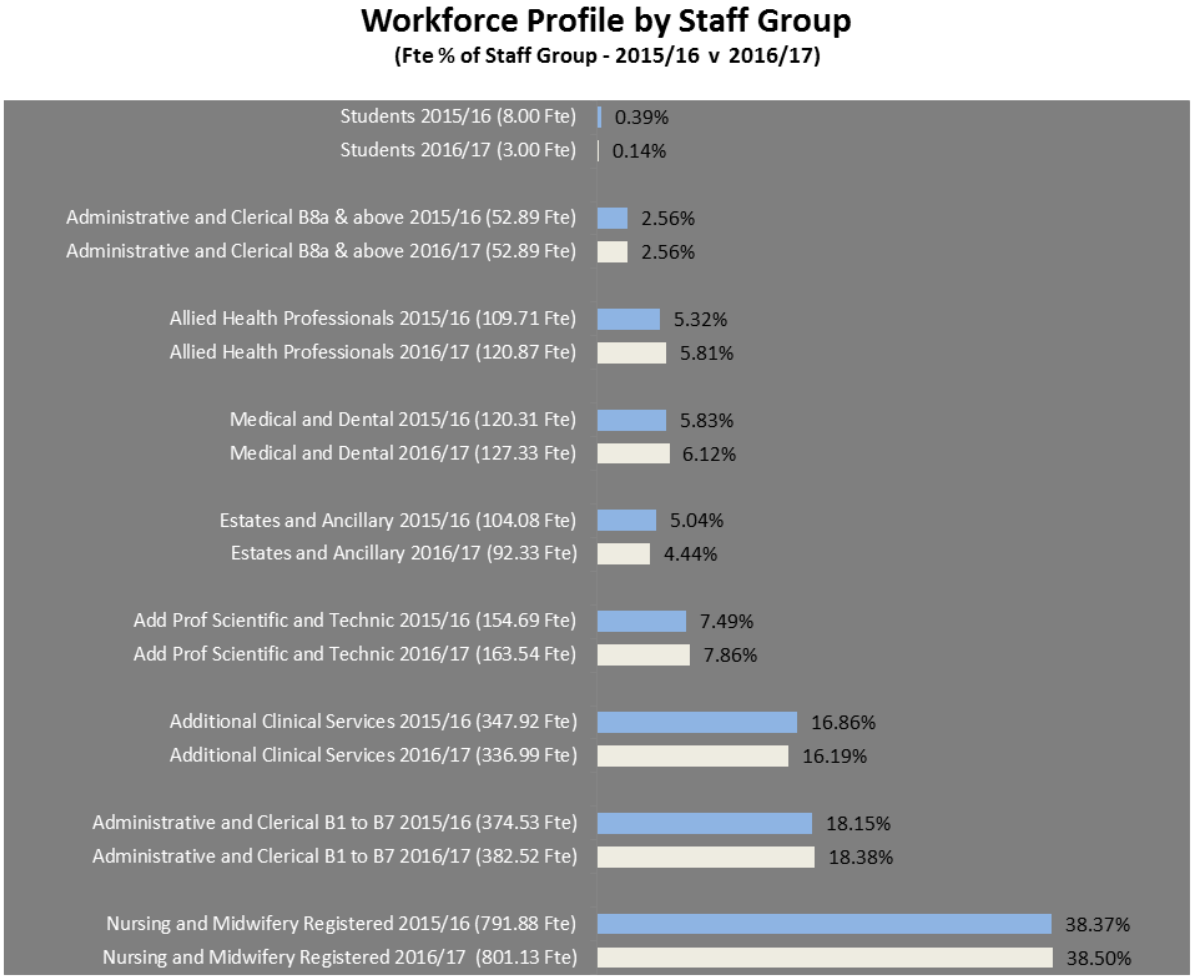
1. Modernising Resourcing
   Creating opportunities across organisational boundaries for new career pathways within health and social care including the promotion of career packages and vacancies available to the next generation through a range of social media.

2. Enhancing the Essentials

Development and enhancement of workforce policies to create new and innovative ways of working which will support the generational differences providing consistency and greater flexibility across the system

3. Transformational Engagement
   Providing a collaborative and enhanced approach to engagement, development and reward strategies for the health and social care workforce of Derbyshire

In conjunction with employers, the Derbyshire Strategic Workforce Implementation Group are considering the recommended opportunities included within the full report.

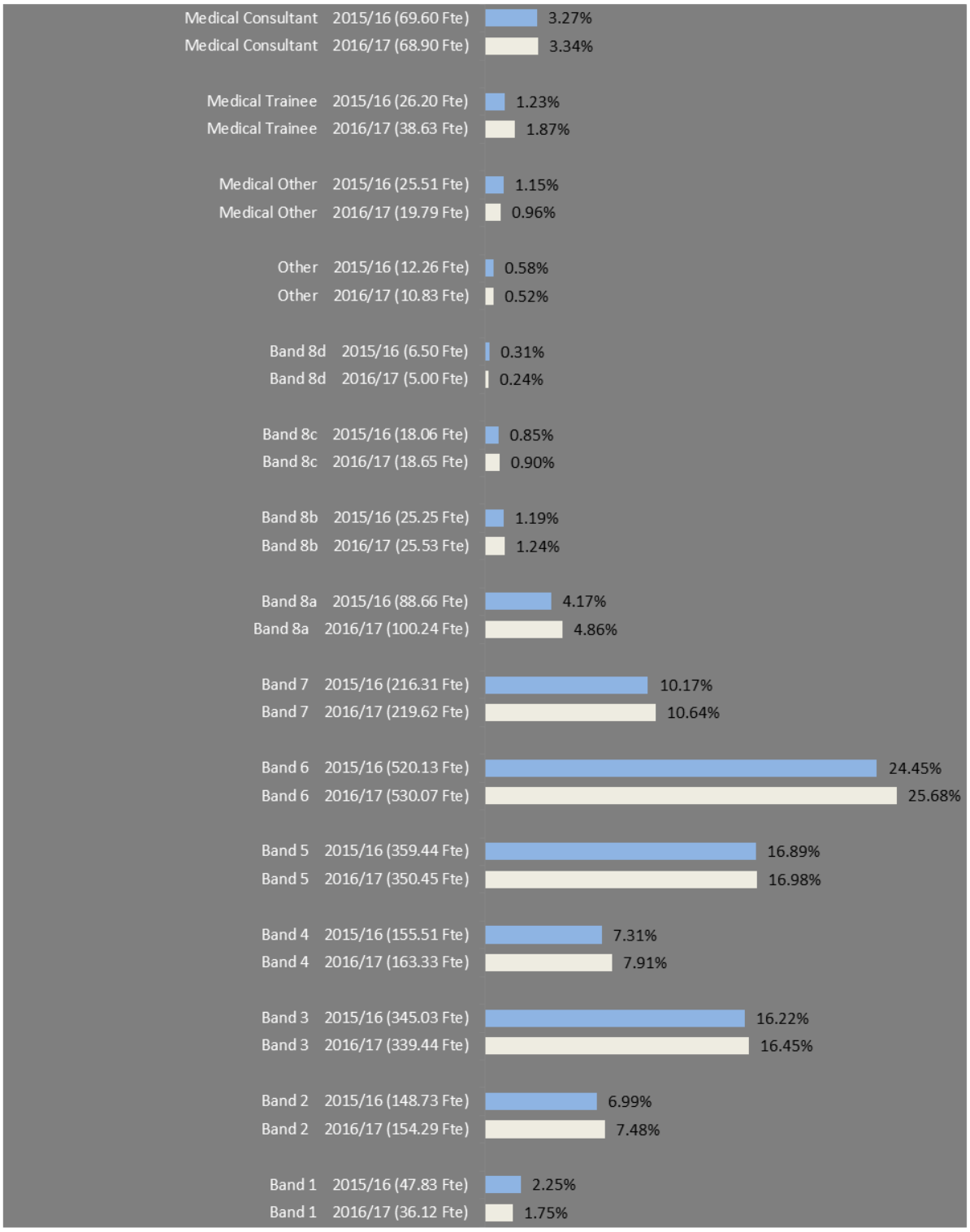


We directly employ 2080.90 full-time equivalent (FTE) staff, contracted headcount 2389 (ESR 31 Mar 2017 which excludes the Chairman, Non-Executive Directors and staff on career break or external secondments). This is an increase of 16.89 FTE and an increase in headcount of 26 since the last iteration of this plan. The budgeted FTE vacancy rate has decreased from 16.24% as at 31 Mar 2016 to 13.95% as at 31 Mar 2017.

As at 31 Mar 2017, 941 employees (39.39% of the Workforce) are recorded as part-time workers, which is an increase of 20 staff or 0.41% compared to last year. A higher head count can sometimes incur additional support costs and pressures, e.g. in terms of equipment, payslips costs, training requirements and appraisals, however part time workers remain a valuable asset in maintaining a flexible workforce.

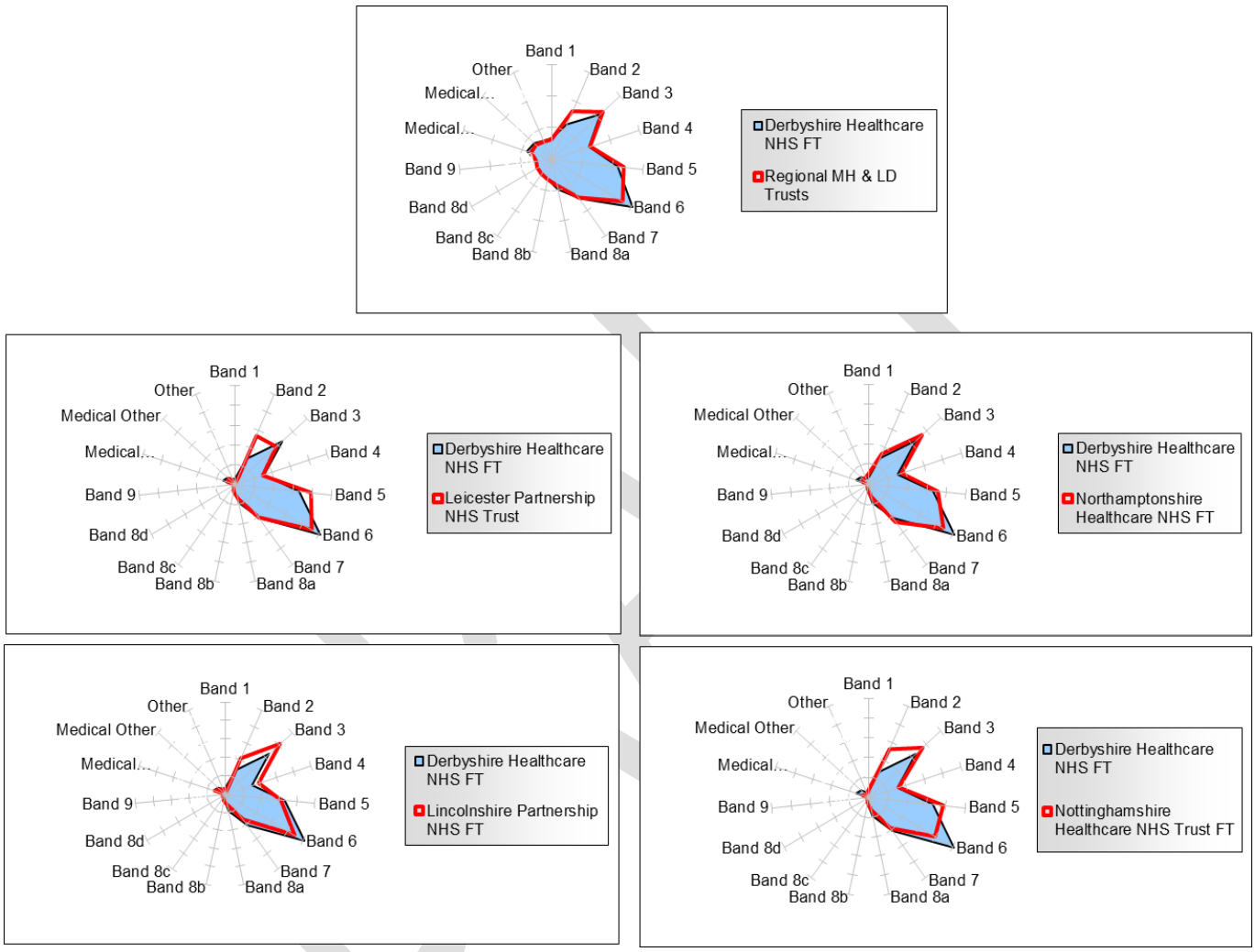
Workforce Profile by Pay Band

(Fte % of Pay Band - 2015/16 v 2016/17)



Benchmarking Against Other Trusts

The graphs below show a comparison of the shape of our workforce with that of other predominantly Mental Health Trusts. There is no other Trust with such a varied portfolio of services as ours and so no direct comparator. The most similar is Northampton (although there are still variations in services). It can be seen that the shape of our workforce remains very similar to both Northampton and Lincoln. We continue to have more Band 6 staff and less Band 2 staff than is general in the region for Mental Health Trusts.



		Derbyshire Health FT	Leicestershire Partners	Lincolnshire Partners FT	Northamptonshire Health FT	Nottinghamshire Health FT
Bands 1 to 4	Workforce % Fte	32.94%	35.31%	40.85%	38.10%	42.06%
Bands 5 to 7		52.37%	52.86%	46.34%	51.70%	48.77%
Bands 8a & above		7.35%	6.65%	6.71%	4.93%	5.63%
Medical		5.92%	4.26%	4.57%	3.40%	2.78%
Other		1.42%	0.93%	1.52%	1.87%	0.76%
		100.00%	100.00%	100.00%	100.00%	100.00%

Source iView HSCIC - rounded to nearest 5 on Fte raw data - vacancies will impact on workforce %

Turnover

Staff turnover remains one of the key performance indicators (KPI's) reported at Trust Board. It is calculated by dividing the number of leavers for the last 12 months by the average headcount for the same period. Our Trust has applied a healthy turnover figure of 10% with an agreed variance of up to 2% either way, i.e. if turnover is between 8% and 12% it remains green on the red/amber/green (RAG) rating. If turnover is below 8% it turns red, indicating problems such as the workforce being too static, not enough new staff entering the Trust etc. If turnover is above 12% it turns red on the RAG rating as this may indicate problems such as an unstable workforce, inexperience, problem areas etc.

