Derbyshire Healthcare NHS Foundation Trust
Public Board of Directors

Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital, Derby

2 April 2019 09:30 - 2 April 2019 12:15

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Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – TUESDAY 2 APRIL 2019
TO COMMENCE AT 9:30am IN CONFERENCE ROOMS A&B
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOPMENT, KINGSWAY HOSPITAL

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies and Register of Interests report	Caroline Maley
2.	9:35	Patient Story	Carolyn Green
3.	10:00	Minutes of Board of Directors meeting held 5 March 2019	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.		Questions from governors or members of the public	Caroline Maley
6.	10:05	Chair's Update	Caroline Maley
7.	10:15	Chief Executive's Update	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY, STRATEGY AND GOVERNANCE			
8.	10:30	Integrated Performance and Activity Report	C Wright/A Rawlings/ C Green/M Powell
11:00 B R E A K			
9.	11:15	Board Assurance Framework (BAF) 2018/19 Issue 5 2019/20 Issue 1	Rachel Kempster
10.	11:30	Preparations for Brexit	Mark Powell
11.	11:35	Learning from Deaths Mortality quarterly report	John Sykes
12.	11:45	Board Effectiveness Survey Report and policy for Engagement between the Board and Council of Governors	Caroline Maley
13.	11:55	Board Committee Assurance Summaries and Escalations: Mental Health Act Committee 8 March, Quality Committee 12 March, Finance & Performance Committee 19 March, Audit & Risk Committee, 21 March 2019 *(minutes of these meetings are available upon request)*	Committee Chairs
14.	12:10	Register Trust Sealings 2018/19	Justine Fitzjohn
CLOSING MATTERS			
15.	12:15	- Identification of issues arising from the meeting for inclusion or updating in the BAF - Draft Forward Plan for 2019/20 - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Glossary of NHS Acronyms Summary report of meeting of Council of Governors held on 5 March 2019			

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

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

The next meeting will be held at 9.30am on 7 May 2019 in
Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion

Derbyshire Healthcare
NHS Foundation Trust

Our vision

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

Making a positive difference

Our values

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

Our Trust values are:

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

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 2 April 2018

Corporate Governance
Register of Directors' Interests 2018/19

Purpose of Report
This report provides the Trust Board with an account of Directors' interests during 2018/19.

Executive Summary

- It is a requirement that the Chair and current Board members who regularly attend the Board should declare any conflict of interest that may arise in the course of conducting NHS business.
- The Chair and Board members should declare any business interest, position of authority in a charity or voluntary body in the field of health and social care, and any connection with a voluntary or other body contracting for NHS services. These should be formally recorded in the minutes of the Board and entered into a register which is available to the public.
- Directorship and other significant interests held by NHS Board members should be declared on appointment and kept up to date.

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

Board Assurances

Directors are asked to disclose to the meeting any changes to the Register of Directors' Interests during the course of the year.

When reviewing their disclosures, each Board member has personally reaffirmed in writing their agreement to comply with the NHS Codes of Conduct and Accountability, and the Seven Principles of Public Life (Nolan), and to state whether there is any relevant audit information of which the Trust's Auditors are unaware.

Governance or Legal issues

The disclosure and statements referenced within this report are subject to the NHS Code of Conduct and Accountability and Licence Conditions of the Trust.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks – there is no impact to those with protected characteristics arising from this report.

Recommendations

The Board of Directors is requested to:

1) Approve and record the declarations of interest as disclosed. These are recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's annual report and accounts for 2018/19.
2) Record that all Directors have signed as to compliance with the NHS Codes of Conduct and Accountability and Nolan principles; no relevant audit matters have been declared.

Report presented by: **Caroline Maley**
Trust Chair

Report prepared by: **Sue Turner**
Board Secretary

Derbyshire Healthcare
NHS Foundation Trust

DECLARATION OF INTERESTS REGISTER 2018/19		
NAME	**INTEREST DISCLOSED**	**TYPE**
Margaret Gildea Non-Executive Director	• Director, Organisation Change Solutions Limited • Non-Executive Director, Derwent Living	(a, b) (a)
Carolyn Green Director of Nursing & Patient Experience	• Husband employed by Derbyshire Probation Service	(d)
Gareth Harry Director of Director of Business Improvement & Transformation	• Chairman, Marehay Cricket Club • Member of the Labour Party	(d) (e)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd	(a)
Ifti Majid Chief Executive	• Board Member NHS Confederation Mental Health Network • Kate Majid (spouse) Chief Executive of the Shaw Mind Foundation which is a global mental health charity	(e) (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	(e) (e)
Dr Julia Tabreham Deputy Trust Chair and Non-Executive Director	• Non-Executive Director, Parliamentary and Health Service Ombudsman • Director of Research and Ambassador Carers Federation	(a) (d)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients.	(e)
Richard Wright Non-Executive Director	• Executive Director, Sheffield Chamber of Commerce • Chair Sheffield UTC Multi Academy Trust • Board Member, National Centre of Sport and Exercise Medicine Sheffield	(a) (a) (d)

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

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.
(e) Detail any connection with a voluntary or other organisation contracting for National Health Services, or hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or any other body which could be seen to influence decisions you take in your NHS role (see Conflict of Interest policy - loyalty interests).

Derbyshire Healthcare
NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

Held in Training Rooms 1 & 2
Research and Development Centre, Kingsway, Derby DE22 3LZ

Tuesday 5 March 2019

MEETING HELD IN PUBLIC

Commenced: 9.30 Closed: 12:20

PRESENT	Caroline Maley	Trust Chair
	Margaret Gildea	Senior Independent Director
	Geoff Lewins	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Director of Finance & Deputy Chief Executive
	Mark Powell	Chief Operating Officer
	Carolyn Green	Director of Nursing & Patient Experience
	Dr John Sykes	Medical Director
	Samantha Harrison	Director of Corporate Affairs
	Amanda Rawlings	Director of People Services & Organisational Effectiveness
	Gareth Harry	Director of Business Improvement & Transformation
	Suzanne Overton-Edwards	Non-Executive Director under NHSI NExT Director scheme
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary (minutes)
	Nicola Lewis	Senior Occupational Therapist
For item DCHFT2019/030	Kully Hans	Freedom to Speak Up Guardian
VISITORS	John Morrissey	Lead Governor and Public Governor, Amber Valley
	Lynda Langley	Public Governor, Chesterfield
	Jo Foster	Staff Governor, Nursing
	Tony Longbone	Staff Governor, Admin & Allied Support Staff
	Kelly Sims	Staff Governor, Admin & Allied Support Staff
	Sandra Austin	Derby City & South Derbyshire Mental Health Carer's Forum and Trust Volunteer
	Martyn Bell	Trust Member
APOLOGIES	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director

DHCFT 2019/019	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** The Trust Chair, Caroline Maley, welcomed all to the meeting. Nicola Lewis, Senior Occupational Therapist from Ward 1, London Road Community Hospital who had been invited to shadow the Chair at today's meeting was welcomed by the Board. Apologies for absence were noted from Deputy Trust Chair and Non-Executive Director, Julia Tabreham due to an extended leave of absence. The Declaration of Interests register, as included in the Board papers, was noted. Non-Executive Director, Geoff Lewins advised that his declaration as a Director at Woodhouse May Limited could be removed from the register. No additional declarations of interest in agenda items were raised. **ACTION: Geoff Lewins declaration as a Director at Woodhouse May Limited to be removed from the Declaration of Interests Register**
DHCFT 2019/020	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 5 FEBRUARY 2019** The minutes of the previous meeting, held on 5 February 2019, were accepted as a correct record of the meeting.
DHCFT 2018/021	**MATTERS ARISING – ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the actions matrix. All completed 'green' actions were scrutinised to ensure that they were fully complete and actions that were not complete were challenged with Executive Director leads.
DHCFT 2019/022	**QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC** No questions had been received from members of the public or governors in advance of the meeting.
DHCFT 2019/023	**CHAIR'S UPDATE** This report provided the Board with the Trust Chair's summary of activity undertaken since the previous Board meeting on 5 February 2019. Caroline reflected on the visits she had made to some of the Trust's front line services which provided her with a good understanding of the services that the organisation provides. A particular highlight was the visit to Ward 1 at the London Road Community Hospital where she joined Nicola Lewis and a number of patients undertaking a craft activity. She was pleased to hear their positive views on the ward, their care, and in particular their praise for the staff who work hard to look after them and help them recover. Caroline also referred to the training event she attended with the Council of Governors which focused on engaging with members and holding the Non-Executive Directors to account for the performance of the Board.

	RESOLVED: The Board of Directors noted the activities of the Trust Chair since the last meeting held on 5 February 2019
DHCFT 2019/024	**CHIEF EXECUTIVE'S UPDATE** This report provided the Board of Directors with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within our local Derbyshire health and social care community. The key findings relating to nursing shortages contained in the Health Foundation's third annual NHS workforce trends report and the impact this will have on the number of students enrolling in nursing degrees was referred to by Chief Executive, Ifti Majid. The Board was concerned that almost a quarter of students starting a nursing degree either did not graduate or failed to do and the impact this is having on the number of nursing applications being made within the NHS. Discussion took place on how to respond to the outlook of the younger workforce by adapting the structure of work and terms and conditions. The recommendations that have been accepted from the review of the Fit and Proper Persons Test (FPPT) by the Secretary of State were noted. The Trust has a FPPT policy that is comprehensive and already covers areas such as full employment history, references and social medial searches. Ifti assured the Board that the Trust's Remuneration and Appointments Committee would undertake a piece of work to understand the impact of these additional recommendations. The Derbyshire Health and Social Care system combined stocktake meeting with NHS Improvement and NHE England was held on 14 February. The purpose of the meeting was to understand the trajectory to contract sign off and planning submissions as well as to evaluate the expected journey towards becoming an integrated care system. It was noted that the challenges arising from the need to adopt different approaches to planning and develop better contracting models to increase income will be further discussed by the Finance and Performance Committee and the Executive Leadership Team. Ifti was pleased to report that the new leadership and management development offer called Leading Team Derbyshire Healthcare has now been rolled out. This initiative has been favourably received and levels of engagement through the session have been high. It would appear that managers have appreciated the tone and content of these sessions as well as having time to discuss and understand their expectations. **RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken.**
DHCFT 2019/025	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT** The Integrated Performance Report (IPR) provided the Board with an integrated overview of performance as at the end of January. The focus of the report is on workforce, finance, operational delivery and quality performance. The Trust continues to perform well against many of its key indicators with maintenance or improvements continuing across many of the Trust's services. Chief Operating Officer, Mark Powell, reported that good progress had been made to reduce agency spend but the challenge going forward will be to minimise these

	costs within the medical workforce. Sickness absence in January was higher than previous months due to winter illnesses. The cause and flow of sickness absence will be further looked at to see what seasonal effort needs to be put in place. The Board was assured that initiatives are in place to support managers to help staff return to the workplace as quickly as possible. . Discussion focused on waiting lists and how they could be reduced. The Board was pleased to see that work is being undertaken to seek best practice from other trusts to reduce waiting times and to understand how other trusts deliver their services and manage demand to establish what the best outcome will be for patients. Methods of how to be more efficient will be discussed in the Finance and Performance Committee. The increased number of patients being treated out of area was highlighted. It was understood that this was due to an increase in PICU (Psychiatric Intensive Care Unit) demand in February which is a service that the Trust is not commissioned to provide. Work is taking place with commissioners to develop a business case to assess the provision of PICU service and potentially to incorporate a PICU facility within the new Estates Strategy. Director of Finance and Deputy Chief Executive, Claire Wright reported on the Trust's financial position. The Trust is expecting to achieve its control total for 2018/19. The Board was informed that the gap between income and costs for next year is more significant than previous years. The work to close the gap for 2019/20 and achieve the CIP (Cost Improvement Programme) target will be discussed in detail at the Finance and Performance Committee on 19 March. Director of People and Organisational Effectiveness, Amanda Rawlings updated the Board on the investment that the Trust is making in Staff Health and Wellbeing. The Board was informed of plans to support and help staff to maintain good physical and mental wellness. We have seen an increase in staff reporting mental health related issues and we are establishing local access to support, Detail relating to this initiative will be taken to the next meeting of the People and Culture Committee. Amanda also referred to the new programme of Executive Director engagement which is planned to take place from April. This will involve every service team receiving an informal visit from an Executive Director over the next year The Board welcomed the charts and benchmarking data contained in the paper and understood that the IPR will be further improved to report on workforce and safer staffing. This will be developed by Carolyn Green, Mark Powell and Amanda Rawlings who are looking at best practice used at other trusts. This detail will also be discussed at the People and Culture Committee. **RESOLVED: The Board of Directors received the report and obtained limited assurance on current performance across the areas presented**
DHCFT 2019/026	**<u>WORKFORCE SAFETY STANDARDS</u>** In October 2019, NHS Improvement wrote to all trusts asking them to review their workforce safeguards and implement some formal recommendations. This report presented by Carolyn Green set out to assure the Board that the Trust is formally assessing its compliance. The report also contained a self-assessment of the workforce safeguards.

	The Board was informed that the People and Culture Committee will scrutinise and review all workforce information, systems and process of staff deployment, rostering and skill mix of our services. Carolyn Green assured the Board that specific plans are in place to measure the Trust's safety standards that will enable us to benchmark ourselves against other trusts. This work will be taken through the People and Culture Committee to ensure that critical work relating to Workforce Safety Standards is embedded within the Workforce Plan. The Board acknowledged that limited assurance could be obtained from key areas shown in the report. Gaps in assurance related to vacancies and the demand on the Trust's services. It was accepted that further improvement work will be undertaken to ensure reporting is enhanced through a revised reporting structure and the final submission of the Workforce Plan to ensure that the Trust has a stable workforce of suitably qualified and trained staff in all our areas. This would include additional checks on fill rates, Bank usage, mandatory training and ensuring all wider compliance checks are all in order. **RESOLVED: The Board of Directors:** **1) Reviewed the self-assessment and the briefing contained in the report.** **2) Received limited assurance of the compliance areas** **3) Accepted that further improvement work is required to produce a revised reporting structure and a final submission of a revised Workforce Plan.**
DHCFT 2019/027	**<u>QUALITY REPORT WELL-LED DOMAIN</u>** This paper presented by Sam Harrison provided the Trust Board with a focused report on well led (leadership) as part of the wider cycle of reporting relating to Care Quality Commission (CQC) domains. The report included an overview of work undertaken within the context of the well-led domain which supported our achievement in receiving an improved rating from the recent CQC report. This prompted strategic discussion about the approach being taken to staff engagement within the Trust. It was acknowledged that staff communication is serving to reiterate the expectation that staff keep up to date and participate in engagement and read corporate communications as a key element of their role within the Trust. It was understood that the principle of delivering team briefing is being highlighted and that feedback and questions on content are returned for reporting to the Executive Leadership Team which will enable us to identify whether further development or focus may be needed. The Board was assured that the principles of well-led are embedded within the day to day business of the organisation. Well-led will continue to be assessed by the CQC and will be reported to the Board on a regular basis. The Board concluded that the paper provided a comprehensive summary of the progress made within well-led domain and that it outlined the continuing work to enable the Trust to achieve a good CQC rating in future. It was noted that an external three year Well Led external independent review is due in 2021 and an internal Trust-wide review is due to be undertaken during 2019. **RESOLVED: The Board of Directors:** **1) Agreed that current priorities for management and leadership, culture and governance adequately address our aim to ensure the Trust is well led to meet its strategic objectives** **2) Received significant assurance on current oversight across the areas**

	presented **3) Agreed that the report would update the 2018/19 Board Assurance Framework and inform the development of the 2019/20 BAF where appropriate.**
DHCFT 2019/028	**STAFF SURVEY RESULTS** Amanda Rawlings' paper updated the Board on the NHS Staff Survey – NHS England results, which show our current position based on the 2018 all staff survey. The Board was pleased to note the improved participation and increase in positive feedback across all domains. The report provided a comparison against 30 other NHS trusts and showed that every one of our themes had either improved or stayed the same compared to the 2017 NHS Staff Survey. Efforts will be focused over the coming months on the four themes that scored below average; these were the quality of appraisals, quality of care, safety culture, and staff engagement. A particular priority will be areas around safety and encouraging people to feel confident in raising concerns. It was established that safety culture will take some time to improve and will be taken forward through the investigation of serious incidents. It was acknowledged that next steps would involve communicating the results of the staff survey to all staff, governors and other key stakeholders. Work is to start on finalising the triangulation of 2019 priorities into current work programmes. This will include further work and analysis on all protected characteristics. A final summary report containing detailed triangulation is to be made to the People and Culture Committee on 23 April 2019. **RESOLVED: The Board of Directors:** **1) Received and review the 2018 NHS Staff Survey – NHS England results** **3) Approved the priorities for 2019** **3) Received significant assurance from the report at this point based on:** • **the significant increase in the response rate** • **the fact that every one of the themes either improved (7) or stayed the same (2) compared to the 2017 NHS Staff Survey**
DHCFT 2019/029	**EQUALITY DELIVERY SYSTEM 2 UPDATE AND DRAFT GENDER PAY GAP REPORT** This paper presented by Amanda Rawlings included the annual Equality Delivery System 2 (EDS2) and incorporated an update for Universal Children Services following a recent focus on children's services. The mandatory annual Gender Pay Gap Report was also presented for approval. Both documents were presented at the Equalities Forum on 26 February 2019. The Board accepted that the Universal Children Services EDS2 positively demonstrated the Trust's commitment to continuous improvement in delivering an inclusive service and evidenced that the Trust has listened and acted on the recommendations of the community. It was noted that the next EDS2 equality assessment will look at forensic services. The Board acknowledged that the report on gender pay gap showed an improvement in the representation of females within the medical workforce but there are not enough females in senior management positions. It is expected that

	a significant piece of work associated with the Clinical Excellence Awards will be taken forward as part of further innovative work that can underpin the progress of our female workforce. **RESOLVED: The Board of Directors:** **1) Noted the EDS2 Children Services Year 1 Report 2018/19 - positive feedback and 'very good' grading by external stakeholders** **2) Noted the EDS2 implementation 2019/20 plan and revised workforce grading process** **3) Approved the Gender Pay Gap Report February 2019 prior to publishing on Trust website by 30 March 2019**
DHCFT 2019/030	**<u>FREEDOM TO SPEAK UP GUARDIAN REPORT</u>** Freedom to Speak Up Guardian (FTSUG) Kully Hans joined the meeting and presented the Board with her second six-monthly update report. The Board was pleased to note the increasing number of people who are coming forward to share their concerns and that key themes were being identified. As a result the Trust had learnt from these concerns and had made improvements from staff speaking up. Over the year 20 cases of bullying and harassment were referred to the FTSUG and a number of concerns were raised with regard to policies and procedures. The Board discussed the need for staff to raise concerns with their line managers wherever possible before taking their concerns to the FTSUG. It was agreed that further engagement would take place with staff to ensure that leaders and managers are the first point of contact for staff concerns as part of development of an open and learning culture. It was also established that the Executive Leadership Team is to be more sighted on the concerns raised by staff in order to understand trends. Work is also to take place on engaging managers so that concerns raised are discussed and reviewed at a divisional level and during performance review meetings. It was noted that any issues relating to safety of staff raised with the FTSUG are fed back to the Director of Nursing and Patient Experience. It was acknowledged that the report reflected the FTSU Guardian's (FTSUG) personal opinion of identified issues and areas for improvement. Formal thanks were extended to Kully Hans for the work she had undertaken within her role as FTSUG in ensuring that staff felt more confident in raising concerns. **RESOLVED: The Board of Directors:** **1) Noted this second report from the Freedom to Speak up Guardian** **2) Received assurance that the role is effective within the Trust, with a clear framework of policies, procedures and personal support to implement this work** **3) Noted the recommendations that the Trust is asked to consider.**
DHCFT 2019/031	**<u>FINAL REPORT ON RECOMMENDATIONS ARISING FROM THE DELOITTE PHASE 3 REPORT</u>** Director of Corporate Affairs, Sam Harrison presented a final report on progress with agreed actions to address recommendations arising from the Phase 3 Deloitte review of the Trust's governance arrangements.