	Annual Turnover Rates		
Staff Group	31/03/2015	31/03/2016	31/03/2017
Add Prof Scientific and Technic	10.15%	8.57%	11.41%
Additional Clinical Services	8.87%	9.65%	10.55%
Administrative and Clerical	9.84%	9.53%	8.72%
Allied Health Professionals	7.97%	13.04%	11.03%
Estates and Ancillary	6.00%	5.73%	2.56%
Medical and Dental	15.49%	10.34%	14.58%
Nursing and Midwifery Registered	8.28%	11.16%	11.02%
Students	50.00%	23.53%	72.73%
Trust Total	**9.53%**	**10.16%**	**10.44%**

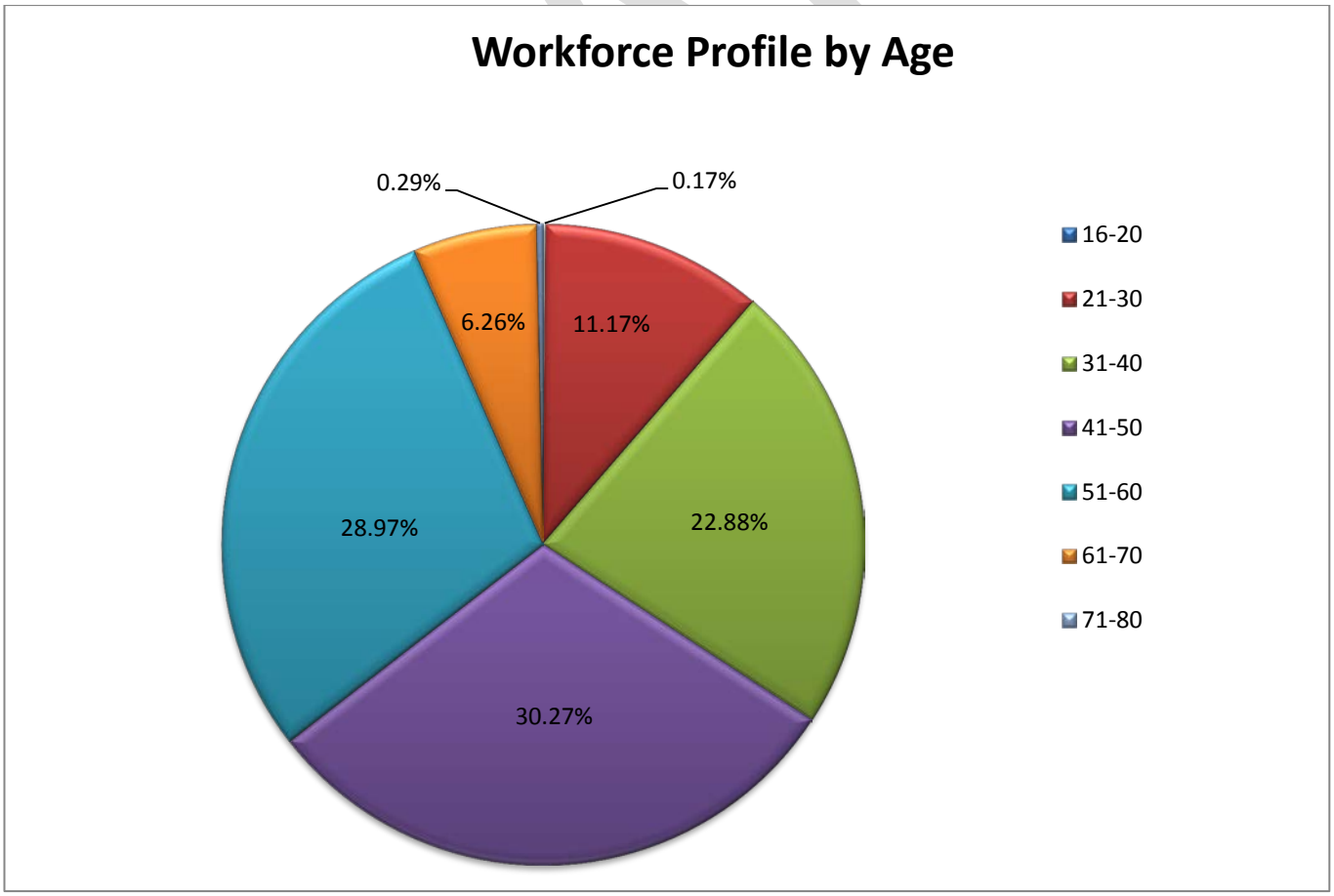
Figure 1 *Staff Turnover (annual turnover for contracted staff)*
Source: ESR March 2017 (NB Junior doctors and TUPE are excluded)

Our current turnover rate is 10.44% (slightly higher than last year and the year before) with a variation between staff groups as detailed in Figure 1. This continues to move us away from the 8% that would give us a red RAG rating and indicate stagnation issues. This KPI has been benchmarked, using NHS iView, against the average Mental Health and Learning Disability Trust turnover rate. The national MH & LD average for turnover is 12.76% and the regional MH & LD average is 12.84%. The implications are that we continue to have much more overall stable workforce numbers than are generally found nationally and we have the lowest locally. Turnover rates for Nursing and Midwifery Registered staff remains high and triangulates with high recruitment activity for this staff group both during the previous 12 months and ongoing. The overall number of staff leaving the Trust remains static for the previous 12 months averaging 21 employees per month; it is the reductions in contracted staff in post i.e. increase in vacancies that have caused an increase in recent turnover rates.

Retirement Profile and Projection

The average employee age in the Trust as at March 2017 remains at 45 and this has been the same for the previous six iterations of this workforce plan. 30.27% of the Workforce is aged between 41 and 50, 28.97% between 51 and 60 and 6.55% over the age of 61 (Figure 3). Since the default retirement age of 65 was removed in April 2011, the number of employees aged 65 and over has risen to 45, compared to 27 in 2009. This is an increase in headcount of 6 since the last iteration of this plan. Our staff will be subject to the same health determinants as the rest of the local population and this increase in our aging workforce highlights the importance of the health and wellbeing agenda.

The average retirement age in the Trust taken over the last three years, has increased slightly to 60.09 compared to 60.04 in the last iteration of this plan with variations between staff groups and pay bands as per the table in Figure 4 below. It has to be noted that, although the average retirement age is 60.09, it is an average. Many staff retire in their fifties, many in their sixties. The average retirement age indicates a trend.



Staff Group	Age Bracket	Headcount	% of staff group
Add Prof Scientific and Technic	21-30	26	13.83%
	31-40	52	27.66%
	41-50	55	29.26%
	51-60	40	21.28%
	61-70	14	7.45%
	71-80	1	0.53%
Additional Clinical Services	21-30	50	12.76%
	31-40	96	24.49%
	41-50	97	24.74%
	51-60	111	28.32%
	61-70	37	9.44%
	71-80	1	0.26%
Administrative and Clerical	16-20	4	0.80%
	21-30	37	7.37%
	31-40	95	18.92%
	41-50	148	29.48%
	51-60	173	34.46%
	61-70	45	8.96%
Allied Health Professionals	21-30	19	12.58%
	31-40	44	29.14%
	41-50	43	28.48%
	51-60	42	27.81%
	61-70	3	1.99%
Estates and Ancillary	21-30	6	5.13%
	31-40	14	11.97%
	41-50	21	17.95%
	51-60	52	44.44%
	61-70	20	17.09%
	71-80	4	3.42%
Medical and Dental	21-30	18	12.95%
	31-40	38	27.34%
	41-50	44	31.65%
	51-60	32	23.02%
	61-70	6	4.32%
	71-80	1	0.72%
Nursing and Midwifery Registered	21-30	109	12.25%
	31-40	205	23.03%
	41-50	312	35.06%
	51-60	240	26.97%
	61-70	24	2.70%
Students	21-30	1	33.33%
	31-40	1	33.33%
	41-50	1	33.33%

Figure 3 Workforce Profile by Age as at March 2017

Staff Group	Average retirement age previous three years as at March 2017
Trust	60.09
Add Prof Scientific and Technic	59.16
Additional Clinical Services	62.61
Administrative and Clerical	62.02
Allied Health Professionals	59.59
Estates and Ancillary	65.79
Medical and Dental	61.02
Nursing and Midwifery Registered	57.56

Pay scale	Average retirement age previous three years as at March 2017
Trust	60.09
Band 1	69.32
Band 2	66.04
Band 3	62.82
Band 4	61.98
Band 5	57.81
Band 6	58.17
Band 7	57.86
Band 8a	58.11
Band 8b	59.19
Band 8d	64.71
Band 8c	55.91
Consultant	60.50
Medical other	62.45
Other	57.06

Figure 4 Average Retirement Age by Staff Group 3 years to March 2017

The Trust retirement profile *(Figure 5)* is still driven by the current occupational pension arrangements, with the peaks being at age 55 *(i.e. where large numbers of staff still have Mental Health Officer status)* and at 60 *(normal pension age for the 1995 pension scheme)*. There is also still a peak at age 65 which is the old national default retirement date which is no longer applicable.

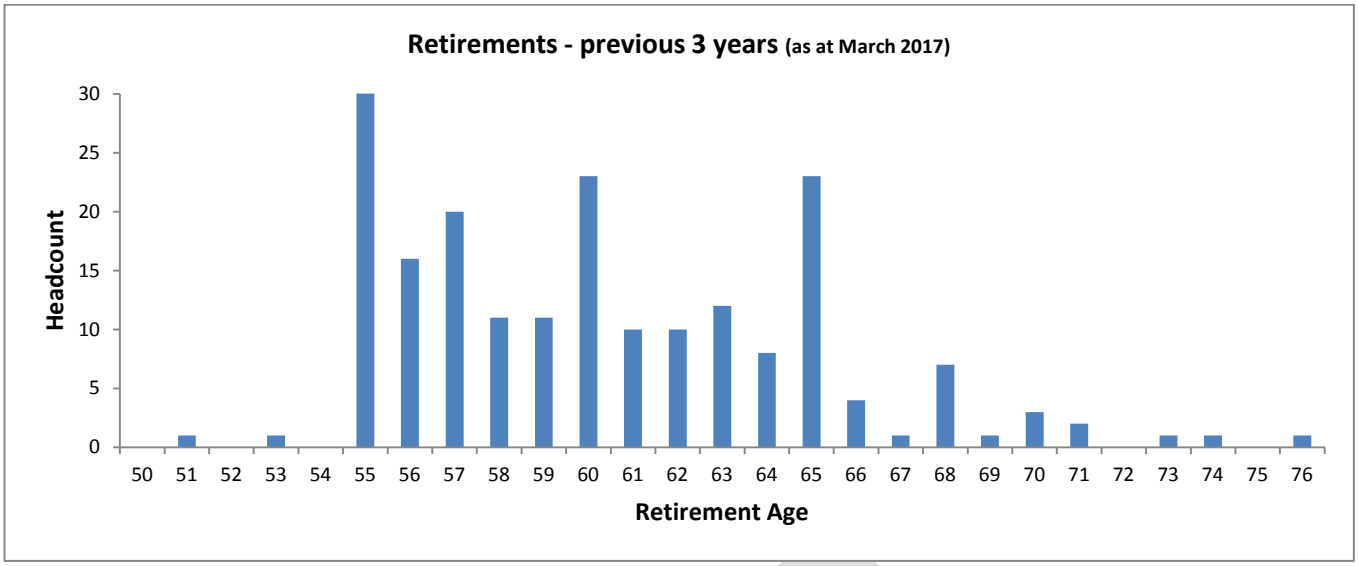


Figure 5 Trust Retirement Profile 3 years to March 2017

There are 197 members of staff who are currently aged 60 or over and have therefore already reached the average Trust retirement age of 60 *(Figure 6).* This is a slight increase of 7 compared to last year and on the whole these will be our most experienced members of staff. The underlying risk is that this group of 197 experienced staff have the potential to exit the Trust at any one time if they suddenly see retirement as a preferred option, leaving us with a skills deficit.

The introduction of Total Reward Statements (TRS) has the potential to influence the number of retirees by drawing individuals' attention to the financial benefits they would receive on retirement and causing them to give consideration to their options.

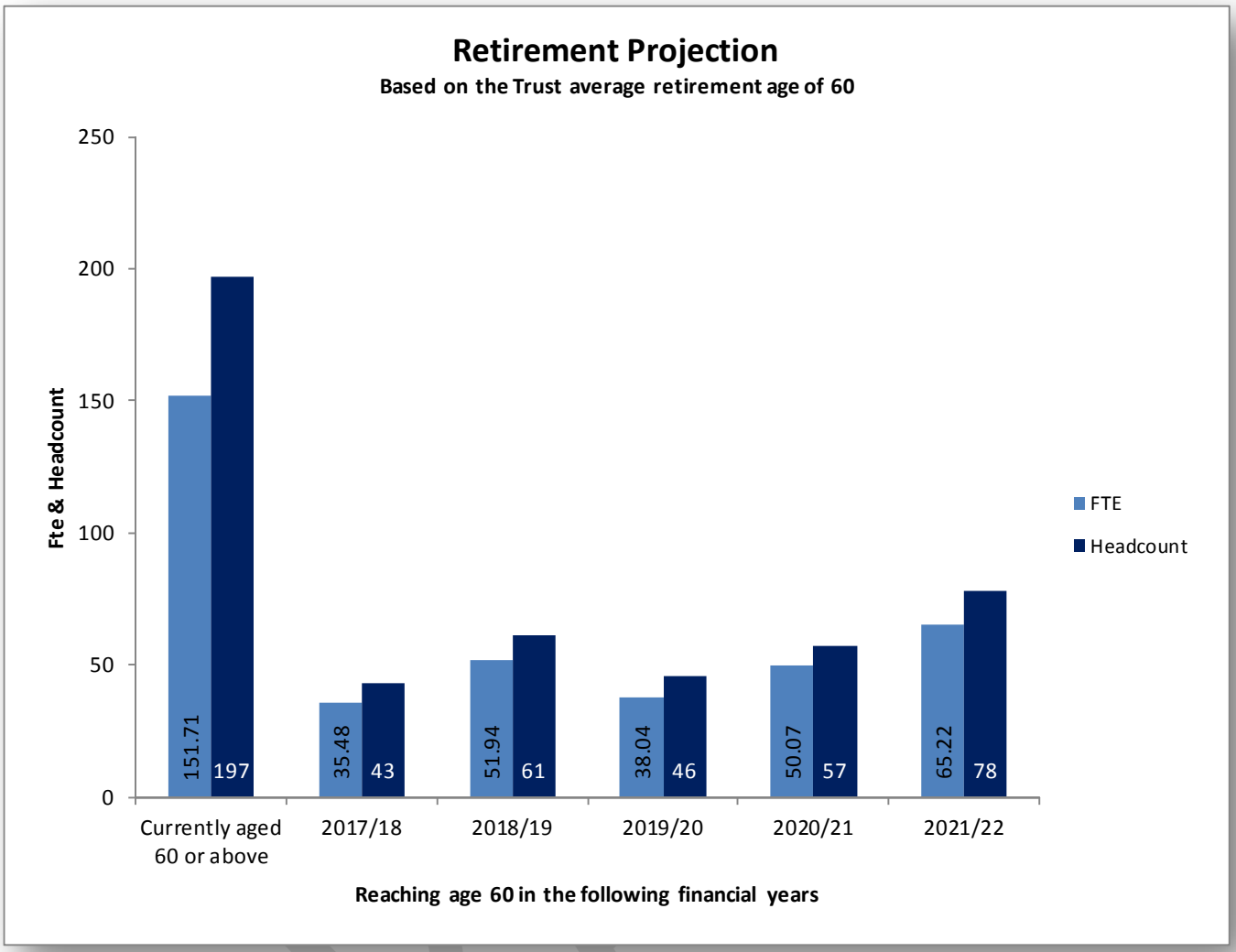


Figure 6 Staff reaching average retirement age each year to 2021/22

The number of staff members coming up to average retirement age year on year is comparatively static, staying at between 43 and 78 per year, however 2018/19, 2020/21 and 2021/22 does show a slight increase in potential retirements and could present a risk that we will lose a large number of experienced Trust staff to retirement. At the very least, the number of people in the pool of eligible retirees will rise, increasing the latent risk of large numbers retiring at any one time.

There are three NHS pension schemes – the 1995 scheme, the 2008 scheme and the 2015 scheme. Anyone joining the NHS from 2008 onwards, who wished to take advantage of the occupational pension, will have been enrolled in the 2008 scheme. At the end of 2010, employees in the 1995 scheme were given the choice of whether to remain in that scheme or switch to the 2008 scheme, with very few making the switch. With the introduction of the 2015 scheme staff who were in the in the 1995 scheme were asked again if they wished to transfer to the 2008 scheme for their previous pension service.

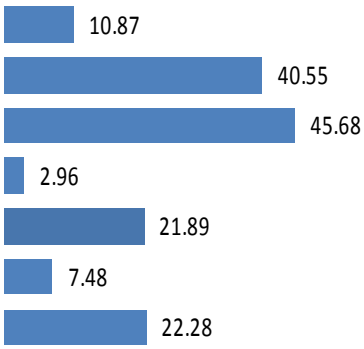
On 1st April 2015, all staff, in both the 1995 and the 2008 schemes were automatically transferred to the new 2015 scheme. The exception was anyone within 10 years of their normal retirement age. They have their current pension rights protected and will not go into the 2015 scheme.

Normal retirement age for each scheme is:

- 60 for the 1995 scheme
- 65 for the 2008 scheme
- Linked to State Pension Age *(currently 67 or 68 depending on date of birth)*

As in the previous three years, the bulk of eligible retirements are in the middle to lower pay bands *(Figure 7).* The indication is that staff in the lower paid areas of work tend to retire up to three years later than higher paid workers. These posts also tend to be the more physically demanding ones, again posing a risk in the area of health and wellbeing. The trend is for retirement eligibility to be even more focused in the lower pay Bands in the next 12 months *(Figure 8).*

Retirement Projection	Staff Group	Fte	Headcount
Curently aged 60 or above	Add Prof Scientific and Technic	10.87	16
	Additional Clinical Services	40.55	47
	Administrative and Clerical	45.68	58
	Allied Health Professionals	2.96	4
	Estates and Ancillary	21.89	29
	Medical and Dental	7.48	10
	Nursing and Midwifery Registered	22.28	33
Total		**151.71**	**197**



Retirement Projection	Payscale Description	Fte	Headcount
Curently aged 60 or above	Band 1	11.72	16
	Band 2	21.63	29
	Band 3	52.12	61
	Band 4	10.26	12
	Band 5	9.83	13
	Band 6	19.23	29
	Band 7	12.27	17
	Band 8 - Range A	6.17	8
	Band 8 - Range B	0.40	1
	Band 8 - Range C	0.60	1
	Band 8 - Range D		
	Medical Consultant	4.40	6
	Medical Other	3.08	4
	Other		
		151.71	**197**

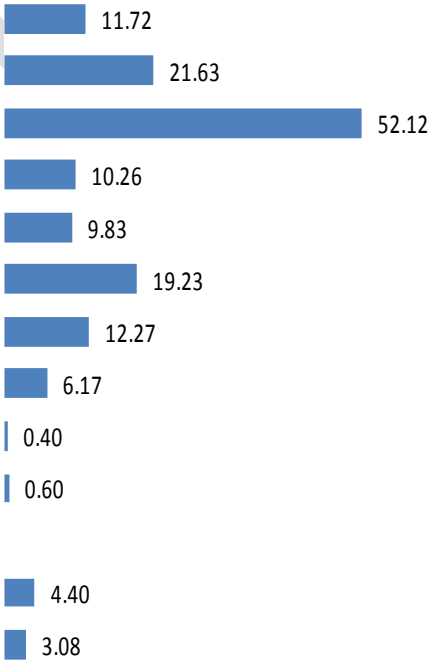
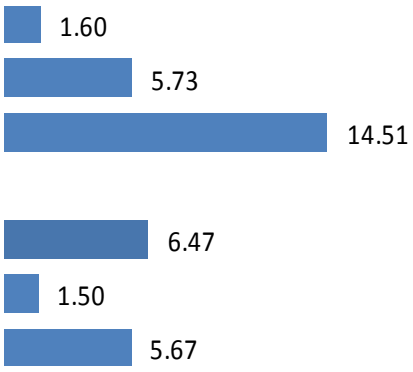


Figure 7 Retirement Projection *(currently aged 60 or above by staff group and by pay scale)*

Projection	Staff Group	Fte	Headcount
Reaching age 60 in 2017/18	Add Prof Scientific and Technic	1.60	2
	Additional Clinical Services	5.73	6
	Administrative and Clerical	14.51	18
	Allied Health Professionals		
	Estates and Ancillary	6.47	8
	Medical and Dental	1.50	2
	Nursing and Midwifery Registered	5.67	7
Total		**35.48**	**43**



Projection	Payscale Description	Fte	Headcount
Reaching age 60 in 2017/18	Band 1	1.80	3
	Band 2	4.48	6
	Band 3	9.53	11
	Band 4	5.70	6
	Band 5	1.80	2
	Band 6	6.87	8
	Band 7	2.60	3
	Band 8 - Range A	1.20	2
	Band 8 - Range B		
	Band 8 - Range C		
	Band 8 - Range D		
	Medical Consultant	1.50	2
	Medical Other		
	Other		
		35.48	**43**

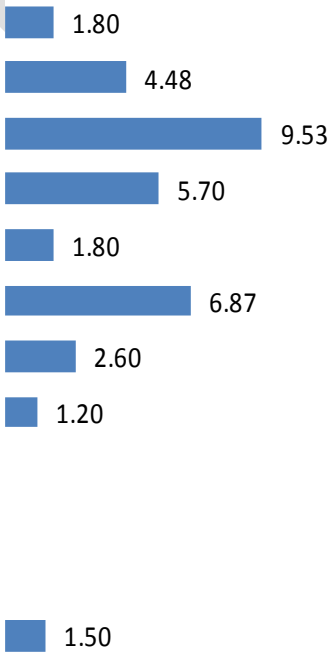
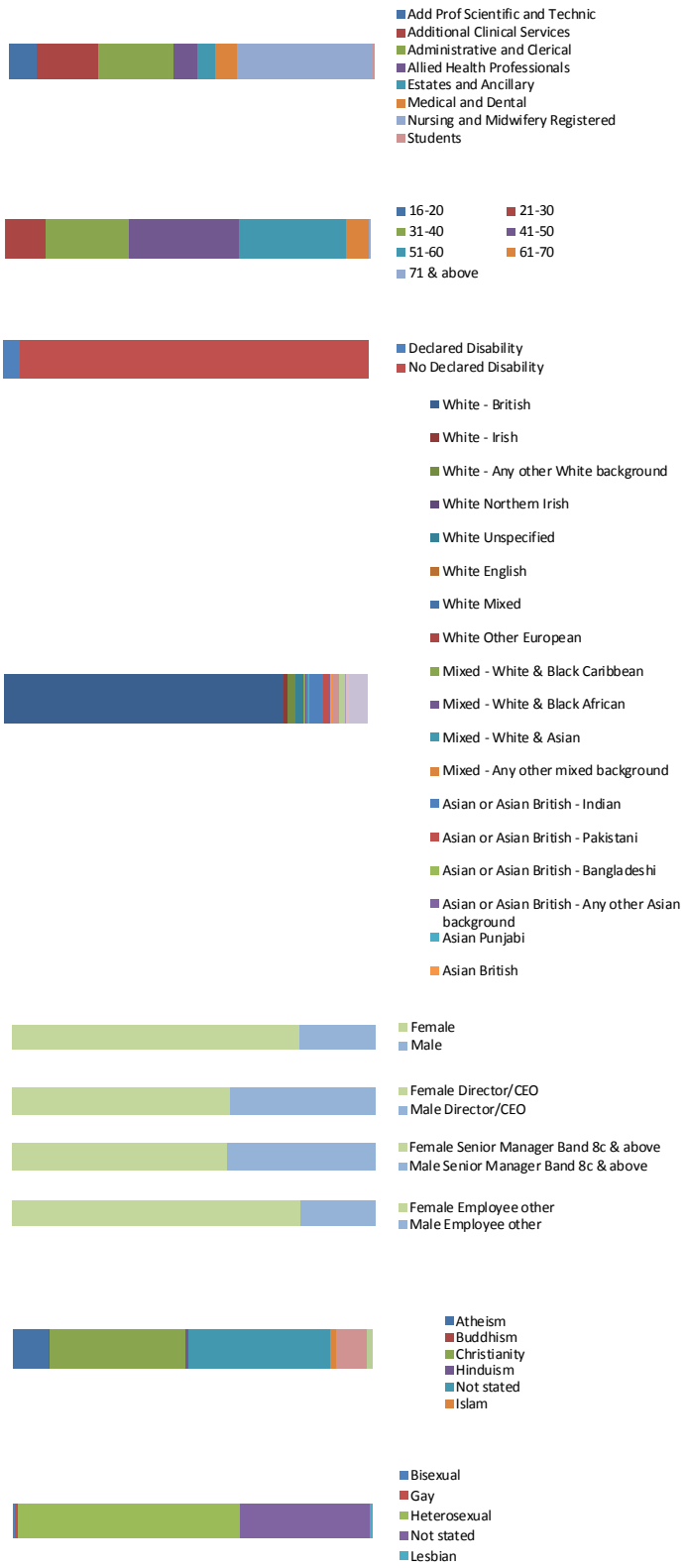


Figure 8 Retirement Projection *(reaching age 60 in 2017/18 by staff group and by pay scale)*

Equality & Diversity

Workforce Profile 31 March 2017

	Headcount	Fte	Workforce %
Trust			
Employees	2389	2080.90	
Staff Group			
Add Prof Scientific and Technic	187	163.54	7.83%
Additional Clinical Services	391	336.99	16.37%
Administrative and Clerical	505	435.71	21.13%
Allied Health Professionals	150	120.87	6.28%
Estates and Ancillary	116	92.33	4.86%
Medical and Dental	146	127.33	6.11%
Nursing and Midwifery Registered	891	801.13	37.29%
Students	3	3.00	0.13%
Age			
16-20	4	4.00	0.17%
21-30	267	247.20	11.18%
31-40	545	466.80	22.81%
41-50	720	635.53	30.14%
51-60	696	605.42	29.13%
61-70	150	117.27	6.28%
71 & above	7	4.68	0.29%
Disability			
Declared Disability	113	94.31	4.73%
No Declared Disability	2276	1986.59	95.27%
Ethnicity			
White - British	1849	1595.91	77.41%
White - Irish	24	20.29	1.00%
White - Any other White background	46	40.53	1.93%
White Northern Irish	1	0.67	0.04%
White Unspecified	48	43.46	2.01%
White English	1	0.64	0.04%
White Mixed	2	2.00	0.08%
White Other European	2	1.45	0.08%
Mixed - White & Black Caribbean	13	11.81	0.54%
Mixed - White & Black African	3	2.60	0.13%
Mixed - White & Asian	13	12.55	0.54%
Mixed - Any other mixed background	10	9.00	0.42%
Asian or Asian British - Indian	96	87.15	4.02%
Asian or Asian British - Pakistani	33	30.75	1.38%
Asian or Asian British - Bangladeshi	3	2.32	0.13%
an or Asian British - Any other Asian background	7	6.55	0.29%
Asian Punjabi	3	2.13	0.13%
Asian British	2	2.00	0.08%
Asian Unspecified	1	0.64	0.04%
Black or Black British - Caribbean	47	43.72	1.97%
Black or Black British - African	39	36.20	1.63%
ack or Black British - Any other Black background	9	8.52	0.38%
Black Nigerian	1	0.80	0.04%
Black Unspecified	1	1.00	0.04%
Chinese	2	1.80	0.08%
Any Other Ethnic Group	10	9.00	0.42%
Malaysian	1	1.00	0.04%
Not Stated	122	106.41	5.11%
Gender			
Female	1888	1611.19	79.03%
Male	501	469.71	20.97%
Gender breakdown			
Female Director/CEO	3	3.00	60.00%
Male Director/CEO	2	2.00	40.00%
Female Senior Manager Band 8c & above	16	13.45	59.26%
Male Senior Manager Band 8c & above	11	11.20	40.74%
Female Employee other	1869	1594.74	79.30%
Male Employee other	488	456.51	20.70%
Religious Belief			
Atheism	236	207.66	9.88%
Buddhism	11	10.15	0.46%
Christianity	893	777.69	37.38%
Hinduism	21	19.43	0.88%
Not stated	952	817.98	39.85%
Islam	30	27.71	1.26%
Judaism	2	1.40	0.08%
Other	206	184.80	8.62%
Sikhism	38	34.08	1.59%
Sexual Orientation			
Bisexual	9	9.00	0.38%
Gay	15	14.41	0.63%
Heterosexual	1482	1298.48	62.02%
Not stated	869	745.65	36.38%
Lesbian	14	13.36	0.59%



We are committed to having a workforce that is reflective of the communities and local neighbourhoods we serve. We will ensure that the Trust's status as a fair and good employer is enhanced and that the principle of fairness and equal opportunities for all protected characteristics as defined in the Equality Act 2010 is evident in all aspects of our employment and development. We recognise that valuing and managing diversity is core to our business as there is a need to respond to demographic and social changes, for example the ageing population and workforce and changing diverse population. We will strive to reap the benefits of a diverse workforce by creating an inclusive workplace, where everyone can be the best they can.

We will use equality monitoring/profiling, analysis and benchmarking such as Workforce Race Equality Standard (RES) and other corporate targets in consideration in this plan to enhance opportunities and the quality of service delivery.

We will focus on understanding and increasing the diversity of the workforce over the next 5years, ensuring the employee profile is diverse across our services. We will prioritise and create opportunities to engage with under-represented groups and ensuring they have equal opportunities to develop their skills and experience to enable them to meet their potential and careers goals.