	The Board reviewed the progress made to implement the actions arising from the Deloitte phase 3 review of governance arrangements (which completed the NHSI well-led review), as assigned to Board Committees. Robust overview and scrutiny was outlined to ensure progress and embeddedness in business as usual of the Trust. The Board acknowledged the significant progress made by the Trust and confirmed full completion of all recommendations. **RESOLVED: The Board of Directors:** **1) Noted and agreed the update presented to the Board in respect of progress with implementation of the outstanding three actions to meet the Deloitte recommendations/address comments, confirming assurance that these are embedded in business as usual of the Trust** **2) Following the process used by Committees, the Board confirmed the ongoing embeddedness and sustained implementation of actions as highlighted in Recommendation 1, which has direct Board oversight** **3) Agreed that this is the final report closing all actions required on the recommendations/comments raised in the Deloitte Phase 3 governance review (February 2018).**
DHCFT 2019/032	**<u>FLU SELF-ASSESSMENT REPORT</u>** Amanda Rawlings' report updated the Board on the current position and next steps in regards to the 2018 Flu Campaign. The Board noted the status of the current campaign, which is based on local lessons learnt and national best practice guidelines. The flu vaccination rate was confirmed as 51% which is the Trust's highest rate to date. The Board was concerned that this figure is significantly lower than the national target of 75% and agreed that further work will take place to understand the reasons why colleagues do not see the value of the vaccination and are choosing not to be vaccinated, particularly in light of the disruption caused to some services this year through high levels of sickness absence. Work is also being undertaken to establish how other trusts have increased their uptake. **RESOLVED: The Board of Directors received limited assurance on the progress of the flu campaign to date.**
DHCFT 2019/033	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS</u>** Assurance summaries were received from the Board Committees and highlights were provided by the respective Non-Executive Chair. **Safeguarding Committee 7 February:** Committee Chair, Anne Wright was pleased to report that as a result of escalating the lack of a community forensic team through the Quality Committee and the Board a community forensics team has now been established. The removal of a commissioning gap in community forensic service could now be removed from BAF Risk 1a *Safety and Quality Standards*. The Board noted the discussions held by the Committee as to whether the Safeguarding Committee will remain as a Board level Committee and agreed that this will be taken forward through the Trust's governance processes. **Quality Committee 12 February:** In the absence of the Committee Chair, Margaret Gildea had chaired the meeting. A deep dive took place on BAF Risk 1d *CPA Approach* that concluded that CPA compliance has now been achieved. The

	Committee reviewed the Trust's quality priorities and strategic objectives and agreed that revisions to the quality priorities would be referred to the Executive Leadership Team. **People & Culture Committee 19 February:** Committee Chair, Margaret Gildea reported that the level of discussion that takes place within the Committee has become much more strategic. The Staff Story heard at the meeting emphasised the real issues that take place in investigations relating to allegations of bullying and harassment. The Committee agreed to downgrade BAF Risk 2a *Staff Engagement* from high to moderate. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries**
DHCFT 2019/034	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** No additional issues were raised in the meeting for updating and including in the Board Assurance Framework. Details from the Well-Led report would however be used to confirm assurances and controls were fully captured in the BAF.
DHCFT 2019/035	**DRAFT 2019/20 BOARD FORWARD PLAN** The draft 2019/20 forward plan was noted by the Board and would be further reviewed by the Executive Leadership Team.
DHCFT 2019/036	**MEETING EFFECTIVENESS** Attendees and visitors were thanked for their attendance at today's meeting. The Board considered that effective discussion had taken place particularly when the IPR and workforce issues were reviewed. Nicola Lewis enjoyed observing the how discussions were held and was pleased to see that the experience of staff on the wards is escalated to this level. She would feed back her team that the Board is listening to staff concerns.
The next meeting of the Board to be held in public session will take place at 9.30 on Tuesday 2 April 2019 in Conference Rooms A&B, Research and Development Centre, Kingsway, Derby DE22 3LZ.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - APRIL 2019			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
4.12.2018	DHCFT 2018/168	Report from Quality Committee on Recommendations arising from the NHS Resolution Report on Learning From Suicide Related Claims	Carolyn Green	Quality Committee to monitor the implementation of NHS Resolution Recommendations	2.4.2019	This will be monitored via a detailed report to be received by the Quality Committee on 12 March following the previous report that went to Quality Committee in November and Board in December. Quality Committee on 12 March approved the NHS Resolution Recommendations action plan. This will be devolved through the Trust Management Team and appropriate Executive Director through our governance / clinical engagement structure as necessary	Green
5.2.2019	DHCFT 2019/009	Safe Staffing and Strategic Workforce Challenges	Amanda Rawlings	Amanda Rawlings to lead a Board Development session to explore wider workforce issues.	~~2.4.2019~~ 7.5.2019	This session will feature in the Board Development Programme for 2019/20 has been prepared and has been provided to the Trust Chair for consideration	Amber
5.2.2019	DHCFT 2019/013	Section 37/41 Briefing	John Sykes	Mental Health Act Committee to provide assurance on approach being taken to Section 37/41	2.4.2019	S37/41 Review held at the Mental Health Act Committee on 8 March concluded that a multi-agency panel is reviewing all S37/41 cases in the light of the recent Supreme Court judgement. This has replaced the planned audit of cases - detail included in the MHAC Assurance Summary submitted to the April meeting	Green
5.3.2019	DHCFT 2019/019	Declartation of Interests	Sue Turner	Geoff Lewins declaration as a Director at Woodhouse May Limited to be removed from the Declaration of Interests Register	2.4.2019	Declaration of Interests Register had been updated	Green

Resolved	**GREEN**	**3**	**75%**
Action Ongoing/Update Required	**AMBER**	**2**	**25%**
Action Overdue	**RED**	**0**	**0%**
Agenda item for future meeting	**YELLOW**	**1**	**0%**
		6	**100%**

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 2 April 2019

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 5 March 2019. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. I continue to make a point of visiting as many front line services as possible, so that my leadership is grounded on the reality of what our staff face every day, and also to ensure that I have a good understanding of the services provided by the Trust.

2. On 6 March I visited the Eating Disorders team based at Unity Mill in Belper. I was able to attend both a clinical meeting and a team meeting. It was useful to hear about some of the challenges the team experiences with interface between community mental health services and eating disorders services, where there may be dual diagnosis. It reinforces how important it is that communication is good and the patient's best interests need to be at the centre of decision making. Once again it was apparent that recruitment into specialist consultant roles is difficult. I am delighted that Gail Tivey is here today as my shadow from that team meeting.

3. Next month I am visiting the Crisis Team North; People Services in the Research and Development Centre; TMAC (Trust Medical Advisory Committee) and attend an induction day for new medical students.

Council of Governors

4. On 26 February, we hosted and I chaired a NHS Providers regional governor workshop. I was pleased with the level of attendance from trusts all around the midlands region, and was particularly pleased with the engagement by our governors who attended. Lead Governor, John Morrissey and I gave a brief presentation on how the relationship between the Board and the Council of Governors had been changed and what we saw as the elements of success.

5. Elections for the Council of Governors closed on 18 March with 434 votes cast for 6 vacancies with overall turnout of 16%. Induction for new governors (and returning governors) will take place on 26 March 2019.

6. Council of Governors met on 5 March after the Public Board meeting in the morning. Once again I was pleased at the attendance at the Board meeting in the morning and the full Council of Governors in the afternoon. At this meeting the Council agreed the Quality Indicators for inclusion in the Annual Quality Report. Chief Executive, Ifti Majid, also gave an overview of the NHS Long Term Plan. Governors also received the staff survey results which had just been released.

7. On 12 March with Gillian Hough who has stepped down as governor for Derby City East. Gillian was Chair of the Governance Committee for a substantial part of her term as a governor and I thanked her for the work that she did for the Trust, including attending many engagement events. Carole Riley was not re-elected as a governor in the recent elections for Derby City East, and I have thanked her for all the work that she too has done for the Trust, as Deputy Lead Governor, and also as Interim Chair of the Governance Committee.

8. I chaired the Nomination and Remuneration Committee of the Council on 13 March. The main business of the Committee was to receive the outcome of the appraisals of the NEDs, which will be formally reported to the Council on 7 May.

9. The next meeting of the Council of Governors will be on 7 May after the public Board meeting. The next Governance Committee takes place on 9 April.

Board of Directors

10. Board Development on 20 March included an excellent session, focussing on simulation training of seclusion with active participation by Board members. This brought to life the experience from both a patient and staff perspective of seclusion and how important it is that staff are able to manage the risk whilst also taking a patient centred approach. The afternoon session looked at our inclusive leadership and we were joined by members of staff from various networks across the Trust to help us explore what leadership and inclusivity means. It has been beneficial to spend this time with quality conversations and reflection.

11. The Remuneration and Appointments Committee met on 20 March. The main business of the Committee included a review of Succession Planning and consideration of the impact of changes to pension taxation introduced in 2014 and 2016. The Committee noted the position with regard to Executive Directors and wider staff who were being adversely impacted by the changes to the pension taxation rules, and noted that this is a national issue. As such, there is no direct action we can take as a Trust to mitigate these impacts, but we are actively engaged with the national debate that is taking place. As a Committee it was decided to escalate to the Board Assurance Framework as a gap in assurance the risk that arises from these changes on the retention of a number of senior staff and consultants. Other matters considered by the Committee included the annual review of the composition of the Board and year end Committee processes such as review of mandatory training, a consideration of the Board Development Programme for the next year and the annual year end effectiveness of the Committee report.

12. On 25 February I joined the recruitment panel for the appointment of a new Trust Secretary. I am pleased to welcome Justine FitzJohn to the Trust and thank her for being flexible in terms of supporting us prior to her official start date in June. I give my thanks once again to Sam Harrison for everything that she did for the Trust over her three year tenure, and also for her support on the transition over the next few months.

13. I have met with Richard Wright as part of my routine quarterly meetings with Non-Executive Directors (NEDs). During these meetings we review performances against objectives set at the beginning of the appointment / review cycle, as well as discuss generally mutual views on the progress of the NED and the Trust and any personal development requirements.

14. I am pleased to welcome Julia Tabreham back to the Board following a period of absence. Julia will be returning on a planned phased return to work, and I am sure will be pleased to give us some good reflection on the work that has taken place during her period of absence. I am pleased with the support and input we have had from Suzanne Overton-Edwards, our NExT Director placement with us until June 2019. I have met with Julia and Suzanne since the last Board meeting.

15. On 27 March, the Chief Executive, Chair of Audit and Risk Committee, Chair of Finance and Performance Committee, the Director of Finance and I met with the Deputy Director of Finance, to scrutinise the Trust 2019/20 Operational Plan ahead of submission to NHS Improvement. I am pleased to confirm that, with delegated authority on behalf of the Board, we were able to sign off the plan. The full set of declarations made can be found in the appendix to my report.

The effort and commitment of the Contracting and Finance teams, along with all other contributing members, should not be underestimated in enabling us to sign our 2019/20 contracts and Operational Plan, so thank you on behalf of the Board.

System Collaboration

1. I attended the JUCD (Joined Up Care Derbyshire) Board on 21 March. It was apparent that the focus was more on collaboration than I reported in my last report, and we received some useful inputs to stimulate strategic debate. There is still a financial challenge in the system finances to be resolved for 2019/20 but progress has been made in terms of the way to tackle this collectively. This will be covered in more detail in the CEO report.

Regulators; NHS Providers and NHS Confederation and others

2. In this month I have attended along with Ifti Majid the NHS Confederation Mental health Conference, and the NHS Provider Chiefs and Chairs meeting. I

was particularly pleased to see the recognition given to Ifti Majid as a member of the Mental Health Board. Ifti did a great job at bringing Brexit to life for those at the Conference. The morning session at the conference on how to achieve a diverse organisational board was thought provoking. Brexit continues to dominate these meetings, with planning for a no deal Brexit at the forefront of minds.

Beyond our Boundaries

3. I am taking part in the assessment panels for the Regional Talent Board (Aspire Together). The vision of Aspire Together is to move talent management from individual organisations to a place where it is owned and valued by the whole system. The first of the assessment days that I took part in was held on 3 December in Leicester. This is a pilot scheme being carried out in the Midlands and East and Dido Harding (Chair of NHSI) has an appetite to move faster with the pilot to identify more potential directors for a national talent pool.

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

There are no adverse effects on people with protected characteristics (REGARDS).	x

There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work.

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

Demonstrating inclusive leadership at Board level

Through the Trust's involvement in the NeXT Director scheme, hosting a placement for Suzanne Overton-Edwards, we are supporting the development of those who may find it more difficult to be appointed as a NED in the NHS. We will also consider this as we look at succession planning for NEDs and Executives in the future.

Recommendations

The Board of Directors is requested to consider the content of this report, and to ask for any clarification or further information.

Report prepared and presented by: **Caroline Maley**
Trust Chair

Appendix 1

Self-Certification declarations in the 2019/20 Operational Plan

Finance Template

Self-Certification

The board is required to complete the following self-certification declarations:

1. **Declaration of review of submitted data**
   "The board is satisfied that adequate governance measures are in place to ensure the accuracy of data entered in this planning template.
   We would expect that the template's validation checks are reviewed by senior management to ensure that there are no errors arising prior to submission and that any relevant flags within the template are adequately explained."
   (Confirmed)

2. **2019/20 control total and PSF,FRF and MRET funding**
   The Board has accepted its control total and has submitted this operational plan for 2019/20 that meets or exceeds the required financial control total for 2019/20 and the Board agrees to the conditions associated with the provider sustainability fund (PSF), financial recovery fund (FRF) and marginal rate emergency tariff (MRET) funding.
   (Confirmed – control total accepted: PSF, FRF and MRET funding incorporated in plan)

3. **2019/20 Capital Delegation Limit**

   "All NHS Trusts have a capital delegated limit of £15m. Foundation Trusts that fulfil any of the distressed financing criteria in rows 25-27 will have a capital delegated limit of £15m. As set out in the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, providers with delegated capital limits require business case approval from NHS Improvement.

   Foundation Trusts that do not fulfil any of the distressed financing criteria are subject to the reporting and review thresholds as per the “Transactions guidance – for trusts undertaking transactions, including mergers and acquisitions (November 2017)” and the Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts."

   Are you in Financial Special Measures? *(Not in Financial Special Measures)*
   If you are an FT, are you in breach of your licence? Or are you an NHS Trust? *(Not in breach of Foundation Trust licence)*

   Have you received distressed financing or are you anticipating receiving this in either of the planning years? (*Not in receipt of distressed financing)*

   Delegated capital limit (£000) – ‘existing reporting and review thresholds apply’

   Adjusted delegated capital limit (£000) ‘N/A’

The Board agrees to the delegated limit for capital expenditure and business case approvals in line with the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts.
(Confirmed)

In signing, the board is confirming that:

To the best of its knowledge, using its own processes, the financial projections and other supporting material included in the completed Provider Financial Monitoring System (PFMS) Template are internally consistent with the operational and, where relevant, strategic commentaries, and are based on assumptions which the board believes to be credible. This operating plan submission will be used to measure financial performance in 2019/20 and will be included in the calculation of the finance and use of resources metrics assessed under the Single Oversight Framework in 2019/20.

Workforce template

Declaration to be signed by the Director of Finance:

“The Board is satisfied that adequate governance measures are in place to ensure the accuracy of data entered in this planning template.

We would expect that the template's validation checks are reviewed by senior management to ensure that there are no errors arising prior to submission and that any relevant flags with the template are adequately explained.”
(Confirmed)

Triangulation template

This template requires sign off by the Director of Finance:

"The Director of Finance is satisfied that adequate governance measures are in place to ensure the accuracy of data linked in this triangulation tool, and specifically that the data within this return is consistent with the most recent submissions for finance, activity and workforce Operational Planning forms submitted to NHS Improvement.

The Director of Finance confirms that, to the best of their knowledge, the financial, activity and workforce projections in the completed triangulation tool are consistent with the most recent version of those forms submitted by the organisation to NHS Improvement as part of their Operational Planning submission for 2019/20, and where differences between these projections are highlighted in this triangulation model the reasons for those differences are fully understood and have been adequately explained by use of the appropriate commentary input fields."

Chief Executive's Report to the Public Board of Directors

Purpose of Report:

This report provides the Board of Directors with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within our local Derbyshire health and social care community. The report also updates the Board on feedback from external stakeholders such as our commissioners and feedback from our staff. The report should be used to support strategic discussion on the delivery of the Trust strategy. The Board should note that the report reflects a wider view of the Trust's operating environment and serves to horizon scan for risks that may affect the organisation. Risks identified are highlighted in the report and taken forward to assess their operational and strategic impact and recorded on operational risk registers or the Board Assurance Framework as appropriate.

National Context

1. NHS Providers have published their review of the mental health sector called *'Addressing the Care Deficit'*. Some of the key findings of the report include:

    - Despite the progress following increased focus on the NHS Five Year Forward View and latterly the Long Term Plan, the survey of frontline mental health trust leader's shows there is a substantial care deficit in mental health that must be addressed. There is significant unmet need for a number of mental health conditions – particularly community services for adults and children, gender identity services and crisis home treatment teams – the report says that NHS commissioning decisions have resulted in services being cut or reduced. The survey indicated that 69% of mental health leaders are worried about maintaining the quality of services over the next two years.
    - Demand for services is outstripping supply and socio-economic factors are contributing to this. 92% of trusts said that changes to universal credit and benefits are increasing demand for services, as are loneliness, homelessness and wider deprivation. Mental health leaders pointed to rising demand during winter but it is clear that these pressures on services are a year-round phenomenon.
    - To overcome the demand challenge facing mental health services and derive full value out of any investment, national policy must focus on increased support for both mental health and public health.
    - As our Board is aware action on workforce is a top priority. The report says a national plan, with appropriate focus on the mental health workforce, must be published as soon as possible, coupled with adequate funding from the comprehensive spending review that meets the plan's education and training budgetary requirements.
    - Pressures on the workforce are twofold. Only 9% of trusts said they currently have the right staff in the right place and nearly two thirds of leaders are very concerned about the numbers and skills of staff in two years' time.

- In terms of financial investment, there are three important issues:
    - First, although additional money is welcome, the funding for mental health will only rise as a share of the NHS budget 0.5%.
    - Second, despite the mental health investment standard, trust leaders said that additional funding does not reach the frontline. Greater transparency and controls over the allocations are welcome steps but must be tightly monitored and enforced.
    - Third, the moves to new payment systems will help substantially as block contracts are inflexible and do not reflect changes in demand once they have been agreed.
- While the focus in the Five Year Forward View for mental health on a number of priorities has delivered progress in, for example in our Trust we have seen developments in eating disorders services and perinatal mental healthcare, we must ensure that this does not come at the expense of investment in core community services.
- The rapid move to system working has changed the mental health landscape. Trusts have mixed views on the impact of integrated care systems (ICSs) and sustainability and transformation partnerships (STPs) on their role, but the roll out of new care models in mental health is reported as a positive step which will help both overcome the fragmentation of commissioning and service provision in mental health and also drive greater value from the investment in services.

As we move from high level plan to implementation, the survey suggests there are a number of priorities and challenges that both mental health trusts and the national bodies will need to consider. They include:

- Mental health trusts, with the support of the national bodies, will continue to focus on reducing the number of patients receiving care out of area and address inpatient capacity problems, although national bodies need to recognise the sustained demand here
- Many providers are in need of capital investment so that urgent improvements can be made to estates
- Mental health trusts need the national bodies to continue to promote careers in mental health and retain the current financial incentives to recruit mental health professionals.
- Mental health trusts will be working hard to continue the progress already made on data collection and data quality to give a better understanding of mental health activity, access and outcomes that can then enable better commissioning.