Our current workforce analysis - in planning for the workforce of the future it is important to take stock of the composition of the current workforce, how it is managed and to be aware of significant underlying trends, gaps, any need to increase certain groups to address under-representation or measures such as positive action. We will use the workforce profile to ascertain if we have an adequate supply of diverse employees to fill the gaps.

The key areas for consideration are:

The data shows we have an ageing workforce, the work currently being undertaken on workforce supply will identify talent pools and succession planning.

Changing shape of the Workforce – CIP and Service Developments

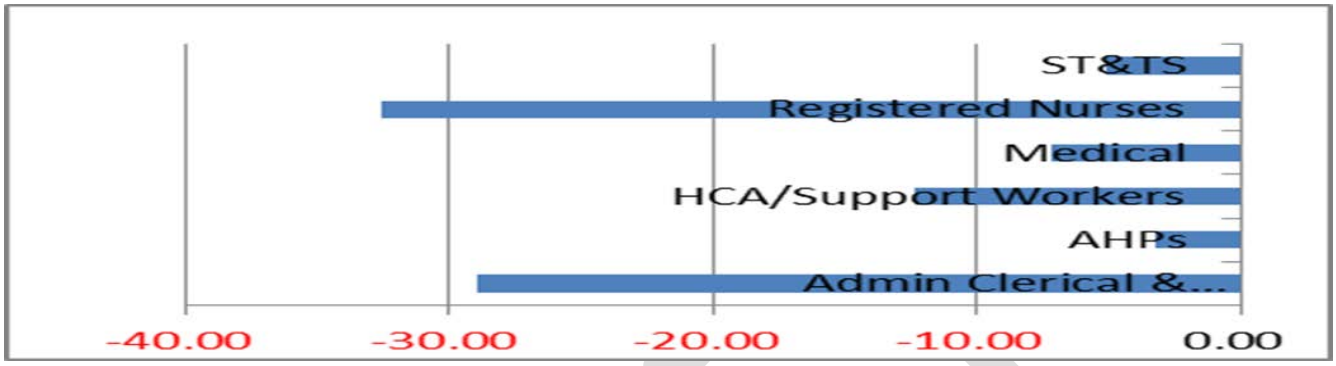
A key driver remains the shrinking financial envelope. In order to achieve our required financial savings, there is a planned reduction of 73.82 in budgeted FTE relating to the Cost Improvement Programme for 2017-18. Service Developments, Disinvestments and skill mix changes during 2017-18 are forecast as a net reduction in FTE of 15.68, resulting in an overall net reduction of 89.50 FTE during the financial year (Figure 2).

The continuing financial pressures push the health and social care community as a whole to continue to look at system wide workforce solutions. Various projects continue to look at how we can collaborate with partner organisations in areas such as recruitment, pooling staffing resource and placing staff employed by one Trust on another Trust's premises if that is where the expertise is required.

Staff Group	Revised budgeted FTE 31/03/2017	Cost Improvement Programme	Other changes	Budgeted Fte 31/03/2017	Fte Variation
Admin, Clerical & Estates	692.05	-21.26	-7.69	663.10	-28.95
Allied Health Professionals	122.11	-3.75	0.49	118.85	-3.26
HCA/Support Workers	328.85	-10.10	-2.27	316.48	-12.37
Medical	175.10	-5.38	-1.79	167.93	-7.17

Staff Group	Revised budgeted FTE 31/03/2017	Cost Improvement Programme	Other changes	Budgeted Fte 31/03/2017	Fte Variation
Registered Nurses	932.55	-28.65	-3.98	899.92	-32.63
Scientific, Therapeutic & Technical	152.27	-4.68	-0.44	147.15	-5.12
Total	**2402.93**	**-73.82**	**-15.68**	**2313.42**	-89.50

Figure 2 Forecast change in budgeted FTE for 2017-18



Changes in Education Funding Models

The government announced in the 2015 Spending Review that from 1 August 2017, all new Nursing, Midwifery and Allied Health Professional Students will receive their funding and financial support through the standard student support system, rather than through the current NHS Bursary Scheme.

New healthcare students will no longer have their course fees paid by HEE (nor a bursary provided by the BSA) but will have access to the standard student support system provided by the Student Loans Company to cover the cost of their tuition fees, and means tested support for living costs.
The changes to the student bursary arrangements nationally have led to uncertainty about the future numbers of graduates who will be available. We will work collaboratively with local partners to seek innovative solutions when developing our existing workforce as well as working with Education providers to secure a suitable supply of staff.

Stakeholder Engagement

There is recognition that we need to strengthen our relationship with education providers, ensuring that we continue to provide high quality clinical placements in order to make us an employer of choice.

Our education partners have confirmed a reduction in the numbers of applicants to pre-registration nursing; i.e. there are now 5 applicants for 1 place compared to the previous 10 applicants for 1 place. We will continue to work alongside our education partners to attract high calibre students from all backgrounds. We will target hard to reach communities via schools outreach, focusing on those communities who would not normally choose careers in health and social care. Success of recruitment to training will mean an increase in student numbers and a lot of work is required to accommodate the students on placements.

Table below shows the number of student nursing placements required for 2017/18 from DHCFT. Ensuring we support high numbers of these requests we will be investing in our future workforce supply pipeline.

University	Total Placements Requested	Total number of students	DHCFT Placement Capacity
Derby MH	**465**	**195**	**122**
Derby MH Fast Track	**75**	**21**(*funded by other organisations)*	
Nottingham MH	**381**	**161**	
Nottingham LD	**9**	**3**	**9**
Nottingham Child Branch	**27**	**16**	**8**
TOTAL	**967 Placements**	**214** *(excluding the 21)*	**139**

Workforce Challenges and Changes

The need to ensure a flexible and adaptable health workforce is a pressing concern for the NHS. It is evident that we are in an extremely challenging situation in respect of a mismatch between the number of posts established by NHS providers and the supply available to meet this requirement. Staff shortages negatively affect patient outcomes and experience. Workforce shortages are hard to rectify rapidly because of the amount of time it takes to train new staff *(three years to train a nurse, up to fifteen years to train a medical consultant).*

DHCFT faces recruitment challenges especially around the recruitment of band 5 and 6 Mental Health Nurses and Psychiatrists *(as is the case nationally)*. Given the national and local changes and challenges to recruitment, our current and future workforce requirements are paramount for the trust as we commit to continue to deliver quality, safe, effective and service user centred care. Recruiting and retaining an adequate supply of staff with the right skills, values and behaviours in the right numbers to deliver safe, effective high quality care is of the most significant importance to the organisation. We need to develop a workforce which enables individuals to apply their skills and knowledge within different clinical settings and work in roles which span across traditional professional boundaries:

- Recruitment
- Introduction of new roles
- Retention
- Multi-disciplinary / cross sector working
- Affordability
- Supporting / retaining higher numbers of pre-registration students
- Professional boundaries
- Workforce Generational Diversity

Workforce Supply

Focusing on the Trust's clinical workforce, supply is a key component of this Workforce Plan because a resilient and sustainable workforce capable of delivering effective, clinically safe, and person-centred healthcare services for the people of Derby and Derbyshire depends on attracting, recruiting, developing and retaining the right people, with the right skill mix, at the right levels, in the right numbers, within the right service areas and at the right times.

This section gives an overview of programmes of work being undertaken, with a view to maximising the Trust's substantive workforce supply. It also enumerates recent and planned initiatives, some of which are still under consideration, in order to identify and explore alternative supply pipelines which, hopefully, would:

- Reduce or eliminate the Trust's long-term 'hard-to-fill' vacancy gaps and 'hard-to-recruit' staffing shortfalls
- Increase vacancy fills rates such that our workforce can adequately meet current and future service demands.
- Reduce reliance on temporary and variable staffing
- Reduce or eliminate agency/locum spend
- For the avoidance of duplication, this section does not cover the entire spectrum of supply sources currently being contemplated or explored. These include:
- Stakeholder engagement with UK-wide academic institutions and training providers, careers service agencies, job centre plus, etc
- Development of alternative clinical roles such as alternative degree pathways, as part of the Trust's 'grow our own' strategy
- Career progression pathways
- Succession planning
- Volunteering, one of the main routes into employment
- Work experience and work shadowing
- Work placements / internships
- Apprenticeships
- Temporary staffing and bank provisions

Workforce Supply Initiatives

In the implementation phase is a recently developed workforce supply action plan, which cover a range of initiatives, some of which are outlined below.

Targeted Recruitment Campaigns

All the Trust's vacancies will be given priority when running recruitment campaigns, which include In-house recruitment campaigns throughout the year, in the north and south of Derbyshire, in order to ensure a regular supply of potential candidates to fill ongoing or anticipated vacancies, with emphasis on 'hard-to-recruit' vacancies, and to establish ongoing presence in the recruitment markets.

Targeted campaigns, in partnership with the key stakeholders, will be run for the 'hard-to-recruit' areas with a high vacancy rate due to national shortages, etc.

Externally, the Trust would have a presence at UK-wide recruitment as well as profession-specific events such as careers fairs in education settings and jobs fairs organised by reputable organisations that champion the healthcare professions.

The Trust's future positioning is partly dependent on our ability to attract and recruit from a wider talent pool, particularly when recruiting to 'hard-to-fill' clinical roles. Hence, overseas recruitment is part of the Trust's recruitment strategy and work is underway to recruit clinicians from overseas - independently and via a staff sourcing organisation. In December 2016, the Trust successfully applied for Tier 2 Sponsorship Licence through the Home Office's UK Visas & Immigration (UKVI) agency to facilitate our ability to recruit from an international pool of talent. The placement of specified healthcare professions on the U.K. Shortage Occupation List (SOL) will continue to enable us to explore overseas recruitment, however continued recruitment activity within the UK will be a significant component of our workforce supply strategy.

In April 2017 the Trust embarked on a medical recruitment trip to India where 13 of the 15 candidates interviewed were given provisional job offers. The Trust continues to proactively engage with these prospective employees through a variety of mentoring programmes and will monitor success rates.

There would be continued online presence on reputable social media platforms to showcase the Trust, including podcasts, webinars, web banners, text alerts and job boards. A recruitment microsite, which will link to the Trust's vacancies on NHS Jobs' website, could also be developed to promote the Trust as a good employer and a great place to work.

Recruitment and Retention

Recruitment and retention of skilled staff, staff engagement and morale are important ingredients that would ensure that the Trust can provide the best care possible

A Recruitment and Retention Incentives Scheme was developed and approved in December 2016 to incentivise suitably qualified healthcare professionals to come and work for the Trust. A Relocation Scheme was also developed and approved in December 2016. Both Schemes are initially being focused on medical vacancies, for which adverts carry information on the offer of recruitment incentives and relocation support to potential eligible candidates. Due to the current labour market, the schemes would be regularly reviewed and benchmarked with other Trusts, including neighbouring Trusts, in order to ensure these and other incentives remain competitive and relevant.

Efforts would continue to be made to reduce staff turnover through developing, recommending and actively offering financial and non-financial recruitment & retention incentives, particularly for 'hard-to-recruit clinical vacancies and 'hard-to-retain' posts.

A range of recruitment and retention initiatives would be actively promoted online and using poster campaigns. To mention a few, these would entail:

- Flexible working patterns.
- Return-to-practice with access to accredited programmes through annual cohorts with a commitment to substantive employment would be promoted to encourage non-practicing nurses, health visitors, AHPs and other profession-specific clinicians to return to the profession and, if they do, the Trust would offer additional support and training along with other flexible initiatives. These would require funding support for registration costs, release time and backfill for existing staff.

- Introduction and enhancement of rotational posts/contracts in all clinical professions such as nursing and therapies. This would encompass acute and community settings Trust-wide and across organisational boundaries within Derby and Derbyshire. A consortium is being developed with a view to exploring and agreeing partnerships with other NHS Trusts to support rotational posts that enhance various patient pathways.
- Secondment of Healthcare Assistants from their substantive posts to salary-supported Foundation Degree student status. Funding will need a business case which will require approval.
- Flexible retirement options - to ensure staff considering retirement are aware of and understand the flexible retirement options available to them. This could help to retain skills and provide additional flexibility with the Trust. There are different approaches to flexible retirement which include reduced, hours/days, stepping down to a lower grade, 'retire and return' to work, and drawn down some pension and continue in employment. The various options can be communicated using posters in the workplace, cascading the message through managers and talking to staff about it. Further information on flexible retirement can be obtained via NHS Pensions.

A Recruitment and Retention 'Task & Finish' Group was recently set up to consider wide-ranging and appropriate measures/initiatives, which could alleviate the Trust's recruitment and retention challenges. The Trust-wide representative staff group meets monthly to consider and develop a variety of staff resourcing solutions and approaches for different staffing groups in partnership with key stakeholders. It would undertake deep dives into relevant recruitment and retention issues and work with relevant stakeholders to resolve them. Other work to be undertaken by the Group would include exploring with staff what makes Derbyshire Healthcare NHS Foundation Trust a good employer and a great place to work and how we can become and be recognised as an employer of choice.

Retention Interviews can be incorporated into the new employees' probationary assessment process within 3 and 6 months of commencing employment with the Trust and then annually within the appraisal process. Existing employees should also be included through' one-to-one meetings, supervision meetings, performance reviews, etc. The information extrapolated from retention interviews as well as exit interviews would be used to inform retention strategies.

The above and other workforce supply initiatives will be monitored and subject to frequent review as part of a wider supply action plan.

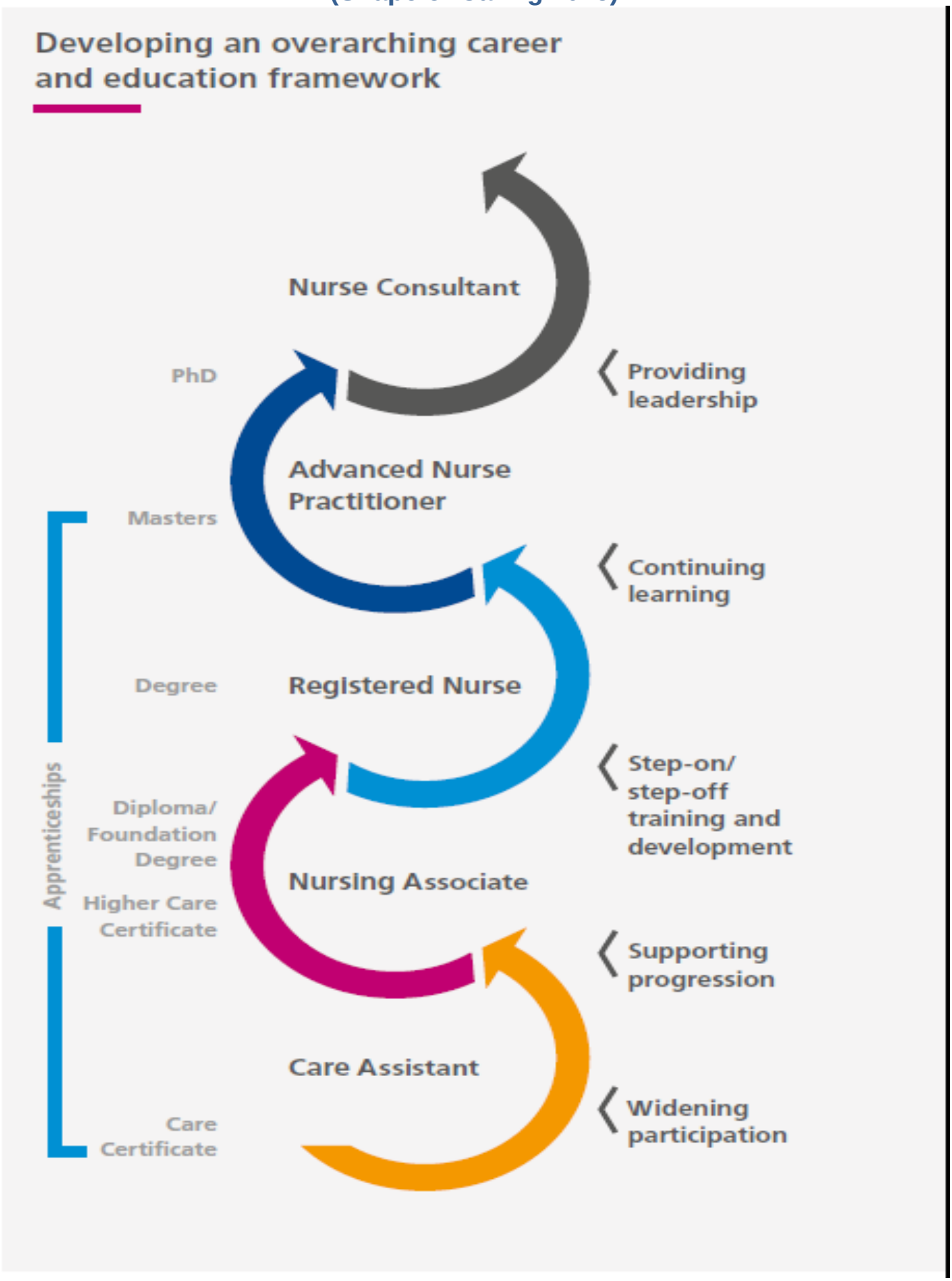
Bank Provision Developments

The current provision provides high fill rates for support role needs in the Trust. However, there is limited availability of multi professional clinicians that reflect the service needs. Work is ongoing to develop internal E-rostering and establish the necessary service structure to enable a more efficient process and increased bank supply. This work is connected to the team developments within the workforce developments and opportunities to maintain an in house service will be undertaken. This action will be linked with the current projects relating to e-Rostering development to ensure compatible timelines to achieve self-serve booking systems. Bank recruitment will also be a mandatory element in the standard operating procedures and recruitment mechanisms within the Trust, such as generic, rolling recruitment campaigns, recruitment fairs and overseas efforts. In response to national shortages and changes in availability to fulfil medical workforce requirements a scoping exercise is underway to establish the best mechanism to achieve a 'Medical Bank' provision.

In achieving high fill rates across all of the services and establishing on going needs a responsive workforce model will be pursued to avoid agency expenditure, this is a peripatetic team that can provide cover and experience to teams that have workforce needs beyond that which can be addressed by the bank provision. This will be multi-professional and be informed by clinical demand ensuring optimal use of skills. Pilots are already underway to establish how Clinicians with Non-Medical Prescribing skills can provide emergency cover for outpatient consultant clinics to avoid service disruption and agency costs, this work and others as detailed in the workforce plan will inform the skill mix of the responsive workforce.

National Overarching Framework and Vision

(Shape of Caring 2015)



Moving Forward - Growing Our Own

Introducing New Roles to Support Challenges in Medical Recruitment

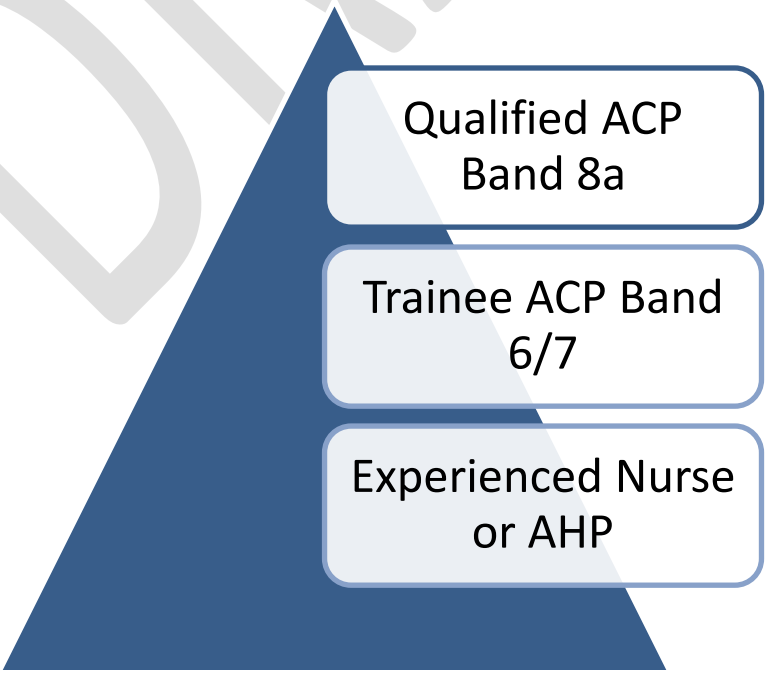
Advanced Clinical Practitioners

The ACP role deploys physical care expertise at the level of a F2 / Core trainee doctor in areas where that input is a major component of health management. MSc takes 3 years part time, benefits not seen in workforce until autumn 2020. Comprehensive curriculum in place across Derbyshire to meet 25 generic competencies and 5 specialist competencies, these reference the GMC Acute Care Common Stem Programme (GMC 2012) and the GP curriculum (RCGP 2015). DHCFT have an opportunity to influence the development of a specialist competence in Mental Health care with reference to Physical Health.

OA Psychiatry would be an ideal area because of the high medical intensity; precarious medical staffing due to spread of medical staff across both community and inpatient settings and current staff grade vacancies. Two staff grade vacancies could be converted into 3 WTE ACPs *(Band 7 or 8 depending on whether they are in training or have completed ACP course across 3 OA wards in the South).*

The acute wards will also benefit from the ACP role. DOH (2016) confirm that Mental Health Nurses have unparalleled opportunities to help people improve their physical health alongside their mental health, both in inpatient settings and in the community.

Figure 1 ACP Career Pathway



Advanced Pharmacy Roles

Development of Non-Medical Prescribing Pharmacist (Advanced Pharmacist) posts - where medical recruitment remains challenging. Staff in this role will work autonomously; possess leadership skills and support training, audits and research.

Figure 2 Advanced Pharmacy Role Career Pathway

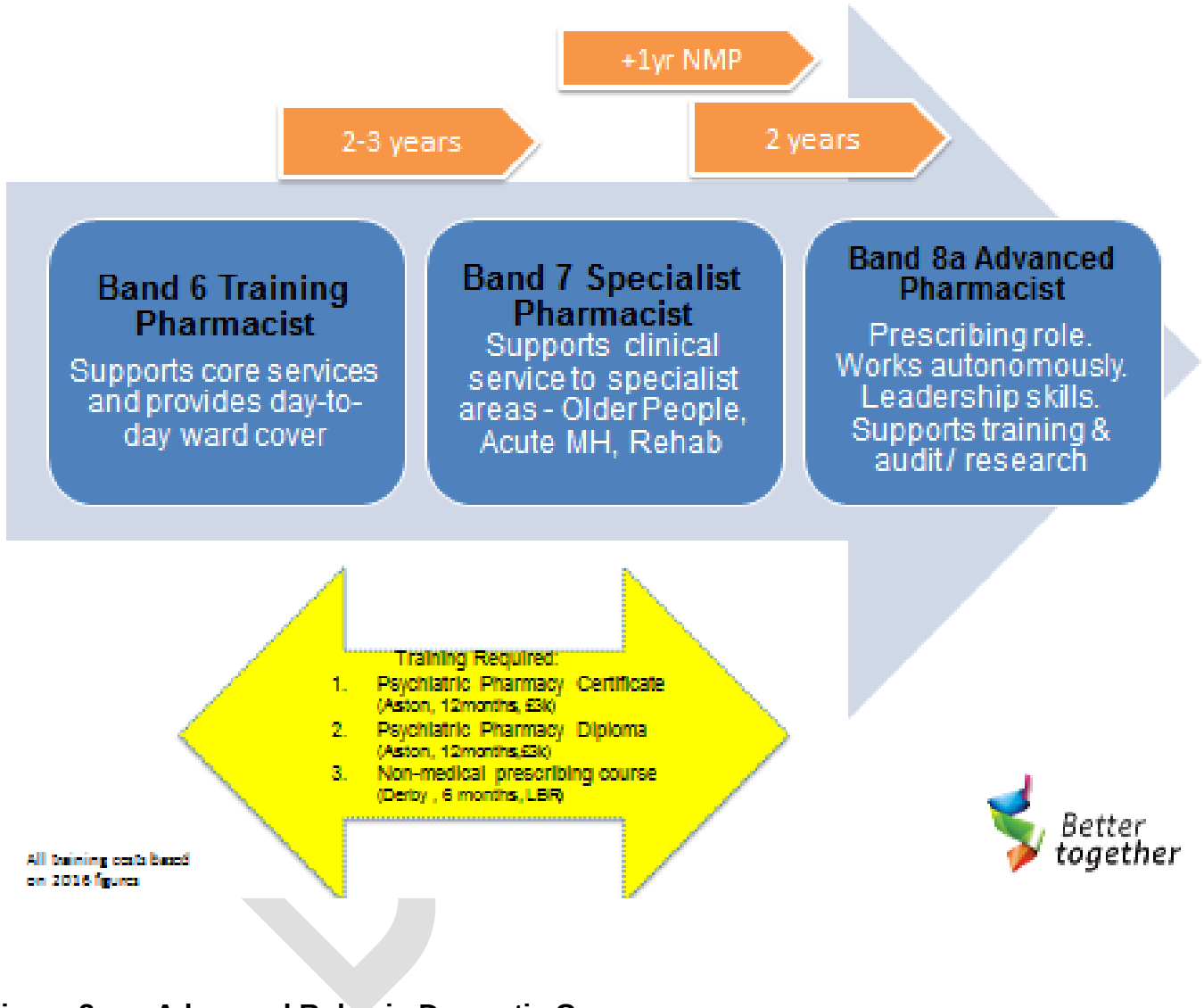
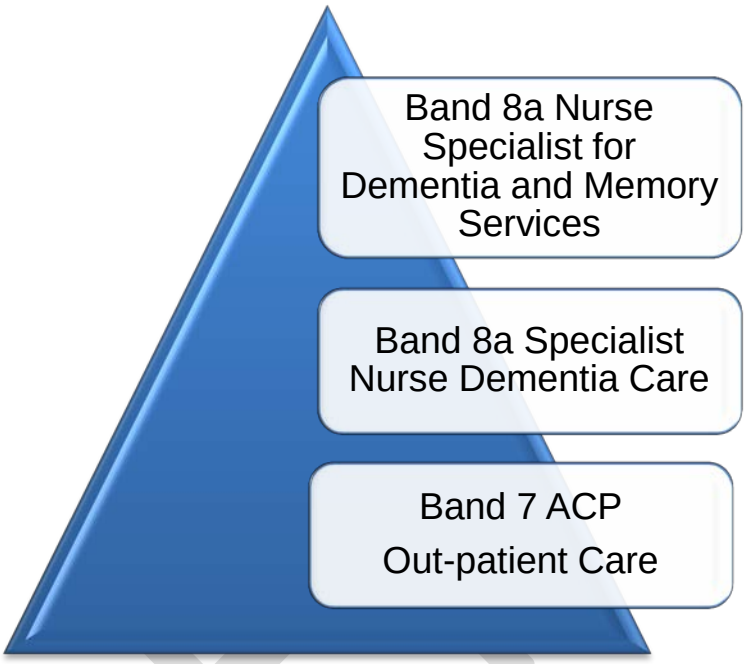


Figure 3 Advanced Roles in Dementia Care

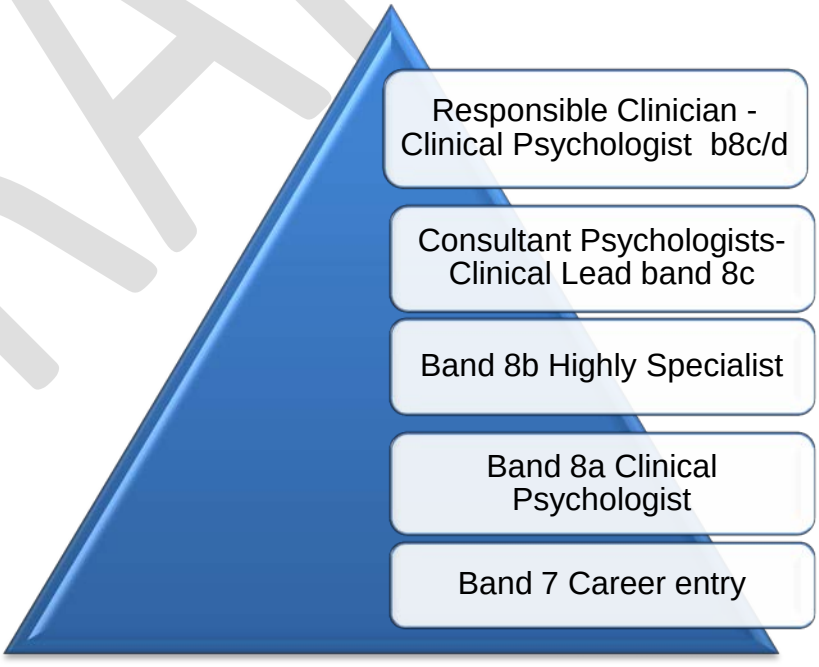
Advanced Roles in Dementia Care

The dementia roles will support the recruitment challenges of older age psychiatrists in Neighbourhoods. There are challenges in recruiting Speciality grade medics and agency costs are high. There are particular issues in Amber-valley and with retirement expected in North areas. This post is likely to save our agency spend in this area. These roles will enable the service to become a nurse led diagnostic service.



Psychology

AFC band 7 is the qualifying grade for clinical psychologists and it is becoming increasingly difficult to appointment to band 7 posts due to a falling number of training posts being commissioned and staff wanting to progress to Band 8a which is essentially a career grade. DHCFT has some attrition of 8a psychologists who move on to posts in other organisations for opportunities to develop areas of special interest and where there are more opportunities to progress to more senior grades.