2. NHS England has now published the response to the twelve week consultation which ran from August to October 2018 on the proposed contracting arrangements for Integrated Care Provider (ICPs). The ICP Contract was developed to give one lead provider responsibility for the integration of services for a population, allowing for the first time a contract designed specifically to enable integration of primary medical services with other health and care services, and creating greater flexibility to achieve integration of care.

   Following the consultation, the intention is that the ICP Contract will be made available for use by commissioners in a controlled and incremental way, conditional

on successful completion of NHS England and NHS Improvement assurance through the Integrated Support and Assurance Process (ISAP). Neither use of the ICP contract nor adoption of lead provider models for integration will be mandatory: they will be options for local commissioners and their providers to consider.

A wide range of stakeholders and members of the public gave feedback to the consultation.

3. Professor Stephen Powes, NHS National Medical Director has published his interim report setting out proposals to update several of the current performance standards in the NHS constitution. The review proposes a number of changes to existing standards and new standards for mental health, cancer, physical urgent and emergency services and elective care.

   With respect to mental health standards his review supports the mental health expectations in the long term plan and includes recommendations around:

   - Expert assessment within hours for emergency referrals; and within 24 hours urgent referrals to community mental health crisis services. (more testing is needed to understand what 'hours' for emergency assessment may mean)
   - Access within one hour of referral to liaison psychiatry services for adults and children and young people
   - Four week waiting times for routine referrals to adult, older adult and children and young people's specialist mental health services.

   Work is already under way in some areas to test the 4 week routine standard.

   Also of interest are the proposals to modernise the four hour wait target in A&E departments that has been in place since 2004. Concerns through the review have developed about the current standard not measuring the whole wait nor differentiating between severity and complexity of conditions. The review is recommending standards around time to initial assessment, time to emergency treatment, total time in emergency departments and utilisation of same day emergency care in community are tested.

Local Context

4. The Joined up Care Derbyshire (JUCD) Board met on 21 March 2019. Key issues discussed included:

   - NHSE have confirmed following a review of all EU exit plans from the Derbyshire system that as a system we are noted as 'assured'
   - Chief executives and local authority leads held a time out session during March in which all system leaders committed to a different approach to the development of a single plan including agreement to work on a shared savings plan and monitoring process, joint objectives associated with the STP Plan refresh and importantly behaviours supported with increased transparency and openness. This commitment has been captured in a letter to all senior leaders in all organisations.
   - Work is ongoing to agree contracts and starting positions within the System for 2019/20 however the position for this year has further deteriorated with a combined system position of deterioration of £13.7m

- Receiving an exciting presentation about the future of our local University Technical College in Derby/Derbyshire and how this could provide an opportunity through partnership working to start to shape our future workforce with different skills. JUCD Board members were particularly taken with the opportunities around the development of our wellbeing offer.
- Approving the process and timescales over the summer that will get us to a refreshed sustainability and transformation plan for Derbyshire by September 2019 in line with the national timescales. I was struck by and welcomed the shift away from focussing on illness to focussing on wellness and from patients to people as well as a commitment from all members to be involved in engaging our local communities in the refresh from the very start.

5. The Mental Health System Delivery Board met on 21 March 2019 receiving feedback about some of the improvements made around the 4 work streams with notable progress being made relating to the planning of the development of wellbeing hubs based on the Tameside and Glossop model, research around the effectiveness of Derbyshire's memory Assessment Service and development, agreement of the dementia 'day hospital equivalent' model and repatriation of local residents with mental health rehabilitation needs back to Derbyshire.

   Moving forward the group agreed there was a need to refocus the work streams to more clearly describe the programme of work they were to undertake for example the group focused on responsive communities would be focussing on reducing hospital admissions during the coming year. The group also noted the benefit of having dedicated resource in terms of delivering tangible outcomes for example in the Dementia/Delirium work stream where significant progress has been made. This was fed up to JUCB as part of the annual report and remains a key risk on the JUCD risk register.

   Finally the group reviewed proposed mental health investment standard areas, in particular sense checking that along with mandated areas of investment and full year effect of last year's investments, as a system we were focussing on the right areas. The group with representatives from all community based organisations including primary care were able to confirm their support.

Within our Trust

6. The Board is aware that the Trust has a strong track record with respect to data security assessments via the Information Governance Toolkit. The Data Protection & Security (DS&P) Toolkit has been completed and was submitted three weeks ahead of schedule this year. The completed toolkit, a culmination of twelve months' work by the DS&P team enables the Trust to evidence actions against the National Data Guardian's ten data security standards. The requirement of the toolkit also supports key requirements under the General Data Protection Regulation (GDPR). The DSP toolkit has changed in format from previous years, requiring compliance with assertions and (mandatory) evidence items. This change means that it has not been possible to draw a direct comparison between this Trust and other mental health Trusts across the UK. However, in 2017/18, the Trust achieved a toolkit score of 98% completed, which gave the Trust the highest score of any mental health trust in the UK. This year, the Trust has increased its completed score from 98% to 100%. Thanks to the DSP team and all staff across the Trust who have helped us achieve this impressive result.

   With Sam Harrison, Director of Corporate Affairs', departure from the trust on 31 March 2018, the role of SIRO (Senior Information Risk Owner) will be taken

forward by Director of Finance and Deputy Chief Executive, Claire Wright who will continue to work alongside Medical Director, John Sykes, Caldicott Guardian, to maintain our strong data security and protection performance.

7. We have seen an increase in media coverage over recent months, particularly in sharing positive news about the Trust, our services and developments.

   In February our communications team worked with First News, the national children's newspaper, to mark Children's Mental Health week. This resulted in a full page article featuring CAMHS (Child and Adolescent Mental Health Services) lead, Scott Lunn, exploring how children look after their bodies and minds and how this affects overall wellbeing. We also received press coverage of Consultant Psychiatrist, Dr Allan Johnston's prestigious new national appointment to advise on mental health to the UK's professional football managers and coaches, and for his role helping British athletes in the run-up to the 2020 Olympics.

   We are working closely with the Derby Telegraph to tackle stigma regarding mental health diagnoses and services, with a particular focus on the Radbourne Unit. We look forward to further developing these relationships to showcase the work of our acute colleagues and to raise wider awareness of mental health care and the ways we support people locally.

   We continue to actively post news and features on Facebook (aimed at staff and the public through the two separate accounts) and Twitter (as part of our wider stakeholder engagement). Our posts on Twitter during February earned more than 40,000 impressions, an increase of 10,000 up on January, while seven of our Facebook posts reached more than 1,500 people.

8. Since our last Board meeting, the clinically-led strategy development work has continued to consider the Working Age Adults pathway and services. Given the size of the service, this was planned over four days and clinicians from across community, crisis, liaison, inpatient and psychology services were represented alongside patient and carer representatives.

   The sessions have brought up over 200 small and big ideas from participants on the days, but also from wider engagement with teams in the weeks between sessions. Nearly 100 ideas have been scoped into outline project plans across the four days. These range from big ideas, such as Crisis Teams acting as the discharging clinicians from inpatient areas, rapid expansion of nurse-led outpatient clinics, central booking systems for clinical rooms and advisory links with GP Practices to small ideas that could make a big difference – a carer noted that it made a massive difference to her and her relative's experience and optimism for the future when staff were friendly and smiled.

   A further session is planned for 28 March to bring together the products of the four working age adults days into a single, cohesive strategy and improvement plan for the whole pathway. We will continue to keep the Board updated on progress on the other pathways in the coming weeks and months.

9. It's great to get feedback from stakeholders outside of our Trust about initiatives we have carried out. During March our Crisis Team in the High Peak attended a QUEST Training session with High Peak GPs at Thornbrook Surgery and created a presentation based on common frustrations GPs have had with our service including areas such as referral, information needed, and responsibility for patient safety and so on. This open dialogue has resulted in local GPs writing in with some really positive comments about the session and the team – great use of initiative and I was

particularly pleased that the senior nurse noted to me that the approach drew on the Leading Team Derbyshire Healthcare sessions I have spoken to Board previously about.

10. During March engagement visits have continued. I have held *Ifti on the Road* engagement events at Ilkeston Resource Centre and St Andrew's House as well as attending the IAPT (Improving Access to Psychological Therapies) administration meeting.

    Key themes that emerged from these sessions included:

    - The need to build on our initial work around veterans mental health with progress on e-learning slow
    - Do we need to consider investing again in a lead post to take veterans work forward
    - The lack of profile that colleagues who work in IAPT feel the service has within the Trust
    - The real benefit of employment advisors in mainstream mental health services
    - Lack of availability of rooms for clinical activity and the practice of trusts cross charging for use of rooms
    - Significant pressures remain with increased referrals to services

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

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

Tackling the care deficit specifically looks at and comments key drivers that could have an impact on inclusion and equality such as our workforce availability make up.

It is positive to read about plans to review access times in mental health services and it would be great through the testing process to be able to evidence how differing application of standards could be used to enhance access from all communities.

To tackle some of these risks requires targeted action and our new leadership and management programme discussed within the paper provides that direct action as does the consideration of access through our local communities within our clinical strategy work.

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

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

Recommendations

The Board of Directors is requested to:

1) Scrutinise the report, noting the risks and actions being taken
2) Seek further assurance around any key issues raised.

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 April 2019

Integrated Performance Report Month 11

Purpose of Report

This paper provides Trust Board with an integrated overview of performance at the end of February 2019. The focus of the report is on workforce, finance, operational delivery and quality performance.

Executive Summary

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

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

1. Regulatory Compliance dashboard:

    - Out of area placements
    - Sickness absence
    - Annual appraisals
    - Compulsory training

2. Strategy Performance dashboard:

    - Cost improvement programme
    - CPA reviews
    - Delayed transfers of care
    - Neighbourhood waiting lists
    - CAMHS waiting list
    - Paediatric referral to treatment
    - Health Visitor caseloads

In addition, a benchmarking section has been added to the end of this report to provide the Board with a contextual view of how the Trust is performing in comparison with other Trusts and to help support a strategic and operational discussion. The following measures/indicators have been included;

- Written complaints
- Psychological Therapies: reports on the use of Improving Access to Psychological Therapy (IAPT) services
- Inappropriate out of area placements

Strategic Considerations

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

Assurances

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

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

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

Recommendations

The Board of Directors is requested to:

1) Confirm the level of assurance obtained on current performance across the areas presented.
2) Determine whether further assurance is required and if so, at which Committee this needs to be provided and by whom.

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

1. Regulatory Dashboard

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ
Finance	Finance Score	Finance Scorecard	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Capital Service Cover	YTD	2	2	G	→		
			Forecast	2	2	G	→		
		Liquidity	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure Margin	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure variance to plan	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Agency variance to ceiling	YTD	1	1	G	→		
			Forecast	1	1	G	→		
	Single Oversight Framework	Agency costs as % of total pay costs	YTD	2.91%	2.81%	G	→		
			Forecast	2.87%	2.79%	G	→		
		NHS I Segment	YTD		2		→		
Quality and Operations	KPIs	CPA 7 Day Follow-up (M)	Feb, 2019	95.00%	100.00%	G	↑		
			Jan, 2019		98.55%	G			
		Data Quality Maturity Index (DQMI) - MHSDS Data Score (Q)	Feb, 2019	95.00%	96.28%	G	→		
			Jan, 2019		96.24%	G			
		IAPT RTT within 18 weeks (Q)	Feb, 2019	95.00%	100.00%	G	→		
			Jan, 2019		100.00%	G			
		IAPT RTT within 6 weeks (Q)	Feb, 2019	75.00%	98.40%	G	↑		
			Jan, 2019		97.26%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Feb, 2019	53.00%	93.33%	G	↑		
			Jan, 2019		74.07%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Feb, 2019	53.00%	100.00%	G	↑		
			Jan, 2019		80.00%	G			
		Patients Open to Trust In Employment (M)	Feb, 2019		10.02%	G	→		
			Jan, 2019		10.27%	G			
		Patients Open to Trust In Settled Accommodation (M)	Feb, 2019		57.67%	G	→		
			Jan, 2019		58.50%	G			
		Under 16 Admissions To Adult Inpatient Facilities (M)	Feb, 2019	0	0	G	→		
			Jan, 2019		0	G			
		IAPT People Completing Treatment Who Move To Recovery (Q)	Feb, 2019	50.00%	57.05%	G	↑		
			Jan, 2019		50.95%	G			
		Physical Health - Cardio-Metabolic - Inpatient (Q)							
		Physical Health - Cardio-Metabolic - EI (Q)							
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)							
		Out of Area - Number of Patients Non PICU (M)	Feb, 2019		19		↓		
			Jan, 2019		20				
		Out of Area - Number of Patients PICU (M)	Feb, 2019		23		→		
			Jan, 2019		23				
		Out of Area - Average Per Day Non PICU (M)	Feb, 2019		7.3		↑		
			Jan, 2019		6.7				
		Out of Area - Average Per Day PICU (M)	Feb, 2019		12.0		↑		
			Jan, 2019		11.8				
		Written complaints – rate (Q)	Q32018/19		0.03		→		
			Q22018/19		0.03				
		Staff Friends and Family Test % recommended – care (Q)	Q3 2018/19	81%	61%	R	↓		
			Q22018/19		73%	R			
		Occurrence of any Never Event (M)	Feb, 2019	0	0	G	→		
			Jan, 2019		0	G			
		Patient Safety Alerts not completed by deadline (M)	Feb, 2019		2		↑		
			Jan, 2019		0				
		CQC community mental health survey (A)	1905		6.9/10		↑		
			2017		7.3/10				
		Mental health scores from Friends and Family Test – % positive (M)	Feb, 2019	81%	95%	G	↓		
			Jan, 2019		96%	G			
		Potential under-reporting of patient safety incidents per 1000 bed days(M)	Oct17-Mar18		36.10	G	→		
			Jan-00		0.00	G			
Workforce and Engagement	KPIs	Turnover (annual)	Feb, 2019	10.00%	10.11%	G	↓		
			Jan, 2019		10.25%	G			
		Sickness Absence (monthly)	Feb, 2019	5.00%	6.73%	R	↓		
			Jan, 2019		7.53%	R			
		Sickness Absence (annual)	Feb, 2019	5.00%	5.74%	R	↑		
			Jan, 2019		5.68%	R			
		Vacancies (funded fte)	Feb, 2019		9.30%		↑		
			Jan, 2019		9.16%				
		Appraisals All Staff (number of employees who have received an appraisal in the previous 12 months)	Feb, 2019	90.00%	75.52%	R	↑		
			Jan, 2019		75.48%	R			
		Medical Appraisals (number of medical employees who have received an appraisal in the previous 12 months)	Feb, 2019	90.00%	90.00%	G	↓		
			Jan, 2019		95.00%	G			
		Compulsory Training (staff in-date)	Feb, 2019	90.00%	84.32%	A	↑		
			Jan, 2019		83.88%	A			
		NHS Staff Survey (A)	Work		60.92%				
			Treatment		72.77%				

Key:

Period Current Month / Previous Month

Achieving target / Not achieving target / Within tolerance / No Target Set

Target

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

1.1 Finance position

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

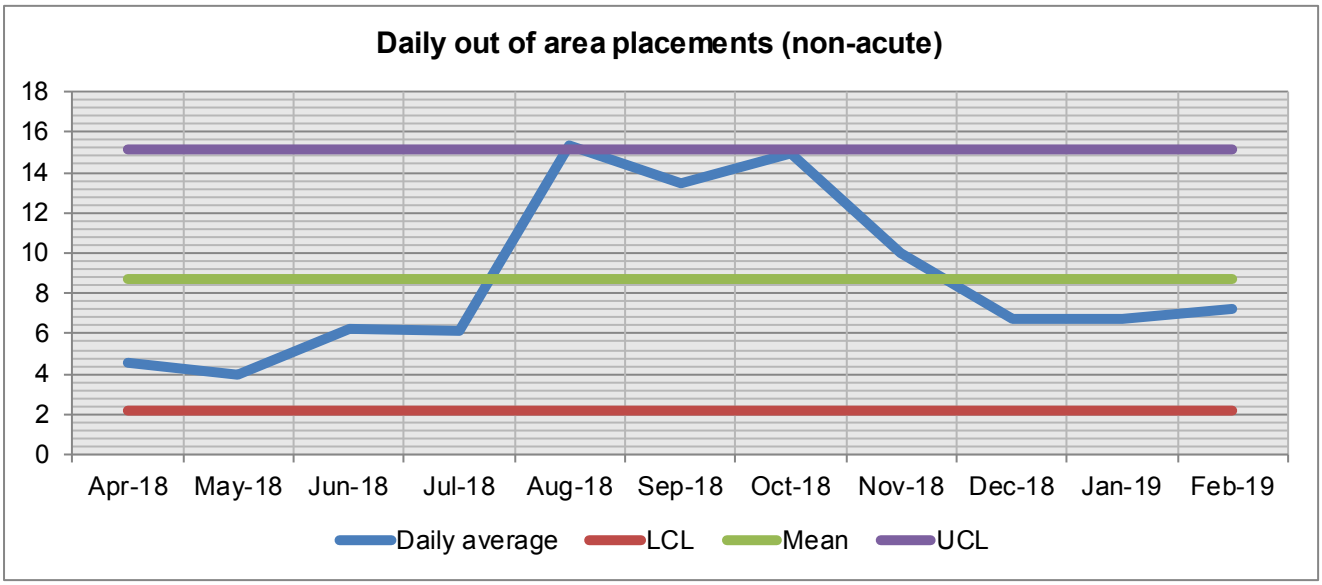
All metrics are forecast to achieve their planned outturn including the agency metric with agency expenditure forecast to be below the ceiling.

Comparing the actual expenditure on Agency to the ceiling, we are below the ceiling value by £148k at the end of February. This generates '1' on this metric within the finance score. Agency expenditure is forecast to be below the ceiling by 5.8% which is generating a score of '1' which is as per the plan.

The forecast agency expenditure equates to the plan of 2.9% of the pay budgets (2.9% last month). National NHSI benchmarking information from 2017/18 showed agency expenditure at 4.5% of pay budgets, with the Midlands and East region at 5.2%.

1.2 Out of area adult placements (non-PICU)

The number of patients whom the Trust admitted to out of area beds in February remains quite static around 6-8 patients on any given day. The Trust continues to take part in the regional learning collaborative that is focused on supporting Trusts to reduce out of area placements. Within the Trust a number of initiatives are in place to optimise bed use and manage available capacity, which include a complex case panel meeting that has been established to review patients with a length of stay over 50 days.



1.3 People position

Sickness absence levels have decreased this month with a reduction from 7.53% to 6.73% which is a 0.8% improvement. Long terms sickness has improved with a reduction from January 2019 of 3.74% to February 2019 at 3.66%. Managers with support from Employee Relations, Occupational Health and Staff side are working hard to resolve many of these cases. Short term sickness for January 2019 was 3.79% with a reduction to 3.07% in February 2019 , a reduction of 0.72%, this is fairly indicative due to the time of year and prevalence of coughs cold and flu like symptoms.

Compulsory training compliance is running at 84.32% a slight improvement from last month at 83.88% and appraisals at 75.52% a minor increase from last month.

The Trust vacancy rate includes funded Fte surplus for flexibility including sickness and annual leave cover and is currently running at 9.30%, a slight increase from the previous month of 9.16%.

Recruitment activity across the Trust continues to remain a key focus. During February 2019, 27 people have been recruited externally, comprising of 6 Nursing and Midwifery Registered, 10 Additional Clinical

Services, 7 Administrative and Clerical, 1 Allied Health Professional, 2 Estates and Ancillary and 1 Medical and Dental.

The use of Trac is supporting a faster and more effective recruitment service where delays are more easily identifiable. Weekly recruitment updates are supporting the hard to fill areas so that any delays in the process can be quickly resolved.