We need sufficient staff to manage the demand – There are significant deficits of core clinical psychology staff to meet demands on waiting lists as identified by the CQC in June 2016. Some preliminary calculations based on benchmark data suggest that we need a further 12 WTE 8a staff in neighbourhoods and a further 9WTE 8a in inpatient services to meet current demand. In line with new ways of working we would like to develop Clinical Psychologist in Responsible Clinician roles.

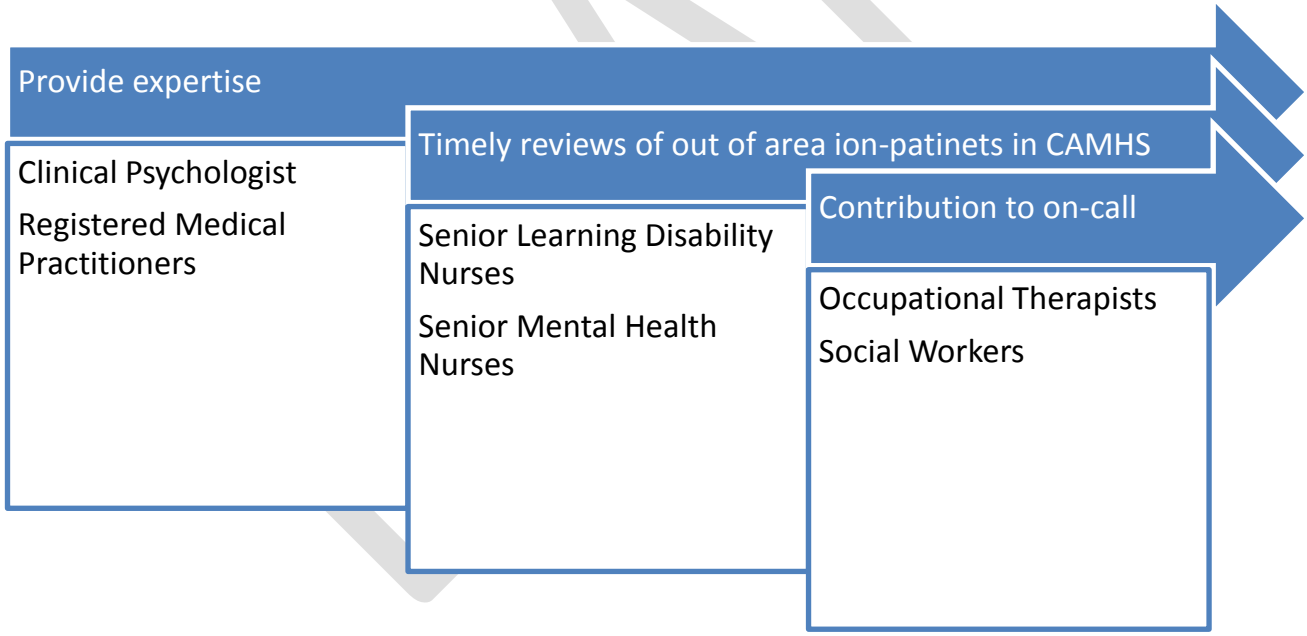
Non-medical prescribing

Over the last few years there has been increasing numbers of referrals to community paediatricians but at the same time there has been a national difficulty recruiting into vacant Community Paediatrician posts. As a result there has been a need to redesign pathways to introduce a different skill mix to provide a safe, effective and timely service. Therefore utilising budget previously used to fund Community Paediatricians, additional nursing posts have been generated within the Neuro-Developmental Team and as a result nurses are now completing much of the initial assessment and follow-up contact for Children and Young People on the ADHD pathway under the supervision of a Community Paediatrician. Therefore the direct input from community paediatricians for children and young people on this pathway is significantly reduced as much of the patient contact is now provided by the nurses rather than Community Paediatricians. This pathway is being enhanced with non-medical prescriber capacity within this nursing workforce which will further reduce the time required by the community paediatricians.

Since the introduction of the Health Hub in Children's Services, non-medical prescribers (nurses) now undertake follow up appointments. This reduces the demand on the Consultant Psychiatrists enabling them to focus on workload that cannot be allocated to any other skill mix within the multi-disciplinary team. DHCFT will prioritise Non-medical Prescribing for identified services when allocating funding for training.

Future Developments to Support the Medical Workforce Recruitment Challenges

Non-Medical Mental Health Act Approved Clinician



The Approved Clinician is defined by the Mental Health Education & Training Network as:

"A person approved by the appropriate national authority to act as an approved clinician for the purposes of the Mental Health Act 1983". Approved Clinicians have many statutory roles and responsibilities within the Mental Health Act 1983. Only Approved Clinicians may be appointed as Responsible Clinicians. Registered Medical Practitioners who are Approved Clinicians are automatically Section 12 approved (even if they were not S12 approved previously)".
Courses to become an Approved Clinician are open to Registered Medical Practitioners, Chartered Psychologists, Social Workers, Senior Mental Health or Learning Disability Nurses and Occupational Therapists.

What is the rationale for developing Non-medical Mental Health Act Approved Clinician roles?

There is currently a significant challenge, both locally and nationally, to recruit substantively to medical Approved Clinician roles. This is resulting in inconsistencies in the quality of care that we provide and increases in our Agency spend. There is also a gap in clinically focussed career pathways for non-medical colleagues, with potentially a missed opportunity to use their skills and resources. These posts might also aid recruitment to Band 5 / 6 roles, if staff can see that we can offer the full range of clinical career options.

Introducing New Roles to Support Challenges in the Nursing Workforce

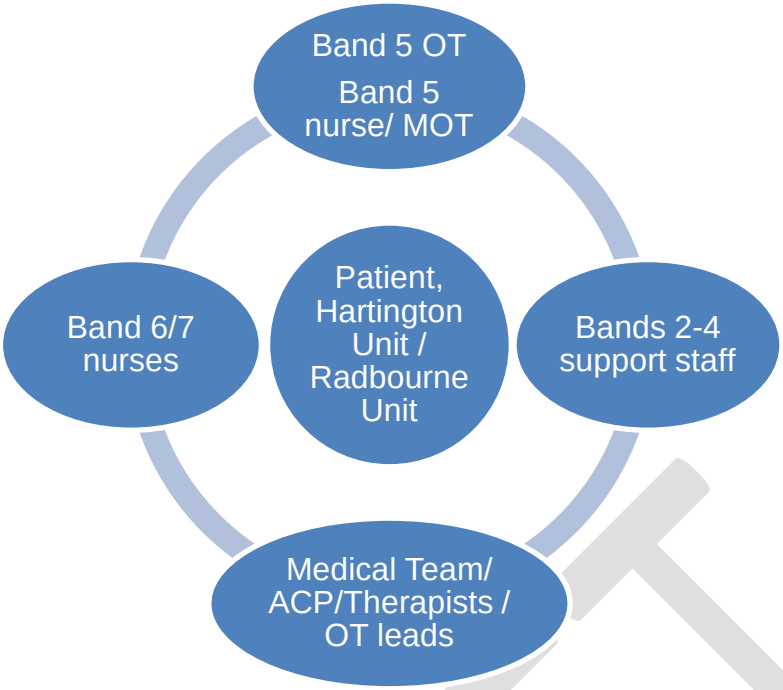
The significant supply shortage of Nurses across the UK is expected to carry into the next few Years. Consequently, we need to look into different alternative roles and focus on 'growing our own'. It is therefore cost effective to look at various ways of meeting nursing demand outside of our normal practice.

Introducing Occupational Therapists on the Acute Wards

DHCFT currently supervises OT students (*approx. 50 per year)* from a range of BSc and MSc OT courses from Derby University and Sheffield Hallam. We want to be able to recruit from these students that we train and nurture into preceptorship posts within our Trust, enabling alternative workforce solutions.

To recruit Band 5 (preceptorship) Occupational Therapists to work within each acute ward working as part of the shift rota during the day shifts. They will work with an occupational focussed approach, working within their professional competencies. This staff group will be able to deliver integrated care alongside other members of the team. Practice will include the following:

- Acting as key worker for patients with identified functional difficulties and contributing integrally as part of the ward based team.
- Support the implementation of meaningful activities as part of the smoke free strategy.
- Introducing a Recovery approach and early intervention with self-management techniques at earlier stages in a person's recovery.
- Use of activity as therapeutic tool and behavioural activation.
- Implementing PAM in acute inpatient areas.
- Facilitating MDM meetings.
- Undertaking admissions.



Growing Our Own Staff – Wider Workforce Development

The Shape of Caring (2015) recommended Valuing and developing the care assistant workforce. The Care Assistant workforce is at the starting point on a career framework: the skills and potential they bring underpin the future development of the nursing and caring workforce. The implementation of the Care Certificate in April 2015 was the start of a long journey. DHCFT commit to valuing and developing this workforce in order to maximise our workforce supply. The organisation will support the following new roles as a future workforce supply pipeline to nursing registration:

- Nursing Associates
- Nursing Apprenticeships
- Assistant Practitioner (Foundation degree)

The table below defines the DHCFT Career Pathway for our support staff:

Band 5 BSc / MSc in Mental Health Nursing	**Preceptorship**	**Return to Practice**	
	REGISTRATION (level 6)		
PLACEMENT SUPPORT	Pre-reg Year 3 Pre-reg Year 2 Pre-reg Year 1 Self-funding trainees	Pre-reg Year 2 Pre-reg Year 1 i. MSc Sponsorship model ii. Self-funding trainees	Nursing Apprenticeships Year 1 Year 2 Year 3 Year 4 Commence Sept 2017
Band 4	Access to HEIs Assistant Practitioner Higher Care Certificate	Nursing Associate / Nursing Apprenticeships	
Band 3	Care Certificate Diploma in Health & Social Care / NVQ Level 3	Foundation Degrees (Assistant Practitioners)	
Band 2	Care Certificate / Apprenticeships / NVQ Level 2	NEW TO DHCFT	

PRE –WORK *(and Community Engagement)*

- Work Experience
- Schools Outreach
- Talent for Care / Volunteers

Train Nurses Faster: New Routes into Nurse Education

Masters in Mental Health Nursing – Sponsorship

The organisation needs to consider sponsoring a group of 10 support staff to access the 2 year training programme. This will see the organisation benefit from a group of registered nurses quicker than the traditional 3 year training.

A total of 14 eligible staff already work for the organisation and have valuable skills and experience which they can build on. This option will contribute to staff retention and morale; the organisation has staff working in support roles that are eligible and keen to undertake the training.

MSc in Mental Health Nursing

- May - June DHCFT internal advert and Interviews
- Training from September 2017 for 2 years

Year 1 of sponsorship

- September 2018 follow up and review of trainees
- Monitor attrition rates

Year 2 of sponsorship

- September 2019 Potential 10 newly registered nurses commence employment in DHCFT
- Staff will be deployed to where the vaccancies are

MSc Sponsorship

Staff: Fully fund 10 existing support workers

Course Fees: £210K

Salaries: Mid Band 4 x 10 over 2 years

Contract: To work in own areas for 40 days over the 2 years *(during university holidays*. Learning contract to ensure on completion, staff will work for DHCFT for at least 3 years

Masters in Mental Health – Scholarship Model

As above, this option will be offered to external applicants who are eligible to undertake the nursing training. The organisation will not incur salary cost, the applicants will be encouraged to join the nurse bank.

MSc Scholarship

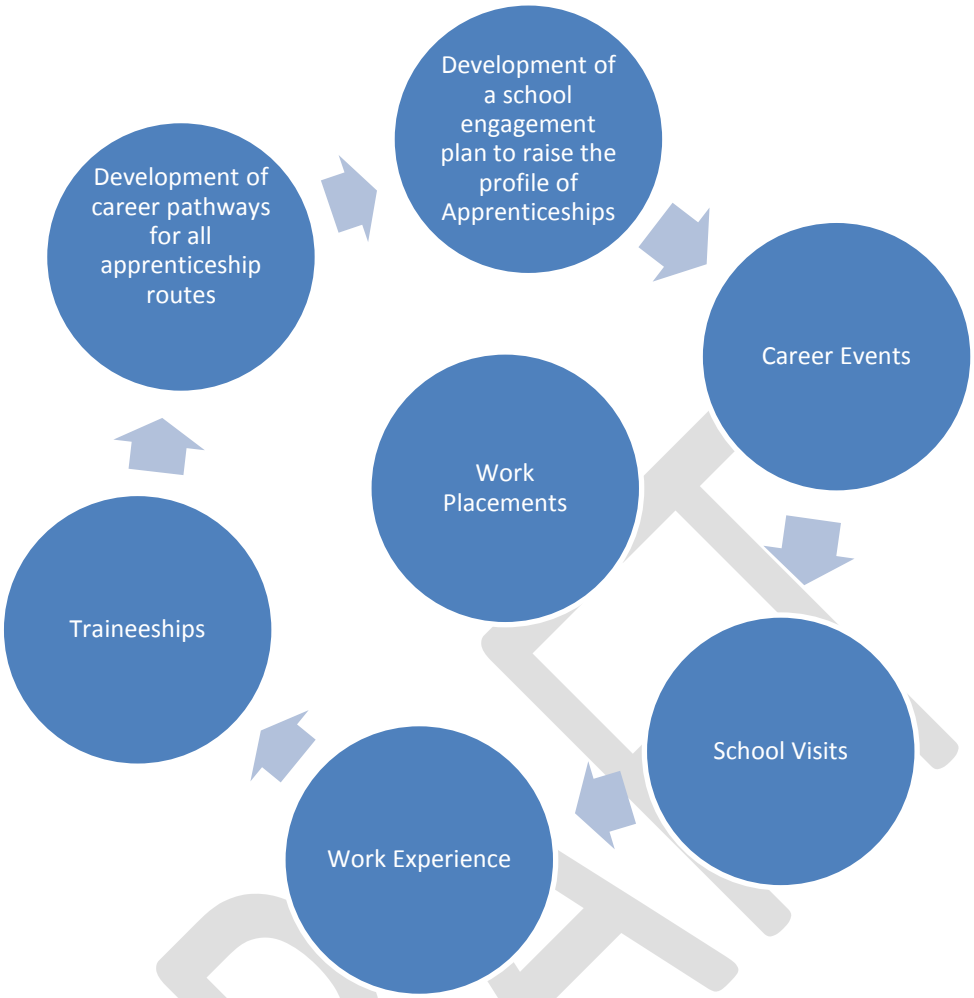
Staff: Fully fund external people with degrees (scholarship model)

Course Fees: £21K per person

Apprenticeships

Apprenticeships will form a key part of our workforce development plan. DHCFT has always been committed to developing apprenticeships and views the development of a wider range of apprenticeships as an opportunity to open up more career pathways across a broader range of professional groups.