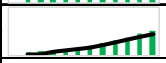
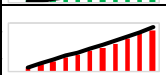
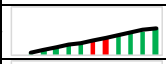
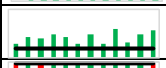
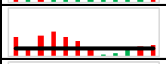
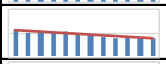
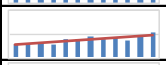
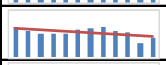
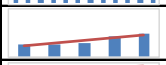
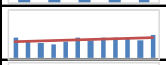
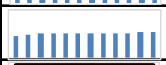
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Sickness Absence KPI	5%	5%	5%	7%	6%	6%	7%	7%	7%	8%	7%
Corporate Services	4%	3%	3%	4%	5%	4%	6%	5%	5%	6%	6%
Business Improvement + Transformation	2%	1%	0%	6%	9%	1%	0%	0%	0%	0%	2%
Corporate Central	0%	0%	0%	0%	5%	4%	1%	3%	1%	1%	1%
Estates + Facilities	5%	4%	5%	6%	6%	6%	8%	7%	7%	9%	8%
Finance Services	3%	1%	1%	0%	1%	1%	3%	2%	5%	8%	11%
Med Education & CRD	2%	1%	1%	1%	1%	0%	3%	0%	1%	2%	0%
Nursing + Quality	7%	7%	7%	7%	9%	8%	12%	11%	7%	8%	9%
Ops Support	3%	2%	3%	3%	2%	2%	5%	4%	3%	2%	4%
IT, Information Management + Patient Records	3%	3%	3%	1%	2%	3%	8%	5%	2%	1%	3%
Ops Management	0%	0%	0%	0%	0%	0%	2%	8%	16%	11%	13%
Pharmacy	3%	0%	4%	6%	2%	2%	3%	3%	1%	3%	3%
People Services	24%	22%	N/A	N/A	N/A	N/A	0%	0%	0%	0%	0%
Operational Services	5%	5%	6%	7%	7%	7%	8%	7%	7%	8%	7%
Campus	6%	8%	8%	11%	10%	9%	10%	8%	9%	11%	8%
Central Services	4%	4%	4%	4%	4%	4%	5%	6%	5%	5%	5%
Children's Services	3%	4%	4%	4%	5%	5%	7%	7%	6%	8%	7%
Clinical Serv Management	4%	0%	3%	3%	3%	2%	1%	2%	0%	3%	3%
Neighbourhood	5%	4%	5%	6%	6%	6%	7%	8%	7%	7%	7%

NB “People Services” consists of 2 staff members employed by the Trust

Compulsory Training KPI	86%	86%	82%	83%	83%	83%	83%	84%	84%	84%	84%
Corporate Services	84%	84%	82%	83%	83%	82%	85%	85%	86%	85%	85%
Business Improvement + Transformation	87%	94%	97%	90%	93%	94%	94%	94%	89%	89%	87%
Corporate Central	73%	73%	70%	72%	76%	77%	78%	80%	79%	77%	78%
Estates + Facilities	82%	82%	81%	81%	81%	78%	82%	82%	83%	84%	83%
Finance Services	98%	97%	98%	97%	99%	98%	99%	99%	97%	98%	98%
Med Education & CRD	77%	79%	77%	77%	73%	76%	80%	81%	80%	76%	76%
Nursing + Quality	85%	85%	83%	85%	87%	88%	86%	88%	87%	86%	86%
Ops Support	91%	91%	88%	88%	90%	89%	92%	92%	93%	93%	92%
IT, Information Management + Patient Records	95%	98%	98%	95%	97%	95%	99%	99%	98%	99%	98%
Ops Management	92%	92%	86%	78%	78%	73%	74%	77%	80%	71%	70%
Pharmacy	87%	85%	77%	80%	83%	84%	85%	86%	90%	90%	89%
People Services	89%	89%	89%	67%	72%	72%	72%	52%	72%	72%	72%
Operational Services	86%	86%	82%	83%	83%	83%	83%	84%	84%	84%	84%
Campus	87%	87%	83%	83%	83%	81%	82%	82%	84%	83%	83%
Central Services	86%	87%	83%	84%	84%	86%	86%	86%	86%	86%	87%
Children's Services	85%	83%	80%	80%	81%	82%	82%	82%	83%	82%	83%
Clinical Serv Management	68%	68%	61%	64%	66%	67%	70%	72%	74%	72%	73%
Neighbourhood	87%	87%	83%	84%	84%	84%	84%	85%	85%	85%	86%

NB “People Services” consists of 2 staff members employed by the Trust

2. Strategy Delivery

Category	Metric	Period	Target	Actual	Variance	Trend	Last 12 Months	DQ
Finance Scorecard	Finance Scorecard	YTD	1	1	G	→		
		Forecast	1	1	G	→		
	Control Total position £000	YTD	2164	2566	G	↑		
		Forecast	2331	2331	G	→		
	CIP achievement £m	YTD	4.453	4.233	R	↑		
		Forecast	4.871	4.584	R	→		
		Recurrent	4.871	1.466	R	→		
	Agency £m	YTD	2.783	2.630	G	↑		
		Forecast	3.030	2.853	G	↓		
	Cash £m	YTD	22.228	27.800	G	↑		
		Forecast	21.608	25.074	G	↑		
Quality and Operations Scorecard	RTT Incomplete Within 18 Weeks (%)	Feb, 2019	92%	95.5%	G	→		
		Jan, 2019		94.9%	G			
	CPA Review in last 12 Months (on CPA > 12 Months)	Feb, 2019	95%	94.2%	R	↓		
		Jan, 2019		95.8%	G			
	Delayed Transfers of Care (%)	Feb, 2019	0.8%	1.21%	R	→		
		Jan, 2019		0.98%	R			
	North Neighbourhood Average Wait (weeks)	Feb, 2019		7.3		↓		
		Jan, 2019		8.8				
	North Neighbourhood Current Waits (number)	Feb, 2019		1770		↓		
		Jan, 2019		1801				
	City Neighbourhood Average Wait (weeks)	Feb, 2019		8.8		↑		
		Jan, 2019		8.5				
	City Neighbourhood Current Waits (number)	Feb, 2019		1525		↑		
		Jan, 2019		1477				
	South Neighbourhood Average Wait (weeks)	Feb, 2019		10.1		↑		
		Jan, 2019		10.0				
	South Neighbourhood Current Waits (number)	Feb, 2019		1716		↑		
		Jan, 2019		1662				
	CAMHS Average Wait (weeks)	Feb, 2019		9.6		↑		
		Jan, 2019		8.2				
	CAMHS Current Waits (number)	Feb, 2019		864		↓		
		Jan, 2019		869				
	Community Paediatrics Average Wait (weeks)	Feb, 2019		23.5		↑		
		Jan, 2019		18.7				
	Community Paediatrics Current Waits (number)	Feb, 2019		858		↑		
		Jan, 2019		803				
	Number of Adult Acute Inpatients (Hartington and Radbourne) LoS > 50 Days	Feb, 2019		67		↓		
		Jan, 2019		72				
	Health Visiting 0-19 Caseload (based on 50.8 WTE)	Feb, 2019	250	327	R	↓		
		Jan, 2019		337	R			
	Distinct LD Caseload	Feb, 2019		1064		↓		
		Jan, 2019		1077				
	Distinct Substance Misuse Caseload	Feb, 2019		5399		↑		
		Jan, 2019		5311				
	RTT Incomplete Within 18 Weeks inc Paediatrics (%)	Feb, 2019		72%		→		
		Jan, 2019		72%				
Workforce and Engagement Scorecard	RETAIN - Staff engagement score	2018 Annual	To see an improvement in the staff engagement score	6.900	G	↑		
		2017 Annual		6.800				
		Q2 Sep 2018		74%	G	→		
		Q1 Jun 2018		74%				
	DEVELOP - Recruitment of preceptorship staff	2017/18	Number of students recruited into preceptorship	31	R	↓		
		2016/17		46				
	ATTRACT - Retention of preceptorship staff	2017 Annual	Number of students recruited into preceptorship who stay for at least one year	91%	G	→		
		2016 Annual		91%				
	LEADERSHIP & MANAGEMENT - Employee relations cases	Q3 Dec 2018	To see a reduction in the number of cases	34	G	→		
		Q2 Sep 2018		34	G			
		Q1 Jun 2018		40	G			
		Q4 Mar 2018		48				

Key:

Period Month / Previous Month

Achieving target / Not achieving target / No Target Set

Target / Trend

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

2.1 Cost Improvement Programme (CIP)

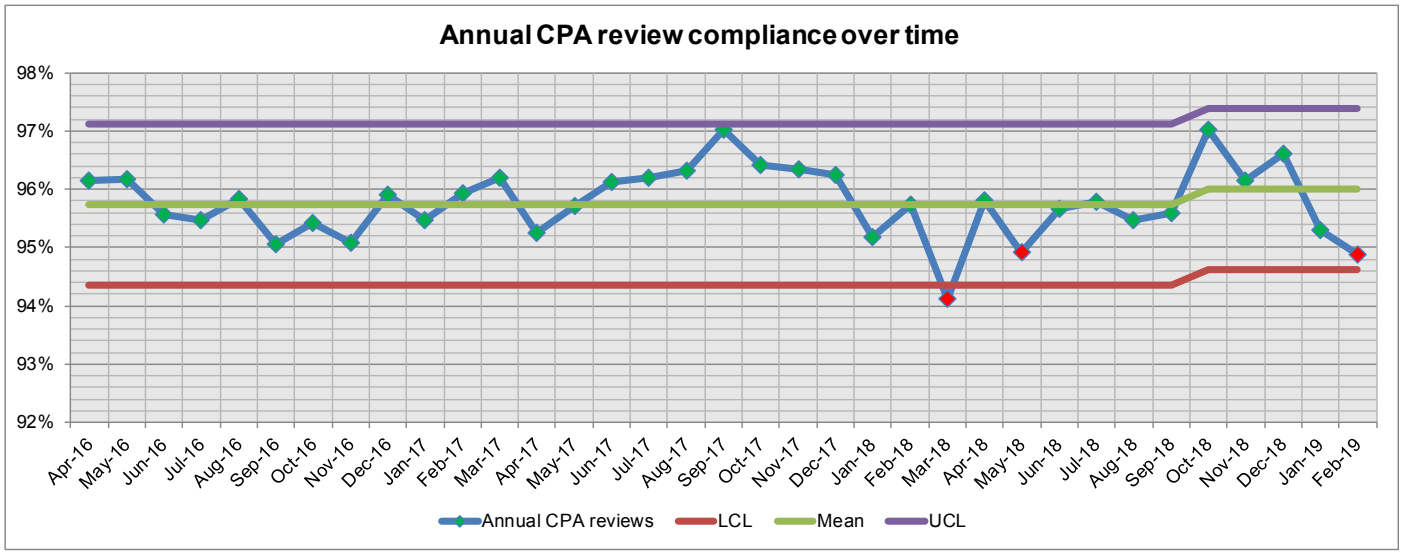
At the end of February £4.6m of CIP has been assured in the ledger with no further schemes to deliver. This then leaves a gap to delivery of the full plan by £287k. Of the total forecast savings only 32% is to be saved recurrently.

2.2 CPA reviews

Routine Actions

A performance pit stop compendium of reports is distributed weekly to all relevant operational teams by Samantha Shaw, Performance Analyst. The compendium includes a CPA review report which provides the dates all CPA reviews will become due and those which are overdue. From October 2018, internally we switched to a 9 month review target. The rationale for this was that if a 9 month review needed to be cancelled for any reason there would still be time to rearrange and hold the review before the formal 12 month target was breached. This strategy has made an improvement to the limits of normal variation.

Performance is monitored at monthly neighbourhood Clinical & Operational Assurance Team (COAT) meetings, at monthly neighbourhood management meetings at monthly Senior Assurance and Support (SASM) meetings and at Trust Management Team performance reviews.



Recovery Strategies

At times when the 12 month target starts to breach, each individual care coordinator is emailed their list of reviews for action. This is very resource intensive and so is not sustainable as routine practice but does elicit positive results.

Further Action

Neighbourhood Service Line Manager has implemented an action plan in their area of responsibility. Weekly meetings are being held with the General Manager to monitor implementation and progress.

2.3 Delayed Transfers of Care

Currently there 3 patients whose discharges are being delayed which is a reduction by 1 since last month. We continue to work with relevant partners to address and minimise delays to avoid unnecessary waits in beds.

2.4 Neighbourhood Waiting Lists

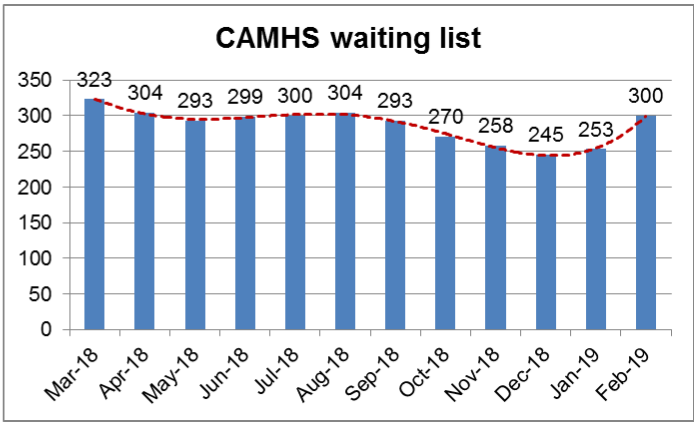
As reported previously, the number of referrals received has been steadily increasing over time. This is likely to continue in line with population growth. A clinical strategy is under development for both working age and older adult community mental health services.

A recently published clinical review of NHS access standards is proposing the introduction of a national standard of 4 weeks from referral to treatment for community mental health services (https://www.england.nhs.uk/clinically-led-review-nhs-access-standards/).

2.5 CAMHS Waiting List

Work is still in progress to seek to reduce waiting times within the resources available. This includes clearly mapping interventions to specific pathways. An action plan is in place and was reviewed at Trust Management Team in February. The action plan includes administrative processes, proactive appointment booking, follow-up of DNA and enhanced clinical oversight. This is monitored at divisional level. We are also in dialogue with commissioners regarding a planned review of CAMHS capacity.

The waiting list in the dashboard is a combination of waits. The current external waits are fairly stable at around 300 children, with around 85% having waited less than 18 weeks:



2.6 Paediatric Waiting List

As reported last month the CCG have suggested that a joint working group be set up and we proactively responded with suggested representatives and dates. We are awaiting confirmation from the CCG. We are working internally to maximise current capacity, respond to referrals and actively reduce long waits.

2.7 Health Visitor Caseloads

Caseloads and staffing have been reviewed. Findings are being considered and options will be explored with commissioners in due course. The safeguarding workload remains high and of concern in this service and rising demand will be explored with commissioners.

2.8 Learning Disability Caseloads

Learning Disability Services are currently in the process of consultation regarding a new model of care and as a result of that have an increased number of vacancies which will have some impact on overarching caseload.

2.1 Substance Misuse Caseloads

This indicator has recently been added. There has been an increase of 88 clients from March to February, which is 1.7% in terms of the whole treatment population for the City and County. In terms of increased workload this would not be significant. We review the figures on an ongoing quarterly basis with commissioners and review any trends developing in terms of impact on workload.

3. Benchmarking

3.1 Written complaints in the NHS 2018/19 Qtr3

		New complaints			HCHS workforce - Full Time Equivalent			Complaints per 1,000 staff		
		2018-19			2018-19			2018-19		
		Q1	Q2	Q3	Apr-18	Jul-18	Oct-18	Q1	Q2	Q3
Mental Health		**3,598**	**3,651**	**3,391**	**177,266**	**180,542**	**180,125**	**20.3**	**20.2**	**18.8**
2Gether NHS Foundation Trust	RTQ	17	14	21	1,826	1,838	1,855	9.3	7.6	11.3
Avon and Wiltshire Mental Health Partnership NHS Trust	RVN	78	72	77	3,490	3,497	3,578	22.3	20.6	21.5
Barnet, Enfield and Haringey Mental Health NHS Trust	RRP	22	19	24	2,791	2,792	2,840	7.9	6.8	8.5
Berkshire Healthcare NHS Foundation Trust	RWX	49	45	38	3,504	3,494	3,568	14.0	12.9	10.7
Birmingham and Solihull Mental Health NHS Foundation Trust	RXT	46	44	39	3,593	3,612	3,669	12.8	12.2	10.6
Black Country Partnership NHS Foundation Trust	TAJ	26	30	29	1,669	1,663	1,682	15.6	18.0	17.2
Bradford District Care NHS Foundation Trust	TAD	6	17	9	2,474	2,483	2,525	2.4	6.8	3.6
Cambridgeshire and Peterborough NHS Foundation Trust	RT1	47	37	35	3,507	3,416	3,446	13.4	10.8	10.2
Camden and Islington NHS Foundation Trust	TAF	44	35	27	1,858	1,858	1,858	23.7	18.8	14.5
Central and North West London NHS Foundation Trust	RV3	125	103	84	5,916	5,944	6,007	21.1	17.3	14.0
Cheshire and Wirral Partnership NHS Foundation Trust	RXA	56	75	92	2,912	2,907	3,070	19.2	25.8	30.0
Cornwall Partnership NHS Foundation Trust	RJ8	31	28	20	3,034	3,030	3,115	10.2	9.2	6.4
Coventry and Warwickshire Partnership NHS Trust	RYG	17	11	19	3,258	3,201	3,128	5.2	3.4	6.1
Cumbria Partnership NHS Foundation Trust	RNN	37	38	33	2,883	2,871	2,970	12.8	13.2	11.1
Derbyshire Healthcare NHS Foundation Trust	RXM	38	54	43	2,117	2,118	2,190	17.9	25.5	19.6
Devon Partnership NHS Trust	RWV	44	56	33	2,229	2,241	2,275	19.7	25.0	14.5
Dorset Healthcare University NHS Foundation Trust	RDY	91	90	92	4,506	4,487	4,514	20.2	20.1	20.4
Dudley and Walsall Mental Health Partnership NHS Trust	RYK	24	37	25	999	994	1,041	24.0	37.2	24.0
East London NHS Foundation Trust	RWK	67	68	64	4,978	4,981	5,120	13.5	13.7	12.5
Essex Partnership University NHS Foundation Trust	R1L	83	64	69	4,299	4,261	4,352	19.3	15.0	15.9
Greater Manchester Mental Health NHS Foundation Trust	RXV	223	195	190	4,386	4,470	4,550	50.8	43.6	41.8
Hertfordshire Partnership University NHS Foundation Trust	RWR	72	67	64	2,842	2,822	2,897	25.3	23.7	22.1
Humber Teaching NHS Foundation Trust	RV9	50	40	51	2,091	2,224	2,239	23.9	18.0	22.8
Kent and Medway NHS and Social Care Partnership Trust	RXY	87	115	121	2,840	2,822	2,843	30.6	40.7	42.6
Lancashire Care NHS Foundation Trust	RW5	288	314	282	5,488	5,469	5,587	52.5	57.4	50.5
Leeds and York Partnership NHS Foundation Trust	RGD	46	46	37	2,267	2,321	2,424	20.3	19.8	15.3
Leicestershire Partnership NHS Trust	RT5	130	123	112	4,427	4,405	4,498	29.4	27.9	24.9
Lincolnshire Partnership NHS Foundation Trust	RP7	54	47	48	1,742	1,772	1,803	31.0	26.5	26.6
Mersey Care NHS Foundation Trust	RW4	70	64	42	6,149	6,158	6,279	11.4	10.4	6.7
Midlands Partnership NHS Foundation Trust	RRE	51	21	16	3,349	6,858	6,827	15.2	3.1	2.3
Norfolk and Suffolk NHS Foundation Trust	RMY	138	152	176	3,552	3,572	3,646	38.9	42.6	48.3
North East London NHS Foundation Trust	RAT	112	147	142	5,000	4,937	5,012	22.4	29.8	28.3
North Staffordshire Combined Healthcare NHS Trust	RLY	10	10	6	1,268	1,280	1,285	7.9	7.8	4.7
North West Boroughs Healthcare NHS Foundation Trust	RTV	68	55	43	3,454	3,391	3,402	19.7	16.2	12.6
Northamptonshire Healthcare NHS Foundation Trust	RP1	54	68	56	3,076	3,085	3,152	17.6	22.0	17.8
Northumberland, Tyne and Wear NHS Foundation Trust	RX4	96	75	80	5,321	5,252	5,282	18.0	14.3	15.1
Nottinghamshire Healthcare NHS Foundation Trust	RHA	93	99	76	7,594	7,517	7,468	12.2	13.2	10.2
Oxford Health NHS Foundation Trust	RNU	50	56	58	4,473	4,472	4,622	11.2	12.5	12.5
Oxleas NHS Foundation Trust	RPG	23	91	80	3,096	3,145	3,229	7.4	28.9	24.8
Pennine Care NHS Foundation Trust	RT2	72	77	56	4,786	4,763	4,792	15.0	16.2	11.7
Rotherham Doncaster and South Humber NHS Foundation Trust	RXE	31	30	26	2,906	2,901	2,925	10.7	10.3	8.9
Sheffield Health and Social Care NHS Foundation Trust	TAH	47	50	50	2,009	2,013	2,045	23.4	24.8	24.5
Somerset Partnership NHS Foundation Trust	RH5	17	14	24	2,953	2,920	2,994	5.8	4.8	8.0
South London and Maudsley NHS Foundation Trust	RV5	111	92	142	4,300	4,307	4,328	25.8	21.4	32.8
South West London and St George's Mental Health NHS Trust	RQY	120	127	116	1,957	1,953	1,998	61.3	65.0	58.1
South West Yorkshire Partnership NHS Foundation Trust	RXG	48	36	37	3,703	3,678	3,671	13.0	9.8	10.1
Southern Health NHS Foundation Trust	RW1	91	95	82	4,925	4,901	4,928	18.5	19.4	16.6
Surrey and Borders Partnership NHS Foundation Trust	RXX	26	36	16	2,144	2,140	2,195	12.1	16.8	7.3
Sussex Partnership NHS Foundation Trust	RX2	209	192	181	3,754	3,801	3,845	55.7	50.5	47.1
Tavistock and Portman NHS Foundation Trust	RNK	43	34	41	567	563	583	75.8	60.4	70.3
Tees, Esk and Wear Valleys NHS Foundation Trust	RX3	56	71	67	5,902	5,867	5,972	9.5	12.1	11.2
West London NHS Trust	RKL	64	75	x	3,101	3,073	..	20.6	24.4	..

Data source: https://digital.nhs.uk/data-and-information/publications/statistical/data-on-written-complaints-in-the-nhs/2018-19-quarter-3

3.2 Psychological Therapies: reports on the use of IAPT services, England - November 2018

Provider Name	Ended Completed	Improvement Rate	Recovery Rate	Reliable Recovery Rate
1829 BUILDING	210	60	48	47
1POINT (NORTH WEST)	30	66	55	52
2GETHER NHS FOUNDATION TRUST	580	66	50	47
ACCESS SEFTON - BOOTLE	130	78	65	64
ADDACTION ASHFORD	335	64	47	44
ADDACTION CANTERBURY & COASTAL	45	66	47	47
ADDACTION MEDWAY & SWALE	25	77	50	50
ADDACTION MERTON	130	61	43	40
ADDACTION REIGATE	60	73	52	51
ADDACTION THANET	95	72	47	44
ADDACTION WOKING	60	78	66	60
ALLIANCE PSYCHOLOGY SERVICES LTD	295	73	58	55
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	1395	62	48	44
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	505	69	50	48
BEACON COUNSELLING	15	78	53	47
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	685	68	52	49
BICS MENTAL HEALTH GATEWAY	215	64	50	46
BIKUR CHOLIM LTD	15	65	57	57
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	940	64	47	44
BIRMINGHAM MENTAL HEALTH CONSORTIUM (HERBERT ROAD)	85	67	55	51
BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	250	75	62	60
BLACKBURN CENTRE	45	55	37	36
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	95	69	47	47
BLAKENALL VILLAGE CENTRE	165	66	40	40
BMHC-FTB	195	70	60	56
BOURNEMOUTH AND POOLE PRIMARY CARE MEDICAL TEAM	355	64	48	45
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	325	62	50	49
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	80	77	57	56
BROMLEY HEALTHCARE	165	64	48	45
BURTON AND DISTRICT MIND	35	92	50	50
CAMBRIDGE AND PETERBOROUGH VOLUNTARY ORGANISATIONS	115	54	30	29
CAMBRIDGESHIRE AND PETERBOROUGH MENTAL HEALTH PARTNERSHIP TR HQ	530	67	53	50
CAMDEN IAPT	160	63	47	42
CITY AND HACKNEY MIND	10	89	88	88
CITY HEALTH CARE PARTNERSHIP CIC	360	77	60	59
CONIFERS	250	72	55	52
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	540	74	52	49
CROYDON PSYCHOLOGICAL THERAPIES SERVICE (CROYDON IAPT)	305	66	52	49
CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	365	70	53	52
DENTON HOUSE	125	54	41	38
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	540	73	57	54
DERMAN	25	79	79	67
DORKING HEALTHCARE LIMITED (DHC)	230	65	55	51
DOVER COUNSELLING CENTRE HQ	365	81	54	54
DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	100	65	53	53
EALING IAPT	145	66	49	47
EAST DORSET STEPS TO WELLBEING (IAPT)	115	70	58	52
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	375	74	55	54
FAVERSHAM COUNSELLING SERVICE LTD	95	85	53	51
FIELDHEAD HOSPITAL	275	64	45	43
GILBERT HITCHCOCK HOUSE	295	66	51	48
GLOUCESTER HOUSE	165	67	52	48
GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	450	59	41	40
HARTLEPOOL AND EAST DURHAM MIND	105	61	53	52
HEALTHY MINDS	280	67	57	54
HERTFORDSHIRE PARTNERSHIP FOUNDATION TRUST (LEXDEN HOSPITAL)	160	61	53	49
HERTFORDSHIRE PARTNERSHIP FOUNDATION TRUST (TEKHNICON HOUSE)	185	67	45	42
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	205	73	60	57
HOPE CENTRE	165	75	67	65
HUMBER TEACHING NHS FOUNDATION TRUST	140	73	58	57
IAPT SERVICES	70	74	56	55
ICCS	160	63	53	49
IESO DIGITAL HEALTH	260	60	52	51
INSIGHT HEALHTCARE TALKING THERAPIES (BASSETLAW)	95	62	48	47
INSIGHT HEALTHCARE - DERBYSHIRE	145	73	54	53
INSIGHT HEALTHCARE - NOTTINGHAM CITY	90	69	46	44
INSIGHT HEALTHCARE - NOTTINGHAMSHIRE	180	67	49	45
INSIGHT HEALTHCARE TALKING THERAPIES (CALDERDALE)	175	69	58	57
INSIGHT HEALTHCARE TALKING THERAPIES (EAST RIDING OF YORKSHIRE)	110	76	54	52
INSIGHT HEALTHCARE TALKING THERAPIES (KENT & MEDWAY)	125	74	62	60
INSIGHT HEALTHCARE TALKING THERAPIES (PETERBOROUGH)	75	58	60	60
INSIGHT HEALTHCARE TALKING THERAPIES (TEESSIDE)	95	73	46	44
ISLE OF WIGHT NHS TRUST	115	67	51	49

Provider Name	Ended Completed	Improvement Rate	Recovery Rate	Reliable Recovery Rate
ISLINGTON IAPT	125	61	49	42
JOHNSON STREET	165	58	42	41
KENDRAY HOSPITAL	105	66	52	50
KINGSTON DRUG & ALCOHOL SERVICE	115	70	51	49
LAKESIDE UNIT	195	61	51	47
LAMBETH PSYCHOLOGICAL THERAPIES SERVICE (LAMBETH IAPT)	330	65	45	43
LANCASHIRE CARE NHS FOUNDATION TRUST	1250	62	50	47
LEEDS COMMUNITY HEALTHCARE NHS TRUST	340	64	51	47
LEWISHAM PSYCHOLOGICAL THERAPIES SERVICE (LEWISHAM IAPT)	235	65	48	44
LGBT FOUNDATION	*	36	*	*
LIFT PSYCHOLOGY SWINDON	475	53	42	39
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	625	70	53	50
LIVEWELL SOUTHWEST	405	64	52	48
MAKING SPACE	20	78	64	64
MEDWAY TALKING THERAPIES	255	73	59	57
MERSEY CARE NHS FOUNDATION TRUST	200	68	53	48
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	865	69	49	47
MILL HOUSE	215	64	53	51
MIND CENTRE	130	54	34	33
MIND IN BEXLEY (HQ)	*	66	50	46
MIND TIME THERAPIES LTD	40	48	46	38
NAVIGO HEALTH AND SOCIAL CARE CIC	90	64	46	46
NEWCASTLE TALKING THERAPIES	120	66	42	41
NEWHAM IAPT	210	64	50	47
NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	1320	64	51	46
NORTH EAST LONDON NHS FOUNDATION TRUST	435	70	50	48
NORTH KENT MIND	220	79	48	48
NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST	385	69	52	49
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	440	71	52	50
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	180	69	48	46
NORTHWICK PARK HOSPITAL	105	61	54	50
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	1340	70	53	51
OUTLOOK SW LTD	*	65	52	49
OXLEAS NHS FOUNDATION TRUST	*	72	54	52
PENNINE CARE NHS TRUST	1075	68	51	49
PSICON LIMITED	55	70	60	60
PSYCHOLOGICAL THERAPIES SOUTHHAMPTON OFFICE	170	71	52	49
RELATE	65	67	47	44
ROSANNE HOUSE	205	64	51	48
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	435	67	54	50
SELF HELP SERVICES (EASTERN CHESHIRE)	115	61	38	36
SELF HELP SERVICES (HQ)	320	67	53	49
SELF HELP SERVICES (PBR)	70	71	59	59
SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	390	66	48	46
SIGN HEALTH (HQ)	10	75	58	58
SIX DEGREES SOCIAL ENTERPRISE CIC	115	57	41	39
SOLENT NHS TRUST	155	70	62	58
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	235	69	55	53
SOUTH TYNESIDE NHS FOUNDATION TRUST	320	66	59	55
SOUTH WESTMINSTER PRIMARY CARE HOME	20	76	52	52
SOUTHERN HEALTH NHS FOUNDATION TRUST	605	65	52	49
SOUTHWARK PSYCHOLOGICAL THERAPIES SERVICES (SOUTHWARK IAPT)	125	61	47	45
ST JOHN'S HEALTH CENTRE	100	58	54	50
STARFISH HEALTH AND WELLBEING	260	64	57	50
STARFISH-EWIT	130	58	51	48
SURREY IAPT	460	72	54	52
SUSSEX COMMUNITY NHS FOUNDATION TRUST	450	71	54	52
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	360	69	53	51
SUTTON & MERTON IAPT	150	60	49	46
TAKE TIME TO TALK	170	56	54	45
TALKING MATTERS NORTHUMBERLAND	215	66	57	53
TALKINGSPACE PLUS	375	66	52	48
TALKPLUS	240	67	62	56
TEES, ESK, WEAR VALLEY NHS TRUST (DURHAM)	420	69	50	49
THE BRIARY UNIT	215	72	60	57
THE KALEIDOSCOPE PLUS GROUP	35	67	52	51
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	80	65	35	34
THE VILLAGE PRACTICE (THORNTON)	30	63	47	44
THINKING AHEAD	360	71	54	52
TRENT PTS	990	77	58	55
TURNING POINT	460	64	47	45
UNIVERSITY MEDICAL CENTRE	155	77	64	62
WALLSEND HEALTH CENTRE	130	72	54	51
WANDSWORTH IAPT	220	62	47	44
WARRINGTON PSYCHOLOGICAL SERVICE	175	66	52	51
WAVERLEY ROAD	945	64	54	51

Provider Name	Ended Completed	Improvement Rate	Recovery Rate	Reliable Recovery Rate
WEST ESSEX IAPT	110	74	53	51
WESTMINSTER MIND	20	83	64	60
WESTMINSTER WELLBEING SERVICE	120	73	64	60
WHITTINGTON HEALTH NHS TRUST	285	74	58	56
WORCESTERSHIRE HEALTH AND CARE NHS TRUST	215	67	54	52

Data source: https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services/november-2018-final-including-reports-on-the-iapt-pilots

3.3 Inappropriate out of area placements April 2018 to November 2019

Sending provider	Percentage of OAP bed days that are Acute adult mental health care	Percentage of OAP bed days that are Acute older adult mental health care (organic and functional)	Percentage of OAP bed days that are Psychiatric Intensive Care Unit	Total Cost	Total inappropriate OAP days
All	67%	5%	28%	£ 97,308,420	212100
DEVON PARTNERSHIP NHS TRUST	73%	1%	26%	£ 10,177,601	19450
SOUTHERN HEALTH NHS FOUNDATION TRUST	66%	0%	34%	£ 8,771,128	14975
GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	87%	1%	12%	£ -	14130
LANCASHIRE CARE NHS FOUNDATION TRUST	77%	1%	22%	£ 7,022,692	13195
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	85%	0%	15%	£ 4,828,814	12095
NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	72%	13%	15%	£ 4,557,661	11145
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	73%	0%	27%	£ 5,237,724	10425
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	86%	4%	9%	£ 4,346,967	8370
OXLEAS NHS FOUNDATION TRUST	47%	0%	53%	£ 4,700,867	7930
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	55%	44%	0%	£ -	7595
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	65%	8%	28%	£ 4,814,352	7515
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	61%	0%	39%	£ 3,285,832	5400
LEICESTERSHIRE PARTNERSHIP NHS TRUST	76%	0%	24%	£ 3,159,192	5305
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	81%	3%	16%	£ 2,714,484	5270
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	36%	1%	64%	£ 1,897,687	5115
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	86%	1%	14%	£ 1,825,048	4880
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	75%	21%	4%	£ 2,044,817	4740
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	53%	4%	43%	£ 2,550,621	4690
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	70%	0%	30%	£ 2,055,933	4225
LIVEWELL SOUTHWEST	46%	7%	47%	£ 2,193,130	4110
OXFORD HEALTH NHS FOUNDATION TRUST	79%	4%	17%	£ 1,998,677	3605
PENNINE CARE NHS FOUNDATION TRUST	44%	0%	56%	£ 1,608,194	3555
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	18%	0%	82%	£ 1,923,118	3020
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	49%	1%	49%	£ 1,671,015	3015
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	57%	0%	43%	£ 1,512,234	2540
BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	57%	0%	43%	£ 1,346,036	2350
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	55%	2%	43%	£ 1,270,652	2195
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	77%	0%	23%	£ 1,302,457	2190
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	88%	0%	13%	£ 1,011,801	2000
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	92%	0%	8%	£ 990,154	1925
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	8%	0%	92%	£ -	1870
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	10%	73%	17%	£ 847,923	1685
2GETHER NHS FOUNDATION TRUST	27%	0%	73%	£ 890,937	1305
HUMBER TEACHING NHS FOUNDATION TRUST	13%	19%	68%	£ 410,974	1195
NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST	100%	0%	0%	£ 622,449	1160
DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	47%	2%	52%	£ 276,815	1085
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	61%	2%	36%	£ 243,964	860
WEST LONDON NHS TRUST	0%	0%	100%	£ 439,041	635
HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	46%	0%	54%	£ 374,546	615
CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	82%	0%	19%	£ 352,713	600
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	87%	12%	0%	£ 282,150	515
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	1%	0%	100%	£ 462,516	480
Unknown	20%	3%	77%	£ 128,129	460
MERSEY CARE NHS FOUNDATION TRUST	51%	49%	0%	£ -	435

Sending provider	Percentage of OAP bed days that are Acute adult mental health care	Percentage of OAP bed days that are Acute older adult mental health care (organic and functional)	Percentage of OAP bed days that are Psychiatric Intensive Care Unit	Total Cost	Total inappropriate OAP days
NORTH EAST LONDON NHS FOUNDATION TRUST	85%	0%	15%	£ 214,929	390
SOLENT NHS TRUST	0%	0%	100%	£ 255,683	355
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	89%	11%	0%	£ 79,426	355
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	85%	2%	11%	£ 146,413	275
NAVIGO HEALTH AND SOCIAL CARE CIC	5%	51%	43%	£ 42,198	185
SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	0%	0%	100%	£ 133,432	185
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	0%	0%	100%	£ 109,959	165
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	10%	0%	87%	£ 92,320	155
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	0%	0%	100%	£ 61,200	90
WORCESTERSHIRE HEALTH AND CARE NHS TRUST	82%	0%	18%	£ -	55
EAST LONDON NHS FOUNDATION TRUST	20%	0%	80%	£ 17,930	25
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	0%	0%	100%	£ 3,885	5
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	100%	0%	0%	£ -	5
ISLE OF WIGHT NHS TRUST	0%	0%	0%	£ -	0
Grand Total				**£ 194,616,840**	**424200**

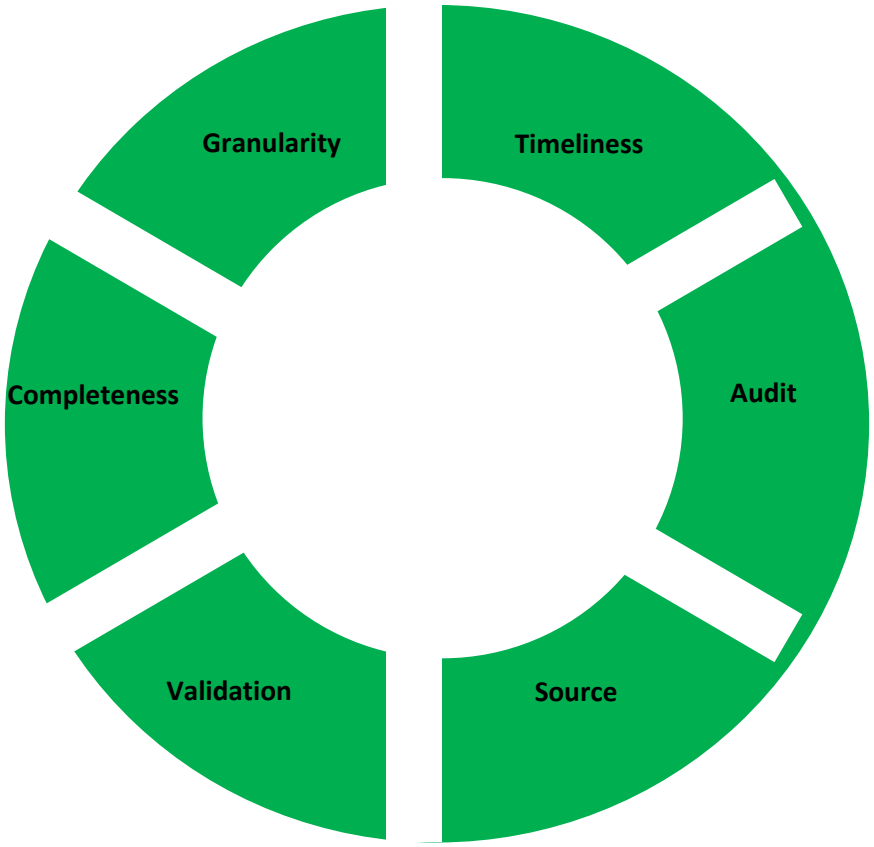
Data source: https://digital.nhs.uk/data-and-information/publications/statistical/out-of-area-placements-in-mental-health-services/november-2018

Data Quality Kite Mark

Background

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

Approach



The Trust has adopted this Data Quality Kite Mark. The assessment of each domain will be based on the following criteria:

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

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

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

KPI Data Quality Reviews

A review will be undertaken every 6 months of 5 to 10 indicators to review their compliance with the defined indicators of quality. This will be done to complement any reviews undertaken by internal or external audit. The results will be shared with the Finance and Performance Committee together with any remedial action required.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 March 2019

Board Assurance Framework (BAF)
Fifth and Final Issue for 2018/19 and First Issue for 2019/20

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the fifth and final issue of the BAF for 2018/19 and the first issue for 2019/20.