We aim to make better use of work placements and collaborative projects with schools, colleges and universities. Such initiatives will be a key focus of our wider workforce initiatives over the next 5 years and include:



We are currently working with a number of stakeholders such as HEE, Skills Funding Agency, and Skills for Health as well as local colleges and HEI's to ensure we are able to offer high quality apprenticeships that reflect our priorities and enhance our ability to grow our workforce.

Based upon Derbyshire workforce plan we aim to work with local partners across the STP footprint and wider education providers to develop apprenticeship standards and trailblazer sites in the professional groups where we are currently facing staff shortages or recruitment and retention challenges

DHCFT is currently part of the new Clinical Nurse Apprenticeship and OT trailblazer projects due to be introduced in summer 2017. The development of new apprenticeship routes is an exciting development and will provide viable career routes for both nursing and AHP support staff to become registrants.

Volunteers

Currently we have a small, but valued pool of active volunteers (61) with a further 69 in process, managed by a 0.7 volunteer co-ordinator/social inclusion OT. Many of our volunteers have roles where they are directly enhancing the experience of the service receivers, supporting our inpatient and neighbourhood teams by co-facilitating activity groups, meet and greet, providing chaplaincy support, breast feeding support and peer support across adult mental health, learning disabilities and specialist services. Their roles are also enabling paid staff to improve service provision.

By having volunteers we have been able to increase ward based activity and relieve pressures on ward staff , freeing up rec staff to carry out level 3 observation off the ward' (Hartington Unit)
78% of our current pool of volunteers are DHCFT service receivers. The role of the volunteer co-ordinator is to support them to continue on their recovery journey, by offering vocational support and sign posting.

We also offer a limited number of volunteer internships to volunteers with lived experience of mental health issues who are finding it difficult to obtain paid work. Vocational support is provided alongside specialist OT assessment and intervention. Of the 4 people who have completed an internship 3 have gone on to obtain paid employment.
DHCFT needs to ensure we have adequate resources to support and increase numbers of volunteers into the trust.

Peer Support

A Peer Support Worker/Volunteer is a member of staff or volunteer with lived experience of mental health conditions. They work directly with the service receiver, and are also involved in service development.

Their relationship with the service receiver is:

- Based on shared personal experience and empathy
- Focus on strengths, not weaknesses
- Works with the with the service-receiver towards individual wellbeing and recovery
- Supports their own recovery journey

There is strong evidence that Peer Support workers and volunteers have a positive effect on service delivery, and there is evidence to suggest that using Peer Supporters within Mental Health Services has a positive effect on peoples recovery and reduces the use of hospital beds, improves social support networks, self –esteem and social function(Centre for Mental Health).

The 'Five Year Plan for Mental Health' (Mental Health Taskforce to the NHS in England, (2016) also actively supports the introduction of Service-users into the workforce. In order to provide a consistent and effective Peer Support Service, a Peer Support Development Worker is essential. Due to the challenging nature of Peer Support role, it is also essential that the workers are well supported in their roles to support their own mental health and recovery.

Peer Support Development Workers role would include:

- Mentor and support Peer workers and volunteers
- Development of the Peer Service, with the aim of increasing the number of peer workers and volunteers across all mental health services
- Develop and support the delivery of Peer training
- Develop and support the delivery of staff training on the Peer role
- Work with partners to establish Peer networks and partnership working
- Monitor the quality and effectiveness of the service

Leadership and Management

We will require innovative, strong leadership across all levels of the organisation, together with high quality people management.

Integrated care delivery will call for leaders that are able to navigate organisational boundaries; as such the role will require very different skills from traditional leadership and management models. Leaders and managers will need effective induction and support such as access to coaching and mentoring and learning opportunities that will assist in the development of system leadership skills and competences, resilience and innovation to bring about the required transformational change.

We will continue with our internal leadership and management training to support and develop our leaders. We will also continue to work with the National and regional Leadership Academy to offer suitable leadership development opportunities. We will also enhance our management development offer to include:

- Coaching and mentoring opportunities
- Shadowing opportunities
- Seeking out and developing the best potential talent

Talent management will form a key component of our workforce development activity. The Trust is currently going through the process of identifying a talent pool (as part of our succession planning process) for key roles and the development needs of groups and individuals. This information will inform the talent development programme for the Trust.

Research

The benefits of research to an organisation are well established and its value is explicitly recognised within the NHS.

As a key principle of the NHS Constitution[1], the NHS aspires to the highest standards of excellence and professionalism through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population.

The Department of health mandate requires Health Education England (HEE) to '…develop a more flexible workforce that is able to respond to the changing patterns of service and embraces research and innovation to enable it to adapt to the changing demands of public health, healthcare and services.' As such one of the HEE Research & Innovation Strategy aims is to 'build the capacity and capability of our current and future workforce to embrace and actively engage with research and innovation.' 2

There is increasing evidence that research-active healthcare provider organisations provide better quality care as well as improved clinical outcomes. [3]
Research is also increasingly important to patients and the public, who recognise its importance and want to access research in order to benefit from new treatments and interventions.

With the promotion, conduct and use of research at the heart of the NHS, we need a workforce and leadership trained to undertake and utilise research and innovation to continuously improve patient care.

A workforce and leadership trained in research and innovation can:

- Lead and contribute to new knowledge about care and treatment to improve patient outcomes.
- Advance practice and improve care through research
- Pursue evidence-based healthcare, improving quality, safety and effectiveness18
- Support research capacity and capability building, thus encouraging a research-rich environment
- Contribute to a well-rounded clinical research community, supporting the development of a healthcare workforce that actively seeks out the best evidence to help improve outcomes and experiences for patient
- Contribute to the health promotion and prevention agenda and support clinical decision-making in partnership with patients
- Facilitate the adoption and spread of best practice, innovation and new technology
- Contribute to the recruitment and retention of high quality staff through increased engagement, investment and support.

The Trust strategic direction for Research and Development aims to recruit, develop and retain a core 'research active' workforce and to support the development of relevant skills in the wider Trust workforce.

There is a need to ensure relevant knowledge and skills development in the wider workforce and the capacity required to implement these as part of core service delivery. Research and innovation which underpins delivery of high quality care and patient choice to participate in research are skills to be developed in an increasing number of staff and as such should be written into most job descriptions and person specifications and delivered through agreed job plans and appraisal objectives.

In addition, the core research active workforce needs to be made up of clinical academics who are clinically active health researchers jointly appointed with Higher Educational Institutions as well as existing clinical roles such as Consultant Nurses, specialist professional roles and the newer advanced professional roles. Development of the academic healthcare and scientific researcher roles and clinical research delivery roles as part of the core research active workforce plan is essential for the future health and wealth of the NHS and the economy. These research active roles will have protected time built in for the delivery of research and innovations, where they are not full time dedicated researcher roles.

Technology

The use of E-learning and agile working is becoming the norm for our staff. In order for the Trust to reap the maximum benefits of future technological change we will need a workforce with increasing proportions of staff whom are computer literate and comfortable with the use of technology as part of their everyday work.

There is clear evidence that innovative educational technologies, such as E-Learning, simulation and mobile learning provide unprecedented opportunities for students, trainees and staff to acquire, develop and maintain the essential knowledge, skills, values and behaviours needed for safe and effective patient care.

Consequently continuing professional development and education will be of increasing importance and will include:

- Assessment of digital literacy
- Enhancement of learning via e-learning podcasts and videos.

Summary

It is important for the Trust to note that all alternative roles and costs identified in this plan will not be the ultimate solution to our workforce supply issues. We will need to continue to invest in line with the ever changing workforce landscape.

Our planning has a different focus from previous years as the organisation sets out an ambitious plan in order to retain, recruit and develop a workforce with the right skills to deliver high quality care across all our services.

Workforce Development Implementation Plan 2017/ 18

Workforce Priority	Service Area	Proposed number and AfC band	Indicative Cost	Funding source	New Funding Required by Trust	Existing Budgets	Strategic Drivers	Leads
Advanced Clinical Practitioners	OA Wards and Radbourne Unit	3 x B 7 (Training HEE funded) 1 x B 8A	137,424 56,752	Existing Medical vacancies	£0	Funding to come from Staff Grade Vacancies	FYFV/MHWS	Dr R.Ahmed, Dr S. Thacker, H. Darn, C. Biernacki, D. Thompson
Non-medical Mental Health Act Approved Clinician	Not applicable	1 x B 8C 1 x B 8D	79,661 95,740	Funding required	£0	Funding to come from existing vacancies	Medics Recruitment challenges	D. Thompson, C. Green, Dr J. Sykes, General Managers, G. Wilkes
Clinical Nurse Specialist	Memory Assessment Service	1 x B 8A	56.752	Existing Neighbourhood Budget	£0	Funding to come from current budgets	FYFV/MHWS	C. Biernacki, Dementia Group
Return to Practice	Trust wide	Band 5 HEE funded	-	HEE funded	£0	Post funded by HEE	HEE	F. Sango, K. Ottywill, S. Khatkar
Nursing Apprenticeships	Trust wide	5 x B 3 Backfill 100 %	134,276	Yes – Service Lines	£134,276 for backfill	Funding required	FYFV/MHWS	F. Sango, Workforce Group, NLG
Recruitment of MH new registrants	Trust wide	20 x B 5	Existing vacancies	Yes – existing vacancies	£0	To go into existing vacancies	FYFV/MHWS	K. Lane, General Managers
Practice Learning Facilitators	Trust wide	3 x B 6	£114,545	Yes	£114,545	Funding required and identified	National & local	K. Lane, F. Sango, C. Biernacki, General Managers

Workforce Priority	Service Area	Proposed number and AfC band	Indicative Cost	Funding source	New Funding Required by Trust	Existing Budgets	Strategic Drivers	Leads
Nurse Associates	Trust wide	4 (Training HEE funded)		Yes	£0	HEE funded	HEE Talent for Care FYFV/MHWS	F. Sango, Workforce Group, NLG
Pharmacy Apprenticeships	Pharmacy	x 3	Apprenticeship Levy	Yes	£0	Levy funded & Pharmacy Budget	FYFV/MHWS/Shape of Caring/HEE Talent for Care	S. Bassi, M. Ladd
MOT – Pharmacy Technicians	Campus areas	14 x b5	£442,824	No(new roles)	£0	To be funded from existing vacancies	FYFV / MHWS/ Local	S. Bassi
OT Acute ward staff	Inpatient Wards	16 x b5	£506,085	Yes – existing vacancies	£0	To be funded from existing vacancies	FYFV / MHWS	K. Wheeler, N. Fletcher
Assistant Practitioners	Trust Wide	X3	Apprenticeship Levy	Yes – Levy funded	£0	Levy funded	FYFV/MHWS	F. Sango
Total Trust funding requirement					**£248,821**			

Contributions

Director of People and Organisational Effectiveness

People and Culture Committee

Strategic Workforce Group

Head of Education

Workforce Supply Lead

Temporary Staffing Lead

Deputy Chief Nurse

Nurse Consultant

Lead Consultant Psychiatrist Radbourne

People and Culture Committee

Acting Chief Operating Officer

Finance Directorate

General Managers

Chief Pharmacist

Occupational Therapy & Professional Development Lead (Neighbourhoods & Central Services)

Consultant Psychologists

Research & Clinical Audit Manager

Volunteer Manager / Social Inclusion OT

Education and Training Team

Principal Workforce and OD Manager

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors - 28 June 2017

Progress on the Staff Survey

Purpose of Report

- Provide the board with an overview of the 2016 staff survey and quarter 1 pulse check results and the approach and actions that we are taking to improve staff engagement and involvement across the trust.

Executive Summary

- The staff survey is an annual survey and in 2016 we moved away from completing a staff sample to a full census of staff. 858 provided the trust with their view at the time and these results when received in early 2017 and have been thoroughly considered and shared with staff through the infographic outlined in Appendix 1. With the help of the Staff Engagement group we have jointly shaped the approach to take to make a step change in improving our position as a great place to work.
- We completed in quarter 1 a follow up 10 question pulse check and 516 staff took part. This quick turnaround survey which is focused on the key 10 questions that measure staff engagement, involvement and advocacy. These results have again been shared amongst staff.
- All leaders have received details of the staff survey results and where their team is of a sufficient size their pulse check results.
- We have identified four areas of focus from the Staff Survey for improvement which are being tracked for progress through the People and Culture Committee. Additionally all leaders have been asked to develop their action plans with 3 key focus areas that they will work on with their teams. Trust Management Team is tracking progress of the local development work.
- Since completing the two recent surveys DHCT has undertaken a cultural survey with EY and on receipt of the survey results we will be look to combine the findings and areas of focus into our improvement plan.

Strategic Considerations

- The turnaround time from completing the staff survey to receiving the results is long and drawn out in comparison to the time we have to make significant improvements
- The time of completing the staff survey the trust was going through a difficult time and this position has now improved
- Increasing staff engagement, involvement and advocacy is key to delivering high quality services and achieving overall success

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

Assurances

This report seeks to assure the Board that:

- We have an inclusive approach to improving staff engagement reported through the staff survey and pulse checks.

Consultation

- We have actively worked with the Staff Engagement Group to shape our development actions
- Leaders have been asked to work with their teams to develop local action plans

Governance or Legal Issues

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

From the staff survey we can retrieve detail about the staffs experience by their protected characteristics, this analysis will be carefully analysed and reviewed at the equalities forum

Recommendations

The Board of Directors is requested to:

1. Acknowledge the staff survey and pulse check results that the approach we are taking to improve staff engagement, involvement and advocacy for the trust.

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

Report prepared by: Amanda Rawlings, Director of People and Organisational Effectiveness

Progress since the NHS Staff Survey 2016 results
(received March 2017)

1. 2016 Staff Survey Findings

The 2016 NHS Staff survey results have been discussed at board and reviewed in detail by the People and Culture Committee. Our results in 2016 show a gradual decline in our staff engagement score from 2014. National research identifies that there is a direct correlation between staff engagement to patient safety and patient outcomes and therefore it is key that the trust focuses on staff engagement in order to deliver good patient care and experience and to create a great place to work.