Executive Summary

Fifth and final issue of BAF 2018/19
At year end, eleven risks are identified in the BAF for 2018/19.

- Since Issue 4 of the BAF, the risk ratings for two of the risks have been revised:
    - Risk 18_19 1d. *There is a risk that the Trust will fail to redesign the Care Programme Approach processes, which may impact upon the quality of care provided to patients and their carers* has been reduced from a risk rating of high to moderate due to strong performance of CPA in line with compliance against national standards. Target risk rating achieved and risk appetite accepted.
    - Risk 18_19 3a *There is a risk that the Trust fails to deliver its financial plans* has been reduced from a risk rating of high to moderate based on Month 11 finance report and therefore financial forecast for year end. Target risk rating achieved and risk appetite accepted.

- Two risks continue to be rated as extreme. These are: 18_19 4a Retention, development and attraction of staff and 18_19 4d Acute inpatient flow. Six risks are currently identified as high and four as moderate.

- The Deep Dive programme has been completed for 2018/19 and all deep dives undertaken. Executive Leads have used a standard template to ensure consistency of approach.

- Throughout 2018/19 the BAF risks for the responsible Board Committee have been presented at the start of each agenda in order to drive the Committee agenda. Reflection of any required changes to the BAF, following discussion of agenda items, has remained as a standing item.

- Significant risks remaining from the 2018/19 BAF have been mapped to the proposed BAF risks for 2019/20. It was expected that Risk 18_19 1d *There is a risk that the Trust will fail to provide full compliance with the Mental Health Act (1983) and Mental Capacity Act (2005)* would be proposed to be reduced from high to moderate by the Mental Health Act Committee at its meeting on 08 March 2019. However the gaps in controls were not felt to be sufficiently reduced to

enable this. Following discussion at the Audit and Risk Committee on 21 March 2019, it was therefore agreed that the remaining gaps in controls would be worked up further in the next round of discussions with executive directors and articulated in the next issue of the 2019/20 BAF.

First Issue of BAF 2019/20

Following significant discussion and consideration by the Executive Leadership Team throughout February and March and the Board Development Session in February 2019, it is proposed the number of BAF risks for 2019/20 be reduced from eleven to five.

The Board and Executive Leadership Team have agreed changes to the BAF approach for 2019/20 to enable the BAF to more tightly reflect the risks to delivery of the strategic objectives. Changes for 2019/20 include:

- Following the review of the Trusts Strategic Objectives at Board in February 2019, risks have been identified to achieving these revised objectives with an enhanced focus on high level strategic actions to ensure that once completed the risk is mitigated and the risk rating reduced
- This has resulted in the number of gaps in controls and assurances for each risk being reduced, to identify only high level key gaps
- Clear measurables have been included for each action identified to outline what is required to close the gaps in controls and assurances. These will be assertively monitored and regulated through the Executive Leadership Team
- The previous 'risk to delivery' of the action detailed in the 2018/19 BAF has been changed for 2019/20 to detail if the action is on track to delivery. This will enable a clearer picture to emerge on the progress of actions. The colour rating is based on the following descriptors:

Actions on track for delivery against gaps in controls and assurances:	**Colour rating**
Action completed or on track to completion within proposed timeframe	**Green**
Action implemented in part with potential risks to meeting proposed timeframe.	**Amber**
Action not completed to timeframe. Revised plan of action required.	**Red**

As we are at the commencement of the year, with actions only recently identified, all actions are currently shown as on track

- It is proposed that Executive Directors will take a more collective responsibility for updating and reviewing the BAF during 2019/20. Updating of the BAF will continue through meetings with the relevant Executive Director and the Risk and Assurance Manager, following which the Executive Leadership Team will then take collective responsibility for ensuring the actions and metrics against which the impact of the actions will be measured are and will directly impact on the risk identified. ELT have agreed for the timescales outlined in this

initial version of the BAF to only be extended following appropriate challenge and approval by ELT. Executive leads for individual risks will remain, apart from risk 1a where it is proposed there is a joint lead by the Medical Director and Executive Director of Nursing and Quality.

The proposed BAF risks for 2019/20 are as follows:

Ref	Principal risk	Director Lead	Initial rating
Strategic Objective 1. To provide GOOD care in all services			
19_20 1a	There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board	Executive Director of Nursing/Medical Director	HIGH 4x4
19_20 1b	There is a risk that the Trust estate does not comply with regulatory and legislative requirements	Chief Operating Officer	HIGH 4x4
Strategic Objective 2. To be a GREAT place to work			
19_20 2a	There is a risk that the Trust will not be able to retain, develop and attract enough staff to protect their well-being to deliver high quality care	Director of People and Organisational Effectiveness	EXTREME 4x5
Strategic Objective 3. To make GOOD use of our money			
19_20 3a	There is a risk that the Trust fails to deliver its financial plans	Executive Director of Finance	EXTREME 4x5
19_20 3b	There is a risk that the Trust fails to influence external drivers (such as the STP and BREXIT) to effectively engage in enhancing service models	Chief Executive Officer	HIGH 4x4

- The Audit and Risk Committee on 21 March 2019 requested that gaps in control/assurances regarding clinical compliance be more clearly articulated and that the expected impact on risk of the neighbourhood redesign be evident. These will be worked up with the Executive Directors and included in Issue 2 of the Board Assurance Framework.
- Discussion at the Remuneration and Appointments Committee on 20 March identified the impact arising from changes to pension taxation introduced in 2014 and 2016 and the gap in assurance that arises from these changes on the retention of a number of senior staff and consultants. This will be reflected in the next iteration of the BAF under risk 2a.Discussion of the BAF by the Executive Team on 25 March 2019 identified the need to further consider the feasibility of delivering all elements of mitigating actions as outlined in the BAF. Timelines and activities will be reviewed and prioritised as part of ongoing BAF management over forthcoming weeks.

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

Assurances

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

Consultation

Executive Leadership Team: throughout Jan – March 2019

Board Development Session – 20 Feb 2019

Audit and Risk Committee - 21 March 2019

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

Specific elements within each BAF risk and associated actions are addressed by the relevant lead Executive Director in taking forward

Recommendations

The Board of Directors is requested to:

1. Agree and approve this fifth and final issue BAF for 2018/19 and the significant assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives, including the amended risk ratings for risk 1d and 3a
2. Receive and agree the proposed BAF version 1.0 for 2019/20
3. Agree to receive a quarterly update of the 2019/20 BAF risks as outlined in the forward plan.

Report presented by: **Rachel Kempster**
Risk and Assurance Manager

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

Rachel Kempster
Risk and Assurance Manager

Board Assurance Framework

Movement of risks and deep dive programme for Fifth and Final issue of the BAF for 2018/19

The Board Assurance Framework (BAF) is a high level report which enables the Board of Directors to demonstrate how it has identified and met its assurance needs, focused on the delivery of its objectives and subsequent principal risks. The BAF provides a central basis to support the Board's disclosure requirements with regard to the Annual Governance Statement (AGS), which the Chief Executive signs on behalf of the Board of Directors, as part of the statutory accounts and annual report. This is the fifth and final formal presentation of the Board Assurance Framework to the Board for 2018/19.

1) Overview and movement of risks 2018/19

A summary of all risks currently identified in the 2018/19 BAF is shown below, together with the movement of the risk rating throughout the year.

BAF ID	Risk title	Director Lead	Risk rating Issue 1	Risk rating Issue 2	Risk rating Issue 3	Risk rating Issue 4	Risk rating Issue 5	Direction of movement
18_19 1a	Failure to provide safety and quality standards	Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	
18_19 1b	Failure to provide full compliance with the Mental Health Act (MHA) and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	
18_19 1c	Failure to develop systems and processes to deliver physical health care for patients	Medical Director	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	
18_19 1d	Failure to redesign the Care Programme Approach processes	Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	MOD (3x4)	
18_19 2a	Risk that we do not engage our workforce to experience aims and values of the Trust	Director of People and Organisational Effectiveness	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	MOD (3x4)	MOD (3x4)	
18_19 3a	Delivery of financial plan	Director of Finance	EXT (4x5)	EXT (4x5)	EXT (4x5)	HIGH (3x5)	MOD (2x5)	
18_19 3b	Failure to influence Joined Up Care Derbyshire	Director of Business Improvement and Transformation	HIGH (4x4)	HIGH (4x4)	MOD (3x4)	MOD (3x4)	MOD (3x4)	
18_19 4a	Unable to retain, develop and attract staff in specific teams	Director of People and Organisational Effectiveness	EXT (4x5)	EXT (4x5)	EXT (4x5)	EXT (4x5)	EXT (4x5)	
18_19 4b	Failure to gain confidence of staff re the electronic patient record	Chief Operating Officer	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	
18_19 4c	Unable to introduce new workforce models and provide training to reskill staff	Director of People and Organisational Effectiveness	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	
18_19 4d	There is a risk that the Trust will not improve the inpatient flow of patients through our services	Chief Operating Officer	HIGH (4x4)	HIGH (4x4)	EXT (5x4)	EXT (5x4)	EXT (5x4)	

2) Deep dives 2018/19

'Deep dives' remain fully embedded in the BAF process and enable review and challenge of the controls and assurances associated with each risk. A timetable for 2018/19, agreed with Executive Directors, is shown below. The deep dive for risks with a residual risk rating of extreme have been undertaken by the Audit and Risk Committee, the responsible committee for these risks is also shown (in brackets).

The current plan for BAF Deep Dives for 2018/19 is shown below. All have been completed.

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

Summary Board Assurance Framework Risks 2018/19. Issue 5.2

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)
Strategic Objective 1. Quality Improvement			
18_19 1a	There is a risk that the Trust will fail to provide standards for safety and quality required by our Board, as set out in the Health and Social Care Act 2009 and measured through the CQC's regulatory process	Executive Director of Nursing and Patient Experience	HIGH (4x4)
18_19 1b	There is a risk that the Trust will fail to provide full compliance with the Mental Health Act (1983) and Mental Capacity Act (2005)	Medical Director	HIGH (4x4)
18_19 1c	There is a risk that the Trust will fail to develop systems and processes to deliver safe and effective physical health care for patients	Medical Director	HIGH (4x4)
18_19 1d	There is a risk that the Trust will fail to redesign the Care Programme Approach processes, which may impact upon the quality of care provided to patients and their carers	Executive Director of Nursing and Patient Experience	MODERATE (3x4) ↓
Strategic Objective 2. Engagement			
18_19 2a	There is a risk that if the Trust doesn't engage our workforce and create an environment where they experience the aims and values of the Trust, there will be a negative impact on the morale and health & wellbeing of staff which may affect the safety and quality of patient care	Director of People and Organisational Effectiveness	MODERATE (3x4)
Strategic Objective 3. Financial Sustainability			
18_19 3a	There is a risk that the Trust fails to deliver its financial plans	Executive Director of Finance	MODERATE (2x5) ↓
18_19 3b	There is a risk that the Trust fails to influence Joined Up Care Derbyshire (the 'system') to effectively engage in enhancing service models for children, and people with mental health problems, learning disabilities, or issues with substance misuse	Director of Business Improvement and Transformation	MODERATE (3x4)
Strategic Objective 4.Operational Delivery			
18_19 4a	There is a risk that the Trust will not be able to retain, develop and attract enough staff in specific teams to deliver high quality care	Director of People and Organisational Effectiveness	EXTREME (4x5)
18_19 4b	There is a risk that the Trust will fail to gain the confidence of staff to maintain a modern and effective electronic patient record system	Chief Operating Officer	HIGH (4x4)
18_19 4c	There is a risk that the Trust will be unable to meet the needs of patients by not introducing new workforce models and provide sufficient training to reskill staff.	Director of People and Organisational Effectiveness	HIGH (4x4)
18_19 4d	There is a risk that the Trust will not improve the acute inpatient flow of patients through our services	Chief Operating Officer	EXTREME (5x4)

Board Assurance Framework Risks 2018/19 v 5.2

Strategic Outcome 1. Quality Improvement

Principal risk:

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

Impact: May lead to harm, delays in recovery and longer episodes of treatment affecting patients, their family members, staff, or the public

Root causes:

a) Financial settlement in contracts chronically underfunded
b) Workforce supply and lack of capacity to deliver effective care across all services
c) Substantial increase in clinical demand
d) Increasing patient and family expectations of service
e) Changing demographics of population
f) Lack of stability of clinical leadership at all levels
g) Lack of compliance with CQC standards
h) Lack of embedded outcome measures

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

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

Key controls:

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

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

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

Corrective – Board committee structures and processes ensuring escalation of quality issues; Annual skill mix review; CQC and GIAP action plans; Incident investigation and learning; Actions following clinical and compliance audits; Workforce issues escalation procedures; Reporting to commissioner led Quality Assurance Group on compliance with quality standards

Assurances on Controls (internal):	Positive assurances on Controls (external):
Quality dashboard Scrutiny of Quality Account (pre-submission) by committees and governors	National enquiry into suicide and homicide NHLSA Scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards and 12/58 for effectiveness CQC comprehensive review 2018, 11 services area domains improved, 5 deteriorated KPMG 2016/17 and 2017/18 BAF and Risk Register Reviews Schedule 4/6 analysis and scrutiny by commissioners

	CQC comprehensive inspection identified Trust fully compliant with NQB Learning from Deaths guidance.

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Fully implemented quality priorities and Quality Improvement Strategy	Roll out of actions in relation to the current quality priorities and Quality Improvement Strategy including a training needs analysis and full implementation plan [ACTION OWNER: DBI&T]	Completed	Quality priorities are required outcomes of quality visits, programme completed. Full training needs analysis in development. Quality priorities implemented 18/19, with exception of physical healthcare and development of clinical strategies. Continuous Improvement will be a module in the Trust Leadership and Management Training programme, in addition to the other resources made available on ELearning and the intranet site.	Achieved
Commissioner commitment to invest in mental health, children's services and learning disability services. Role of primary care models underdeveloped in Derbyshire.	Commissioner lobbying and provision of evidence to support need to increase funding or to provide an alternative strategic plan [ACTION OWNER DON]	Completed	New mental health modelling national data shows Trust staffing is less than other Trusts and activity higher. This is the key information with benchmarking and other information for the bids for the National Mental Health investment standard. Commissioning gaps map to be submitted to Quality Committee April 2019. Identified actions achieved.	Achieved
Lack of effective forensic clinical service pathway following prison release. Release of IPP prisoners (indeterminate imprisonment for public protection) increases risks.	Recruit to and operationalise community forensic team, following funding settlement [ACTION OWNER:COO] Recruit to and operationalize additional investment in Neighbourhoods and Crisis service [ACTION OWNER:COO]	Completed	Team recruited and operationalised since early Feb 2019.	Achieved
Non commissioned services for Derbyshire based PICU beds and CAMHS Tier 4 beds	Improvement plan with commissioners in place for CAMHS Rise and HTT model [ACTION OWNER COO]	31/03/2019	Commissioners are to tender for PICU provision and provision of transport. The procurement aims to establish core contracts with PICU providers which should secure bed spaces for Derbyshire patients as close to Derbyshire as possible, reducing access, quality and transport issues relating to long journeys to hospitals. (CRR)	Medium
Early warning signs of service failure and independent service modelling	Implement QUESTT. Explore and commission remodelling exercise of community mental health services and inpatient beds [ACTION OWNER COO]	31/03/2019	Further developmental work undertaken. Revised timescale for QUESTT go live to be finalised.	Medium ⬇
Fully embedded Clinical and Operational Assurance Teams	Embed CPD and complete development work for COATs [ACTION OWNER COO]	Completed	Positive assurance received from KPMG internal audit.	Achieved
Gap in knowledge and competence in relation to treatment of autism and support in complex cases	Implement clinical quality improvements as identified in Schedules 4 and 6 in autism treatment during 2018/19 [ACTION OWNER DON]	Completed	All actions completed.	Achieved
Lack of capacity for autism assessment services and non-compliance with the statuary autism act which recommends assessment within 12 weeks	Quality improvement mapping to understand referrals. Sharing this information with commissioners to undertake an equality impact assessment on commissioning decisions [ACTION OWNER DON]	Completed	Completed and included in quality account	Achieved
Clinical buy in to review NICE guidelines	To be evidenced through compliance with quality priorities assessed during Quality Visit programme [ACTION OWNER DON]	Completed	Quality visit season completed for 2018/19. Extensive evidence of the use of NICE guidelines	Achieved

Full compliance with Trust strategy to be 'smoke free'	Further develop improvement plan with ward teams to prevent smoking on inpatient wards to reduce risks of potential fire if smoking in undesignated areas [ACTION OWNER DBI&T]	31/03/2019	E-burn implementation in place. Exploring pilot of E-cigs/vaping in NHS settings. Fire officer monitoring and maintaining fire checks and positive recommendations for improvement in design. No disinvestment by CCG in live well mental health smoking cessation programme. Programme of work continues.	High
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
2018 CQC comprehensive inspection has identified a deterioration in the safety domain across 3 service: adult acute, older people community and learning disability community	Extensive CQC action plan to be developed 'bottom up' with required evidence per area being established at the outset. [ACTION OWNER DON]	Completed	Actions developed bottom up, evidence required very clear. Deputy Director of Nursing reviewing this to ensure delivery closed	Achieved
Effective plan to ensure ability to achieve quality priorities, CQUIN and Non CQUIN targets including 'Sign Up to Safety' and 'Always Events' campaigns	Implement CQUIN action plan for 2018/19, and action plans for 'Sign up to safety' and 'Always Event' campaigns [ACTION OWNER DON]	Completed	CQUIN targets implemented successfully, with exception of flu target.	Achieved
Lack of clinical strategies with Divisional areas.	Develop new clinical strategies for recovery and enablement, substance misuse and Co- existing substance misuse and then Eating Disorders [ACTION OWNER DBI&T]	31/03/2019	Clinical strategies work in place. Dual diagnosis policy to be led by consultant lead from 1st March 19. Eating Disorder clinical strategy paused until new consultant in post.	Medium
Evidence to support sexual safety of patients is maintained across inpatient areas	Identify issues re sexual safety of patients in inpatient areas and develop a plan to improve where gaps are identified [ACTION OWNER DON]	31/03/2019	Trauma conference in February 2019. screening of risk issues and the development of a sexual safety practice guideline in design	Medium
Full compliance with safe use of medicines, with breaches still continuing to be identified.	Improvement plan in place to deliver compliance with medicines management code, including implementation of the Medicines Optimisation Strategy [ACTION OWNER MD]	Completed	Implementation plan for Medicines Optimisation Strategy approved by Quality Committee October 2018	Achieved
Achievement of required levels of compliance with mandatory and role specific training	Increase compliance with mandatory and role specific training requirements [ACTION OWNER COO]	31/03/2019	Some deterioration in performance and concerns re key safety training. Recommendation of additional monitoring at TMT	High
Timely completion of actions following serious incidents and complaints	Increase focus on completion of outstanding actions led by operational managers [ACTION: COO/DON]	31/03/2019	Escalated to Chief Operating Officer and Performance Review Meetings. Open Nursing and Quality Directorate escalated through Deputy Director of Nursing and Quality. Progress is moderate pace	Medium
Evidence of compliance with recommendations from NHS Resolution in relation to suicide related claims	Implement requirements from NHS Resolution reviews of suicide-related claims to help prevent future harm. Implement recommendations and provide assurance [ACTION OWNER MD]	Completed	Update report provided to Quality Committee March 2019, action complete	Achieved
Potential lack of continuity of psychotherapy services following CCG launch of consultation to fully decommission	Complete a Quality Impact Assessment process in line with any QUIPP scheme to disinvest from mental health services and respond to consultation. [ACTION OWNER DON and MD]	Completed	Plan to decommission not pursued by CCG. Action closed	Achieved