Staff Engagement Scores

Scale Summary Score - the higher the score the better

Trust score 2016						3.69
Trust score 2015						3.73
Trust score 2014						3.75
National 2016 Average for combined MH/Community NHS Trusts						3.84 (2015 was 3.81)
	1	2	3	4	5	

In 2016 we had 2200 eligible employees out of 2400 who could complete the survey and 858 – 39% participated. This compares with 35.9% for the worst preforming Mental Health/Community Trusts and 55.3% for the best performing. The average response rate nationally was 46.5%. In 2015, although our response rate was slightly higher at 41%, the number of eligible staff was only 800. The 2016 staff survey results compared to 2015 show that we are:

- Significantly better on 1 question
- Significantly worse on 10 questions
- No significant difference on 77 questions

From the survey we have seen deterioration in two significant fundamentals that measure how engaged staff are in the trust:

- Recommending DHCFT as a place to work or receive treatment
- Staff motivation *the extent to which staff look forward to going to work, and enjoy and absorbed* in their jobs)

The Trust has improved significantly in one area from 31% in 2015 to 41% in 2016

- In last 3 months, have not come to work when not feeling well enough to perform duties

Findings from the NHS Staff Surveys as well as interviews with teams /staff show the following:

- Not feeling safe to raise concerns about clinical practice
- Feeling that career progression is not fair
- Quality of appraisals is poor
- Feeling that the trust is not interested in health and well -being of staff
- Feeling that managers do not appreciate staff

2. Progress

The Trust has taken the results of the Staff Survey and developed a framework to ensure we are acting at every level of the organisation. Four organisational priorities have been agreed to steer the direction and vision and then agreed actions at both service and team level to drive and embed change. They are not all quick-wins but address the cultural issues underpinning staff concerns. This will build a process of collective leadership and greater engagement. The priorities emerge from the most significant challenges in the Staff Survey results

The four organisational priorities:

- *Employee Voice*
- *Leadership engagement*
- *Staff/Resources*
- *Tools for the job*

3. Description of each of the four priorities

Employee Voice

- A core Staff Engagement Group working to introduce a new wider Staff Forum –The Voice
- A new quarterly Pulse Check to measure Staff Engagement
- Chief Executive weekly blog
- Drop in sessions with members of the Executive Team
- Bi monthly Spot Light on Leaders sessions

Tools for the job

- Hearing from staff that we need to fix the basics – phones, laptops/PC's, parking, connectivity

Leadership Engagement

- Building a leadership development framework
- Talent Management and succession planning
- Coaching conversations
- Providing support to challenged areas
- Building compassionate leadership

Staffing /Resources

- Building a workforce plan to introduce new workforce models/roles
- Focused recruitment campaigns including overseas
- Tackling retention

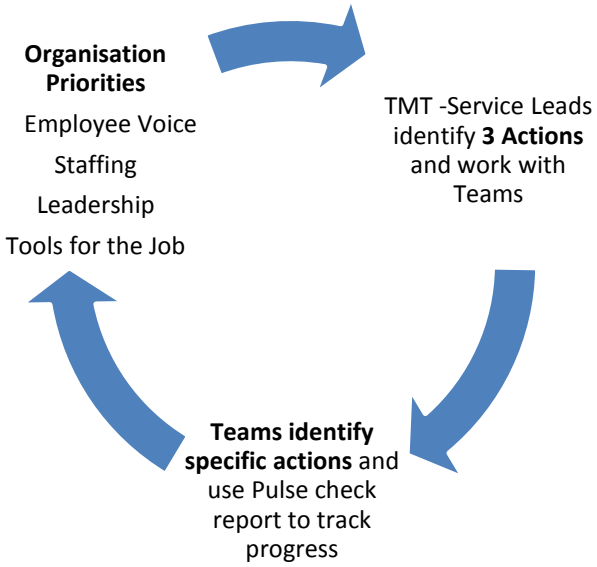
4. Service level

The Trust Management Team (TMT) brings together all service leads and is therefore a key group in driving change. Each Service Lead has received a staff survey report and now a pulse check report. From this, they have agreed three action points for their areas with rationale for their choice and a plan for monitoring progress. These will be monitored by the Trust Management Team (TMT) Teams will then work with service leaders on the actions.

5. Team level

We know that building effective and cohesive teams is crucial in terms of improving morale and changing culture. Service leaders will therefore work with team leaders on the actions. This is a significant challenge as many teams do not have regular team meetings and are feeling pressured due to shortages. At a recent Spotlight event some managers worried that this way of working was becoming the norm instead of the exception.

This is why we are offering support to teams through focus groups, coaching and team events to purposefully support the visible distribution of leadership responsibility at all levels in the organisation. Specific services have requested further support in light of their staff survey findings. This includes focus groups to help teams to gain more understanding of their results and identify solutions. This approach takes time and requires intensive work with teams who are in distress. In each session opinions of participants will be sought in relation to key areas highlighted in the team's staff survey results. Overall themes can be analysed to give a snapshot of the Trust's culture and identify trends. The approach used draws on appreciative inquiry and participatory methods.



6. Pulse Check

The Pulse check has 10 questions - including the 2 mandatory Staff Family and Friends questions. The results of the first quarterly Pulse check have now been received. The response rate was 22.4%. (516). Although this seems low in comparison to the staff survey results (39%) this is an improvement of 11% since the last full Staff Family and Friends Test in June 2016. As staff become more aware of the Pulse Check and receive reports this should increase. Reports have been circulated to 40 areas. Teams with 5 or more employees will now receive a report. This is a new approach for the Trust and will hopefully begin to build greater involvement at team level. Quarter 1 2017 is now live and results will be available early July. Teams will be able to benchmark against Staff Survey and Pulse check reports. Teams also receive any comments received from staff. We are testing a new approach to increase response rates via the use of secure boxes for people who prefer to use paper copies. This is being used at the Radbourne Unit.

7. Results of Quarter 1 Pulse Check April 2017

Comparison with previous years

- Q1 June 2016 – 258 responses, 11.14% of the Workforce *(National response rate 12.68%)*
- Q2 Staff Survey 2016 - 858 responses 39%
- Q3 *Campus only, therefore not used for comparison in this report*
- Q4 Pulse Check - 516 responses 22.4%

Staff Family and Friends questions

Question	Base	Picker Average	Trust % score	Staff Survey2016	Lowest (to date)	Highest (to date)
Q1How likely are you to recommend this organisation to friends and family if they	514	76%	70%	56%	56%	70%

needed care or treatment?						
Q2 How likely are you to recommend this organisation to friends and family as a place to work?	511	64%	51%	43%	43%%	51%

The 8 additional questions

Question	Base	% score	Staff Survey 2016	Lowest (to date)	Highest (to date)
Q5 Care of patients/service users is the trust's top priority.	494	77%	68%	68%	77%
Q6 I am able to make suggestions to improve the work of my team/department.	488	77%	74%	74%	77%
Q7 There are frequent opportunities for me to show initiative in my role.	493	70%	74%	70%	70%
Q8 I am able to make improvements happen in my area of work.	489	63%	55%	55%	63%
Q9 I think that it is safe to speak up and challenge how things are done	497	57%	New question	57%	57%
Q10 I look forward to going to work.	504	55%	53%	53%	55%
Q11 I am enthusiastic about my job.	492	67%	70%	67%	67%
Q12 Time passes quickly when I am working.	497	77%	77%	77%	77%

8. **Examples of improved engagement**

Radbourne Unit

The Radbourne Unit has a number of challenges not least staff shortages and difficulties in recruitment and retention. Response rates in the staff survey have been low and conversations with teams suggest that staff feel disconnected from the rest of the Trust and unsupported. The Staff Engagement Group held a meeting at the Unit and invited staff to attend. Two members of the Hope and Resilience Hub wanted to try out the use of staff suggestion boxes to find out what staff really thought. Within a week 133 responses had been received (compared to 33 in the Staff Survey). The responses have been collated into themes and results feedback to staff. A Senior Nurse has now been released to develop a supervision model as this was major theme and set up a staff forum within the Radbourne Unit. This will then link into the new Trust Staff Forum. .

9. The Voice

The Voice is a new staff forum suggested by the Engagement Group. Draft terms of reference have been written and ready for discussion and approval with the Chief Executive. This would be a quarterly forum with participation from every service and would build partnership working with the Executive Team. The Voice will require dedicated support and an independent Chair.

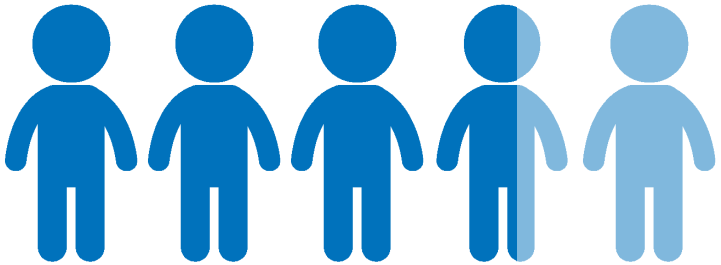
10. Next steps

Over the next couple months we will continue to work on the trust four priorities as well as supporting leaders and teams at a local level. We are waiting for the output of the cultural work we completed with EY and will look to bring the findings into our improvement plan.

Derbyshire Healthcare
NHS Foundation Trust

2016 National NHS Staff Survey: results summary

Overall staff engagement



We scored
3.69 out of 5

3.73 – our score for last year (2015)

3.80 – average score for similar trusts

77
Questions with results similar to last year
1 significantly better,
10 significantly worse

39%
Response rate
858 out of 2200 Derbyshire Healthcare employees completed the 2016 NHS staff survey

How is the staff engagement score calculated?

Staff willingness to recommend the Trust as a place to work or receive treatment
+
Staff perception of their ability to contribute towards improvement at work
+
How far staff feel motivated or engaged with their work
=
Staff engagement score

Our best areas

+ More staff know how to **report unsafe clinical practice**
+ More staff are satisfied with the opportunities for **flexible working patterns**
+ More of you are **reporting** experiences of harassment, bullying, abuse or violence
+ Fewer of you feel pressure to **attend work when unwell**
+ **Fewer experiences of physical violence** from staff in last 12 months.

Areas we need to improve on

We've heard you say…

- You want more opportunities for **career progression or promotion**
- You are reporting incidents but are not confident the Trust will **act on your concerns** and give feedback
- You are not sure the **process for reporting** is fair
- You want **appraisals** that leave you feeling valued and with a plan
- You want to see better use of patient/service receiver **feedback**.

Summary of Board Assurance Framework Risks 2017/18. Issue 1

Ref	Principal risk	Director Lead	Current rating
Strategic Outcome 1. We will deliver quality in everything we do providing safe, effective and person centred care			
1a	Failure to achieve clinical quality safety standards required by our regulators	Executive Director of Nursing and Patient Experience	HIGH
1b	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients	Executive Director of Nursing and Patient Experience	HIGH
1c	Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)	Medical Director	HIGH
1d	Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident	Acting Chief Operating Officer	MODERATE
Strategic Outcome 2: We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time			
2a	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME
Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff			
3a	Ability to attract and retain high quality clinical staff across all professions	Interim Director of People and Organisational Effectiveness	HIGH
3b	There is a risk to staff engagement and wellbeing by the trust not having supportive and engaging leaders	Interim Director of People and Organisational Effectiveness	HIGH
3c	There is a risk that the Trust will continue to be subject to NHSI enforcement action and CQC requirement/warning notices	Acting Chief Executive	MODERATE
3d	There is a risk that the Trust does not operate inclusively and may be unable to deliver equity of outcomes for staff and service users	Interim Director of People and Organisational Effectiveness	MODERATE
Strategic Outcome 4. We will transform services to achieve long-term financial sustainability			
4a	Failure to deliver financial plans	Executive Director of Finance	EXTREME
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	EXTREME
4c	That the process leading to acquisition of DHCFT by DCHS may have a detrimental impact on the Trust's ability to manage day to day performance due to increased capacity demands on senior leaders and directors	Acting Chief Executive	HIGH

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 28 June 2017

Report from Confidential Meeting of Council of Governors
6 June 2017

The Council of Governors has met once since previously reported to the Public Board. The second confidential meeting of the Council of Governors was held on Tuesday 6 June 2017. It was chaired by Caroline Maley, Acting Trust Chair. Nine governors attended the confidential meeting, which was held at the Agricultural Business Centre in Bakewell.

Tuesday 7 June 2017 – Confidential Meeting
A confidential meeting of the Council of Governors was held as scheduled on 6 June. The Trust's Board of Directors relayed their decision not to proceed with the proposed merger of the Trust with Derbyshire Community Health Services NHS Foundation Trust (DCHS) at this time. The reasons for the decision were outlined and discussed. The governors present unanimously supported the Board's decision.

Governors were thanked for their contribution to the discussions to date on the potential merger and for their ongoing support throughout this process.

Details on how the Trust is to utilise the valuable feedback obtained through the process to date and the planned focus on the development of an Accountable Care System for the whole of Derbyshire were outlined. Plans for staff engagement relating to the withdrawal from the transaction were discussed and governors invited to raise queries and questions.

The Board will move to consider its structure. The Senior Independent Director had been asked to initiate conversations with the Governors Nominations & Remuneration Committee regarding the recruitment process for a substantive Trust Chair. The appointment for the other Acting Board roles will follow.

A request was received to consider lowering the age of eligibility for membership of the Trust to age 12. This will be discussed at the Governance Committee.

It was highlighted that meetings that had been scheduled to further discuss aspects of the proposed merger would now be cancelled and a new meetings timetable will be circulated to governors shortly.

RECOMMENDATION

The Board is asked to note the summary report from the Council of Governors.

Report prepared by: **Donna Cameron, Assistant Trust Secretary**

Report presented by: **Samantha Harrison**
Director of Corporate Affairs & Trust Secretary

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	**18 Apr**	**15 May**	**19 Jun**	**17 Jul**	**18 Sep**	**23 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	NHSI Annual Plan *TBC awaiting NHSI guidance*	FT Constitution/NHSI Risk Assurance Framework (RAF)										
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 - annual report April interim report November	Strategic Outcome 1 Strategic Outcome 3 Information Gov toolkit	AR					IR				
AR	Staff Survey Results and Action Plan	Strategic Outcome 3 and 4	X									
AR	Equality Delivery System2 (EDS2)	Strategic Outcome 3 and 4	AR									
AR	Approval of Equality Delivery System2 (EDS2) 2017/18	Strategic Outcome 3 and 4					X					
SH	Review SOs, SFIs, SoD	FT Constitution Standing Orders				X						
SH	Trust Sealings	FT Constitution Standing Orders	AR									
SH	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	AR									

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	Board Assurance Framework Update	Licence Condition FT4	X				X		X		X	
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	X	X
SH	Review of Policy for Engagement between the Board & COG								AR			
SH	Board Development Programme										X	
LWS	Business Plan 2017-18		X			X		X			X	
LWS	Measuring the Trust Strategy		X			X			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												

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	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
CG/JS	Safeguarding Children Annual Report	Children Act Mental Health Standard Contract							AR			
CG/JS	Safeguarding Adults Annual Report	CQC Mental Health Standard Contract								AR		
CG	Control of Infection Report	Health Act Hygiene Code		AR								
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							AR			
CG	Annual Community Patient Survey	Clinical Practice CQC							AR			
JS	Re-validation of Doctors	Strategic Outcome 3			AR							
CG	Annual Review of Recovery Outcomes *							AR				
CG	Annual Looked After Children Report *									AR		

* Incorporated in Quality Position Statement