Board Assurance Framework Risks 2018/19 v 5.2

Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

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

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Improvement in practice and recording made in inpatient areas yet to be made in community settings	Focused workplan for improving compliance in community team with development of relevant guidance and documentation [ACTION OWNER MD]	31/03/2019	Re-audit completed. Reported to the MHA Operational Group Aug 2018 and MHAC Sept 2018. Improving compliance, plan to re-audit in 3-4 months. Re-audit completed Nov 2018. Compliance remains stable at 67.5% (49.7% Oct 2017, 68.2% May 2018). Clear actions	Low ⬇

			identified to continue to improve compliance. Risk to delivery of action reduced.	
Comprehensive training to support application of MHA and DoLs	Develop and implement comprehensive training plan to support application of MHA and DoLs. [ACTION OWNER MD]	Completed	Training plan in place and monitored by MHA Committee. Action complete.	Achieved
Real time feedback to clinicians following rapid tranquilisation	FSR to be developed to enable pharmacists to give clinicians 'real time' feedback following rapid tranquilisation to their patient. Pilot operation now on Enhanced Care Ward [ACTION OWNER MD]	Completed	Conclusion is that electronic prescribing is required which is part of review of our EPR systems. Action complete	Achieved
Consistent approach to management of Associate Hospital Managers (AHM's)	Develop a plan to ensure a consistent approach is implemented with respect to recruitment, job descriptions, appraisal, offers of appointment and training for AHM's [ACTION OWNER MD]	Completed	Paper presented to Mental health Act Committee March 2019. Action complete.	Achieved
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Evidence of actions taken and embedded following CQC mental health act focused related visits	Action matrix to cover all actions from all units, and to highlight those overdue, to be in place by September 2018 as per KPMG recommendation [ACTION OWNER MD]	Complete	CQC portal functionality now being used to follow up actions. Approach and paper with current position agree at MHAC Sept 2018, Quarterly reporting to MHAC now included in forward plan, next update due Dec 2018..	Achieved
Potential breaches of Section 136 waiting times. (Due to reduction in length of time a person can be held in a S136 suite under the new Police and Crime Bill).	Raise at Board level with escalation to Commissioners [ACTION OWNER MD]	31/03/2019	This risk is impacted on by the difficulties accessing CAMHS/learning disability and PICU places. Issue escalated through ELT to Board. Potential breaches have not materialised since introduction, risk to delivery of action reduced.	Low ⬇

Board Assurance Framework Risks 2018/19 v 5.2

Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

Preventative – Range of physical health related training in place i.e. physical health care screening and monitoring , ILS/BLS, infection control, delirium

Detective – Physical health care monitoring clinics pilots in various trust services

Directive – Physical Health Care Strategy; Physical Care Committee; Trust Infection Control Committee; Drugs and Therapeutics Committee; infection control and tissue viability link nurses; Policies and procedures support a range of physical health interventions and monitoring; 'Smoke Free' Trust, targeted initiatives i.e. sodium valproate

Corrective – Practice Development and Compliance Lead for physical health care, to support ward/team based best practice, Advanced Clinical Practitioners, access to primary care summary records, waiting list action for LD access to SLT

Assurances on Controls (internal):	Positive assurances on Controls (external):
Programme of physical health care related audits and associated action plans	Safety Thermometer

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of single location on PARIS for recording and monitoring of physical health care	Develop a physical health care tile on PARIS to record in a single place all physical health care related information, initially focused on LESTER Tool compliance [ACTION OWNER MD]	31/03/2019	Early Intervention pilot data collection completed. Initial analysis / results identified significant improvement, with approximately 85% of compliance with physical health care checks. Tool requires development to be 'scaled up' for all relevant patients. Physical Health Care Committee to agree way forward Jan 2019. Compliance checks of inpatient proforma and 136 physical health checks in place (paper based). Auditing framework in place.	Medium

Trust led physical healthcare monitoring following initiation of medications	Expand Derby pilot of physical health care monitoring clinics to Chesterfield [ACTION OWNER MD]	Completed	Lead clinician and HCA's appointed. Training package developed, to roll out from Jan 2019, to deliver extension of Derby pilot, and new services in Chesterfield and Amber Valley, to ensure full compliance with LESTER monitoring in these areas.	Achieved
Uptake of intervention focused training re physical healthcare	Compliance reporting and monitoring of hotspots, to target in specific areas, including resuscitation training [ACTION OWNER MD/COO]	31/03/2019	Physical health in mental health e-learning (LESTER), in place for just over 12 months. As of December 2018, compliance is at 72%. Monitored through CQUIN delivery group. CRH providing some additional resuscitation training at Hartington Unit. Increase in ILS compliance, Exploring simulation training and RAMMPS. Trust is part of national learning set. .	Medium
Gaps in communication with GP practices re awareness of SMI cohort leading to potential gaps in physical healthcare monitoring	Continue to work with GP practices to ensure SMI databases are maintained and kept up to date [ACTION OWNER MD]	31/03/2019	Audit of SMI registers undertaken during Q4 17/18 demonstrated 91% compliance with required information shared with GP's. 2018/19 CQUIN requires defined process across Trust, workplan for Derbyshire agreed with Commissioners and public health. Quarterly meetings in place to monitor progress. Solution agreed with IT/IG for our access to primary care summary care records. To explore whether SCR can be uploaded onto Trust EPR systems as administrative routine.	High
Specific process and training to manage sepsis, in line with national guidance	Review the current infection control policies to ensure information around the identification and management of sepsis, and other high profile infections, are in line with current national guidance and best practice	Completed	Sepsis policy developed. Action complete	Achieved
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Consistent monitoring and recording of physical healthcare standards across inpatient and community settings	Develop automated compliance checks and audits in PARIS [ACTION OWNER MD]	31/03/2019	Community 1st contacts, admission and NEWS2 compliance checks in test. 136 checks compliance checks in place.	High
Consistent implementation of the LESTER tool	Scope the implementation of a module in PARIS to enable local teams to receive early notification of patients commencing medication to enable monitoring to be put in place [ACTION OWNER MD]	31/03/2019	Trigger notifications to clinicians involved in a patient's care being developed based on diagnosis to instigate use of LESTER tool. Scoping of implementation of E-prescribing remains underway. Specification and interface issues being explored with development team and CIVICA.. Further work required to develop trigger systems.	High

Board Assurance Framework Risks 2018/19 v 5.2

Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Current policy not fit for purpose	Redesign CPA Policy and approach [ACTION OWNER DON]	Completed	Policy reviewed and revised policy approved by Quality Committee Oct 2018, subject to refinements on operational implementation issues	Achieved
	Engage and consult with social care colleagues and develop collaboratively.[ACTION OWNER DON]	Completed	Positive feedback received on the concept of redefining policy from social care	
	Engage and consult with colleagues around best approach for implementation [ACTION OWNER DON]	Completed	National CPA associate conference held in DHCFT in June 2018, DoH and National speakers on CPA explored the future direction. This learning will be included in the CPA review, all eLearning included in the next draft of CPA policy.	
	Complete revised V3 of CPA policy	Completed	Policy revised and approved	

	Design and redesign training methodology using experts by experience and carers[ACTION OWNER DON] Continual audit of compliance and outcomes., connecting to recovery and enablement strategy.[ACTION OWNER DON] Adopt a learning and scrutiny culture in supervision that reviews the adequacy and meaningfulness of CPA in supervision [ACTION OWNER DON] Embed CPA monitoring into COAT practice and include routinely on compliance and clinical audit programme.[ACTION OWNER COO]	Completed Completed Completed Completed	Operational implementation issues in design Redesign of PARIS CPA information required Findings from community audit of CPA and safety plan reviewed by COAT and reported to July 2018 Quality Committee. Completed Key component of the roll out of the revised CPA policy, the supervision and records audit already monitor these standards. Reports to COATs and summary report to QC has occurred, this approach will continue Findings from community audit of CPA and safety plan will be reviewed by COAT at regular intervals, and monitored at TMT. Performance monitoring against the code of practice standards in final agreed policy. Operational teams to develop implementation strategy, performance monitoring schedule and implement clinical standards. Residual risk to be logged as neighbourhood risk on the risk register.	
Compliance with revised policy	Develop and implement audit of compliance over an 18 month period [ACTION OWNER COO]	31/03/2019	Assistant Director of Clinical Professional Practice leading this development with Heads of Nursing, to be completed by end of March 2019	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Delivery of improvement plan	Production of a 'deep dive' on the improvement plan with evidence of implementation and reporting structures in place [ACTION OWNER COO]	Completed	Deep dive presented to Feb 2019 Quality Committee	Achieved

Strategic Outcome 2. Engagement

Principal risk:

Risk: **There is a risk that if the Trust doesn't engage our workforce and create an environment where they experience the aims and values of the Trust, there will be a negative impact on the morale and health & wellbeing of staff which may affect the safety and quality of patient care**

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

Root causes:

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

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

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

Key controls:

Preventative – Team Derbyshire leader's events to engage leaders. Ongoing wider engagement activities for all staff and staff communications which reinforces vision and values and staff communications which reinforces vision and values. Establishment of network groups i.e. BME, disability and health, and LGBT+. Ongoing dialogue with union representatives via formal and informal routes

Detective – Management and leadership questions from staff survey, staff survey engagement questions. 'Ifti on the Road' programme, programme/wider Board engagement feedback. Wider feedback including concerns raised as part of Freedom to Speak Up

Directive – Leadership development training supporting managers as part of a coordinated Leadership and Development Strategy. Refreshed Trust Strategy which outlines vision and values.

Corrective – Appraisal process (revision of documentation under consultation) and supervision processes. Organisational Development support to teams identified as low engagement or negative feedback

Assurances on Controls (internal):	Positive assurances on Controls (external):
Improvement from staff survey to pulse check evident during 2018. Consistent response rate from pulse checks Report in Chief Executive report to Board and Weekend Note to staff highlighting staff engagement and feedback Positive Staff forum feedback ('You said: We did' infographic) Feedback from Quality Visits Positive feedback from staff forum (limited response)	Positive CQC feedback on embedding of visions and values across a range of service Staff Survey engagement 2018, 54%. Positive trend in survey results Pulse Checks

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Staff survey participation levels in comparison to peer group Positive feedback from network groups (BME Disability and Wellness LGBT+, reverse mentoring)		Friends and Family Test		
Gaps in control:	**Actions to close gaps in control:**	**Review due:**	**Progress on action:**	**Risk to delivery:**
Lack of leadership development strategy	Develop leadership and management development strategy to include: management development; leadership development; coaching and mentoring, reverse mentoring. [ACTION OWNER DPOE]	Completed	Leadership programme now rolling out. Action closed.	Achieved
Further development to embed and coordinate wider engagement activity, including capturing feedback from all engagement activities	Range of activities are in place including Staff Forum, Team Derbyshire Healthcare Leaders events, team briefing, raising concerns, director/CE visits etc. to provide opportunity to engage with staff. Continuing implementation and evaluation of effectiveness to be undertaken including review of feedback captured from all engagement activities. [ACTION OWNER DPOE/DCA]	31/03/2019	Development of structured Director programme of engagement visits to teams from Jan 2019 and ongoing refinement of team brief and encouragement for delivery at team meetings.	Low
Lack of response/analysis of feedback from staff	Broad oversight of feedback from all staff engagement to be coordinated and themes identified in order to address these. Ensure response to issues staff raise and promoting 'you said, we did' to encourage further engagement and feedback. [ACTION OWNER DPOE/DCA]	31/03/2019	Current work programme being aligned to actions identified from 2018 staff survey	Low
Staff awareness and ownership of Trust vision and values	Refreshed Trust strategy, vision and values to be cascaded through Trust and reinforced by staff communication, branding and role modelling from senior leaders. Promotion of examples of positive behaviours in practice to be disseminated and example of this happening in practice celebrated. Ensure staff are aware of what behaviours/practice is not acceptable and how to report this. [ACTION OWNER DPOE/DCA]	31/03/2019		Low ⬇
Gaps in assurances:	**Actions to close gaps in assurances:**	**Review due:**	**Progress on action:**	**Risk to delivery**
Staff survey identifying issues with leadership and management.	Identify resources to implement leadership and management development programme which will help reiterate vision and values, behaviours, expectations for leaders and managers throughout the Trust. [ACTION OWNER DPOE]	31/03/2019	Leadership and Management post now appointed to. Leadership and management development programme now established and being rolled out.	Low ⬇
Staff responses on morale and health and wellbeing questions in staff survey	Address hotspot areas and wider trust actions to address [ACTION OWNER DPOE]	31/03/2019	ELT are finalising investment into staff well-being offer. Deep dive on hotspot areas planned for People and Culture Committee in April 2019.	Moderate ⬇
Coverage of engagement and collated staff feedback themes and evidence of actions to address	Refine team brief and encourage wider implementation, reinforced through Core Leaders programme	31/03/2019	Participation in team brief increasing month and month.	Low ⬇

Board Assurance Framework Risks 2018/19 v 5.2

Strategic Outcome 3. Financial sustainability

Principal risk:

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

Impact: Trust becomes financially unsustainable.

Root causes:

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

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

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

Key controls:

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

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

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

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

Assurances on Controls (internal):	Positive assurances on Controls (external):
Financial performance reports to Trust Board and Finance and Performance Committee evidence the overall actual performance as well as the forecast performance. Includes several sections covering the efficacy of controls include: - CIP delivery achievement - Agency expenditure - Balance sheet cash value The Integrated Performance Report evidences delivery of services, workforce information, quality information set against the financial performance evidencing whether we deliver services within our resources	- Internal Audits– significant assurance with minor learning opportunities for internal audits: 2017/18 Expenditure Data Analytics (3 medium, 1 low risk findings) and 2017/18 Payroll Data Analytics (1 medium, 2 low risk findings) - External Audits – strong record of high quality statutory reporting - Grant Thornton and KPMG audits show good benchmarking for key financial metrics (including liquidity) - NHSI Finance Rating Metrics – shows good performance - National Fraud Initiative – no areas of concern - Local Counterfraud work – Referrals show good counterfraud awareness and reporting in Trust and no material losses have been incurred - Deloitte Well Led review – positive affirmation of the effectiveness of the Finance and

Board Assurance Framework Risks 2018/19 v 5.2

Use of Resources report to Trust Board meeting November 2018 evidences strategic approach to effective use of resources	Performance Committee

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Agency approvals controls are failing to reduce agency expenditure to under the NHSI ceiling level	Executives continue to have regular meetings and take appropriate actions.[ACTION OWNER: COO] AIM: achieve average £250k per month agency spend (or less)	Completed	Agency controls have led to reduced total agency expenditure and better adherence to capped hourly rates, but ceiling not achieved. Agency spend reduced from c£5m in 1617 to c£4m in 17/18 Trust vision/priorities: Financial sustainability – the leading indicators chosen are achieving agency ceiling and recurrent CIP Reported position at end of month 4 (31/7/18) is that we are under agency ceiling. Action closed, to be reopened if required.	Achieved
Cost control/Cost improvement – requirement for firm plans for full 18/19 CIP programme (and longer term pipeline of cost and quality improvement)	QIPP and CIP incorporated into the mental health STP workstream [ACTION OWNER DBI] Increased CIP meetings and project scrutiny, management action via PAB {ACTION OWNER – CEO] AIM: full CIP programme, quality assured. Updated PMO and associated structures with new Director Business Improvement and Transformation in place	Completed	CIP and QIPP continue to be part of Mental Health STP Workstream. New Programme Delivery approach planned. Gap remains: full assured programme for 18/19 required. Further action: ELT decided to reconcile 2018/19 programme which left a c £300K gap and to move focus to 2019/20 programme. PAB had been re-instated, chaired by CEO . PAB now replaced by updated TMT/ELT and Programme Office approach in order to urgently shift the full focus to 2019/20 planning and delivery. Continuous cost and quality improvement remains a key deliverable in the new Director of Business Improvement and Transformation role Efficiency focus for 2019/20 and beyond is informed by the ten main improvement areas described in the Use of Resources paper presented to November 2018 Trust Board The Trust has also engaged with Midlands and East Productivity team regarding opportunities for increased productivity as shown by Model Mental Health Hospital benchmarking	Achieved

Board Assurance Framework Risks 2018/19 v 5.2

Strategic Outcome 3. Financial sustainability

Principal risk:

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

Impact: If not delivered could lead to a deterioration of services available to patients and a negative impact on the Trusts financial position, which could result in regulatory action

Root causes:

a) Priority in other parts of the system i.e. A&E
b) Financial constraints nationally and locally
c) Lack of system wide leadership
d) Lack of engagement with staff from other organisations
e) Changing national directives
f) Regulatory bodies imposing different rules and boundaries
g) Move to system wide working causes tension between loyalty to the system v's sovereign organisation

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

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

Key controls:

Preventative - Maintenance of strong relationships with commissioners particularly mental health and learning disability SRO (Senior Responsible Officer); Close alignment between emerging CCG QIPP plans and STP workstream objectives; Full involvement with appropriate system wide groups; Maintenance of strong relationships with other providers; service receiver engagement; Working openly and honestly with clear line of sight to impacts on sovereign organisation

Detective - Scrutiny of national directives; Translation to local action i.e. are national directives being adhered to?

Directive- Agreed contract with CCG and adherence to Mental Health Investment Standard

Corrective- Ongoing discussions with key stakeholders on proposed changes, progress, establishment of partnerships etc. ; Engagement and consultation with patients, carers, public and staff as appropriate; Interrelationships with other STP workstreams; Active CCG membership and participation in STP Mental Health Delivery Board; Fortnightly CEO and DOF meeting across Derbyshire system

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of capacity and cohesion across clinical pathways	Transform clinical pathways to provide more joined up care (internal focus)[ACTION OWNER DBI&T]	31/03/2019	Development of Trust Clinically-led Strategies commenced in February 2019. Trust continues to be	Medium

			engaged in the development of Places at a locality level	
Delivery of 'Five Year Forward View'	Develop new clinical models for service delivery via Mental Health System Board (external focus). Work with commissioners to deliver Mental Health Investment Standard in developing new pathways and services [ACTION OWNER DBI&T]	31/03/2019	Contract negotiations with commissioners and discussions in the STP MH Delivery Board will prioritise investment areas for the 19/20 MHIS investments	Medium
Level of influence on system wide children's and urgent care QIPP schemes	Ensure Trust is actively participating in workstreams for children and urgent care [ACTION OWNER DBI&T]	31/03/2019	COO attendance at Urgent Care Strategy Board meetings. Meeting scheduled in Oct 2018 with children's commissioners to discuss system approach. General Manager and other staff engaged in Children's STP meetings.	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery.
Compliance with Mental Health Investment Standard	NHS England monitoring of CCG's compliance with investment standard [ACTION OWNER DBI&T]	Ongoing monthly	NHS England will continue to monitor CCG compliance with the investment standard.	Low
Agreed contract with commissioners for 2019/2020	To agree a contract with commissioners which delivers investment in our priority areas and core services, and meets the requirements of the Mental Health investment Standard	31/03/2019	Contract negotiations underway. Trusts executive's directors in process of agreeing priorities for investment. Contract meetings diarised until end of March 2019	Medium
Agreed contractual income results in the need for a cost improvement programme with a very high risk to delivery.	Agreement with commissioners of a contact which delivers core services and priority areas	31/03/2019	Actions as above	High

Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating	Likelihood	Impact	Rating	Likelihood	Impact	Direction	Rating	Likelihood	Impact	Accepted	Tolerated	Not accepted
EXTREME	4	5	EXTREME	4	5	⟷	HIGH	3	5			

Key controls:

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of available staff in hotspot areas	Increase availability of staff in hotspot areas [ACTION OWNER MD/DPOE	31/03/2019	Focused work being undertaken via ELT and PCC on hotspot areas. Actions being taken to address the availability of staff through: reduction of sickness absences, increasing fill rate to vacancies, and increasing bank and agency fill rates where appropriate.	High
Workforce plan to include alternative workforce models both medical and nursing	Work in partnership with clinical pathway work programme to develop workforce models for each pathway with an MDT approach.	31/03/2019	Interim report to PCC in Dec 2018 on current position with medical workforce and alternatives available. Full report to emerge from clinical pathway workforce modelling. Expected by early 2019/20	High

	[ACTION OWNER MD/DPOE]		LBR and Levy funding will be aligned to new emerging workforce models.	
Appeal of the trust as a place to work	Further develop multigenerational offer to attract staff for key national occupational shortages, and for development and retention of staff in key areas [ACTION OWNER DPOE] Develop an 'itchy feet' programme and also consider rotational opportunities across inpatient and community services in order to proactively manage the flow of workforce across these areas [ACTION OWNER DPOE/COO]	31/03/2019 31/03/2019	Starting to offer more flexible contracts to attract staff including staff wishing to return to work following retirement Programme paused to enable capacity to focus on recruitment at this stage.	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
National funding sources to develop our workforce	Gain funding streams from Learning Beyond Registration (LBR), Apprenticeship Levy and STP funding for Mental Health [ACTION OWNER DPOE]	Completed	On track to invest our Levy. Pulled down additional funding from Health Education England for specific projects.	Achieved

Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

Preventative – PARIS training; Bite size courses to support continued learning; Basic IT Training; Provision of equipment to support agile working; PARIS "Play" environment ; Establishment of 'super-user' groups responsive development to Paris concerns, clinical systems lead support to teams.

Detective – Audits and compliance checks; monitoring of Enhancement log requests through CRG; Work with ward and community teams to understand how clinical functions work using patient records

Directive – Clinician led Paris (FSR) Clinical Reference Group reporting to TMT/ELT and Quality Committee in order to review current PARIS functionality and develop a work programme to enhance the FSR based on clinical feedback

Corrective – Engagement with staff to rationalise documentation and improve user interface; Learning based visits to other Trusts using PARIS and other FSR's

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Clear specification for improvements required	Develop clear specification of improvements required to PARIS, with project plan, and timeline to meet agreed scope. FSR CRG to develop plan and report	31/03/2019	Inpatient pro-forma being tested, to launch by April 2019. Physical healthcare specification completed, To be rolled out from April 2020.	Low

	back to the Finance and Performance Committee [ACTION OWNER COO]			
Confidence of staff in using the FSR to enhance patient care	-Ongoing support and review from Clinical systems lead -Involve clinicians in the FSR CRG to seek opinion and advice. -Ensure focus is maintained on reducing complexity and number of templates and time taken to complete by staff [ACTION OWNER COO] -Identify medical clinical information officer to develop clinical involvement in PARIS [ACTION:MD]	Ongoing Completed Completed Completed	Additional training sessions continue to be delivered in locations across the organisation. Increased number of clinicians now attending the FSR CRG (5) Now robust challenge to request for new forms and streamline of forms is business as usual toward achieving single tool for supporting clinical practice with specialist elements, rather than individualised forms for each clinical area. Job description approved by ELT. Recruited	Low
Fragmented recording of physical healthcare information on PARIS	Remapping of physical healthcare health care recording and monitoring on PARIS [ACTION OWNER MD]	31/03/2019	Specification nearing completion and is partially built on Paris.	Medium
Limited staff engagement with safety planning process	Developing the safety plan framework on PARIS in line with commissioner feedback to include a stepped approach to safety planning and review of the existing form [ACTION OWNER MD]	Completed	Safety plan development is on track. Developers have the new specifications and these are being built. Teams in place to test new form	Achieved
Too many locations on PARIS to record same information	-Rationalisation and reduction of clinical documents held on PARIS -Conversation of 'forms' to 'locations' to centralise similar clinical information in one place. -Increasing auto population of forms where relevant -Development of tiles to improve access to key information (Care planning/ physical health care/ safety planning [ACTION OWNER COO]	31/03/2019	Around half of forms on enhancement log have now been rejected or amalgamated thus reducing the number of forms available to staff. Audit of little used forms in place, and around 30 have been removed as assessed as not required.	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Oversight of other Trust development of FSR's	Continue to develop supporting arrangements with other Trusts using PARIS and other EPR's to support learning and development [ACTION OWNER COO]	Completed	Trust colleagues have visited another trust that uses Civica to establish what learning can be transferred to our own trust. Any positive learning is being reviewed at the CRG meeting. Trust actively engages with the wider user network on an ongoing basis as required.	Achieved

Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Workforce plan: Oversight of delivery via fully functioning strategic workforce groups. Leadership ownership of the plan with sponsors for introducing new roles	Reshape the strategic workforce group and education group membership. [ACTION OWNER DPOE]	Completed	Year 2 workforce plan has been agreed. Investment into key roles such as Nursing Associates, Nursing Apprentices and ACP's agreed. ELT and PCC to track progress. New strategic workforce and education group in place.	Achieved
Funding: Ownership across the leadership team to transform current gaps in supply to new posts. Trust and HEEM funding availability	Executive oversight at ELT to delivery and transformation. HEEM funding – bid for every available work stream [ACTION OWNER DPOE]	31/03/2019	Medical Director working with workforce planning lead and chief nurse to present a paper to PCC for Dec 2018 and a revised workforce model per clinical pathway to emerge from clinical pathway work. Clinical strategies to be developed and agreed by Sept 2019	High
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to

				delivery
Lack of regular review at ELT and strategic workforce group of workforce plan delivery	Increase the focus on the ELT and Strategic workforce groups quarterly [ACTION OWNER DPOE]	Completed	Strategic Workforce Group now meets monthly and engages across all parts of the organisation and has a balanced agenda between strategic and operational issues.	Achieved

Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating	Likelihood	Impact	Rating	Likelihood	Impact	Direction	Rating	Likelihood	Impact	Accepted	Tolerated	Not accepted
HIGH	4	4	EXTREME	5	4	⟷	MODERATE	3	4			

Key controls:

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

Directive – 'LEAN' based approaches to service change; Recruitment to key leadership posts in acute care i.e. Urgent Care Improvement Lead, Clinical Lead, 136. – Clinical Lead, General Manager secondment, Clinical Director. Coaching support by Programme Assurance Office and Head of Programme Delivery. Introduction of Royal College of Psychiatry Standards to provide service with a framework to inform practice

Corrective – Board reporting on Trust Strategy; Dementia Rapid Response Teams; In-reach to Ward 1; CAMHS home treatment model; Ongoing engagement with urgent care staff

Assurances on Controls (internal):	Positive assurances on Controls (external):
Bed status dashboard Red2Green weekly tracker Monthly Integrated Performance Report to Board	CMHT Community Service Survey CQC 2018 comprehensive review (gaps in assurance)

Gaps in control:	Actions to close gaps in control:	Review due	Progress on action:	Risk to delivery:
Lack of clear Urgent and Emergency Care clinical model	Deliver 100 day plan. Plan focuses on delivering improvements to: clinical standards and re-energising clinical practice; improving clinical and operational leadership and staff engagement; redesigning and transforming service model; delivering and supporting staff; improving the physical environment. [ACTION OWNER COO]	Completed	100 day plan delivered and closed, longer term actions being implemented. All identified posts recruited to. Leadership and management review completed and recommendations being implemented. PARIS app launched to enter data from a hand held device. Community Clozapine Initiation clinic developed to take pressure off inpatient beds. Bank fill rates above 80%. Royal College of Psychiatry Standards introduced, self-review completed.	Achieved

			Increased support for clinical leaders to monitor and manage absences. 25 new starters to Radbourne and Hartington Units.	
Lack of clearly defined clinical pathways	Agree and implement clearly defined clinical pathways to ensure people are cared for by the right staff with the right skills for the right length of stay [ACTION OWNER COO]	31/03/2019	Project plan in place for developing personality disorder pathway	High
High numbers of patients with length of stay over 50 days	Identify causes of delayed discharges and review practice to ensure discharge process starts at point of admission in order to reduce length of stay. Work more closely with stakeholders such as social care to support reduction in length of stay. [ACTION OWNER COO]	31/03/2019	Out of area programme of work agreed as part of CIP and continuous improvement programme. Specific projects either developed or in development to improve patient flow.	High
High vacancy rates and and high levels of sickness absence in urgent care services	Deliver bank fill rate of 80% for Radbourne Unit and CRHT [ACTION OWNER COO]	31/03/2019	Bank fill rate for acute services remains below 80%	Medium
Increased use of health services by some high risk individuals	Improve packages for high intensity users of health services through projects supporting the acute care pathway [ACTION OWNER COO]	Completed	High intensity users project (JET -Joint Intensity Team) team commenced. Training commenced and working through cohort of patients identified. Continues to progress well, action closed	Achieved
Delayed discharges above specified lengths of stay	Bed optimisation project, including 'Red2Green' project implementation to increase flow in inpatient areas [ACTION OWNER COO]	31/03/2019	Red2Green continues to be undertaken across all wards, data being collated to evaluate impact. Improvement plan being delivered which will include a focus on further reducing lengths of stay. Continued escalation focus on patients who have stayed in hospital over 50 days, evidence of impact. Regular escalation meetings in place with local authority around detox.	Medium ⬇
High caseloads and long waiting lists in community based mental health teams	Complete Neighbourhood review, to ensure services are meeting commissioned needs in line with 'Joined Up Care Derbyshire' approach [ACTION OWNER COO]	Completed	Recommendations from Neighbourhood review being implemented, linked with person disorder pathway work	Achieved
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Continued high use of out of area beds resulting in reduced patient experience and financial impact	Actions outlined above to be implemented, with an expectation that they will reduce demand on beds but will not reduce to levels sufficient to impact on risk rating i.e. consistent low level usage of out of area beds, of around 1-2 patients. [ACTION OWNER COO]	Completed	As outlined above. Going forward overall strategic review required, aligned to estates strategy and risk 1a of the BAF relating to patient safety and experience. Out of area use reduced and stabilised to approx. 6-7 patients.	Achieved

Board Assurance Framework Risks 2018/19 v 5.2

Risk Assessment Matrix

The Risk Score is simply a multiplication of the Consequence Rating x the Likelihood Rating.
The Risk Grade is the colour determined from the Risk Assessment Matrix below.

LIKELIHOOD	CONSEQUENCE				
	INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
RARE 1	1	2	3	4	5
UNLIKELY 2	2	4	6	8	10
POSSIBLE 3	3	6	9	12	15
LIKELY 4	4	8	12	16	20
ALMOST CERTAIN 5	5	10	15	20	25

Risk Grade/ Incident Potential
Extreme Risk
High Risk
Moderate Risk
Low Risk
Very Low Risk

Summary Board Assurance Framework Risks 2019/20. Issue 1.2

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)
Strategic Objective 1. To provide GOOD care in all services			
19_20 1a	There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board	Executive Director of Nursing/Medical Director	HIGH 4x4
19_20 1b	There is a risk that the Trust estate does not comply with regulatory and legislative requirements	Chief Operating Officer	HIGH 4x4
Strategic Objective 2. To be a GREAT place to work			
19_20 2a	There is a risk that the Trust will not be able to retain, develop and attract enough staff to protect their wellbeing to deliver high quality care	Director of People and Organisational Effectiveness	EXTREME 4x5
Strategic Objective 3. To make GOOD use of our money			
19_20 3a	There is a risk that the Trust fails to deliver its financial plans	Executive Director of Finance	EXTREME 4x5
19_20 3b	There is a risk that the Trust fails to influence external drivers (such as the STP and BREXIT) to effectively engage in enhancing service models	Chief Executive Officer	HIGH 4x4

Summary Board Assurance Framework Risks 2019/20. Issue 1.2

Strategic Objective 1. To provide GOOD care in all services

Principal risk: There is a risk that the Trust will fail to provide standards for safety and effectiveness required by our Board

Impact: May lead to avoidable harm including: increased morbidity and mortality; delays in recovery; and longer episodes of treatment; affecting patients, their family members, staff, or the public

Root causes:

a) Financial settlement in contracts chronically underfunded
b) Workforce supply and lack of capacity to deliver effective care across all services
c) Substantial increase in clinical demand
d) Increasing patient and family expectations of service
e) Changing demographics of population
f) Lack of stability of clinical leadership at all levels
g) Lack of compliance with CQC standards
h) Lack of embedded outcome measures
i) Known links between SMI and other co-morbidities, and increased risk factors in population
j) Lack of processes for communication between primary and secondary care with respect to physical health monitoring

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction 1st issue	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Quality governance structures, teams and processes to identify quality related issues; Induction and mandatory training; 'Duty of Candour' processes; clinical audits and research, health and safety audits and risk assessments, physical health care screening and monitoring

Detective – Quality dashboard reporting; Quality visit programme; Incident, complaints and risk investigation; Annual Training Needs Analysis; HoNoS clustering; FSR compliance checks; mortality review process; Physical health care monitoring clinics pilots; Daily assurance safety check log

Directive – Quality Improvement Strategy. Physical Health Care Strategy; Recovery Strategy; Policies and procedures available via Connect; CAS alerts; Clinical Sub Committees of the Quality Committee

Corrective – Board committee structures and processes ensuring escalation of quality issues; Annual skill mix review; CQC action plans; Learning from incidents, complaints and risks; Actions following clinical and compliance audits; Workforce issues escalation procedures; Reporting to commissioner led Quality Assurance Group on compliance with quality standards

Assurances on Controls (internal):	**Positive assurances on Controls (external):**
Quality and NHSI dashboard Scrutiny of Quality Account (pre-submission) by committees and governors Programme of physical healthcare and other clinical audits and associated plans	National enquiry into suicide and homicide NHLSA Scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2018, 11 services area domains improved, 5 deteriorated; Identified Trust fully compliant with NQB Learning from Deaths guidance.

		2017/18 BAF and Risk Register Reviews (internal audit) Schedule 4/6 analysis and scrutiny by commissioners			
Key gaps in control:	**Key actions to close gaps in control:**	**Impact on risk to be measured by:**	**Action review date:**	**Summary of progress on action:**	**Action on track:**
Effective plan to ensure urgent care is improved to a level that the CQC would assess and rate as at least 'requires improvement' across all domains	Delivery of plan for urgent care to meet CQC rating of least 'requires improvement' delivered by May 2019 [ACTION OWNER DON/MD/COO]	Outcome of acute core service CQC inspection. Due May 2019	31/05/2019		
Compliance with physical healthcare standards as outlined in the Physical Healthcare Strategy	Develop and agree a Physical Healthcare Strategy Implementation Plan (by June 2019) [ACTION OWNER MD]	Implementation of year 1 targets as identified within Physical Health Care Strategy Physical health care dashboard reporting (specific measurables with respect to % compliance to be identified and added)	31/03/2020 30/09/2019		
Effective plan to ensure ability to achieve quality priorities, CQUIN and Non CQUIN targets	Implement CQUIN action plan for 2018/19 (by March 2020) [ACTION OWNER DON]	Delivery of CQUIN targets for 2019/20 Quarterly submissions to Commissioners on achievements to date	31/03/2020 30/06/2019		
Care plans and /or relapse prevention plans effectively involve the patient concerned	Ensure care and/or relapse prevention plans are person centred and made available to the patient involved (by March 2020) [ACTION OWNER DON]	85% of care and /or relapse prevention plans are assessed as patient centred and are made available to the patient	30/06/2019		
Effective implementation of NICE/best practice guidance	Evidence of individual teams implementation of NICE guidance, evidenced through the Quality Visits (by close of 19/20 Quality Visit programme) [ACTION OWNER DON]	100% of clinical teams can evidence use of NICE guidance	30/09/2019		
Effectively implemented plan to ensure continuous quality	Identify gaps to delivery of quality improvement against NHSI guidance and	Achievement of the 19/20 milestones and any 18/19	30/09/2019		

improvement in the Trust in line with NHSI guidance	implement agreed Quality Improvement Plan (by March 2020) [ACTION OWNER DBI&T] Evidence of individual teams development of a quality initiative, evidenced through the Quality Visits (by close of 19/20 Quality Visit programme). [ACTION OWNER DON]	milestones that have not yet been delivered of the Quality Improvement Implementation plan 100% of clinical teams can evidence implementation of a quality initiative	 30/09/2019		
Lack of coherent vision of the purpose of services at pathway level with a clear plan of how services need to adapt to meet changes in the demand	Workshop for clinically led strategy development (by June 2019) [ACTION OWNER DBI&T] Strategies agreed by Board (by Sept 2019) [ACTION OWNER DBI&T] Governance around implementation agreed by May 2019 and implemented from June 2019 [ACTION OWNER DON/MD/COO]	Delivery of outcomes as defined in implementation plan for clinically led strategy development	31/05/2019		
Lack of a co-ordinated approach to collecting and acting on patient feedback across all services	Develop and implement a Patient Experience Strategy (by March 2020) [ACTION OWNER DON]	Agreed Patient Experience Strategy to Board (by July 2019) (specific measurables with respect to impact to be identified and added)	31/07/2019		
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Action review due:**	**Summary of progress on action:**	**Action on track:**
Gaps identified in CQC comprehensive assessment of services June 2018 (reported in September 2018) and Mental Health Act focused inspections	Completion of CQC action plan following the 2018 CQC comprehensive inspection (by May 2019) [ACTION OWNER DON/MD/COO]	Completion of all actions following CQC comprehensive inspection Completion of all actions	31/05/2019 31/07/2019		

undertaken throughout year	Completion of all actions following MHA focused CQC inspections (by timescales agreed in individual reports) [ACTION OWNER DON/MD/COO	following MHA focused CQC inspections			
Achievement of Royal College of Psychiatrists (RCP) Standards across Acute Services	Complete RCP self-assessment (date tbc) Develop and implement plan to achieve RCP standards (date tbc) [ACTION OWNER MD/DON/COO]	Achievement of RCP Standards	30/09/2019		

Summary Board Assurance Framework Risks 2019/20. Issue 1.2

Strategic Objective 1. To provide GOOD care in all services

Principal risk: There is a risk that the Trust estate does not comply with regulatory and legislative requirements

Impact: Low quality care environment
Crowded staff environment
Non-compliance with statutory care environments
Non-compliance with legal requirements for asbestos, legionella and electrical compliance

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction 1st issue	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Routine environmental assessments for legionella and asbestos; Environmental risk assessments reported through Datix;
Detective – Monthly reporting progress against Premises Assurance Model (PAM) to TMT
Directive – Capital Action Team role in scrutiny of capital projects
Corrective – Short term investment agreed to support key risk areas

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Health and Safety Audits	

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Action review date:	Progress against action:	Action on track:
Board approved Estates Strategy for 5 years, and implementation of 2019/20 plan	Estates strategy engagement event to finalise strategy (by Sept 2019) [ACTION OWNER COO] Present Estates Strategy to Board (by Nov 2019) [ACTION OWNER COO] Implement relevant year 1 milestones set out in the Estates Strategy	Agreed Estates Strategy (by Oct 2019) Achievement of 2019/20 milestones and target identified within the Estates Strategy	31/08/2019 31/12/2019		

	implementation (date to be determined in line with key dates outlined in the plan) [ACTION OWNER COO]				
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Action review due:**	**Progress against action:**	**Action on track:**
Comprehensive assessment of estates compliance with statutory legislation with Board approved improvement plan	Completion of self-assessment of premises assurances model (PAM) and plan for annual reassessment (by April 2019) [ACTION OWNER COO] Development of an agreed 2019/20 action plan, prioritised by level of risk (by April 2019) [ACTION OWNER COO] Associated resource plan agreed (April 2019) [ACTION OWNER COO]	Achievement of statutory compliance with legionella, electric, asbestos (by March 2020)	31/05/2019		
Lack of assurance on full cycle of governance for estate compliance	Implement best practice with identified skilled roles to ensure routine regulatory and legislative checks are completed (to commence April 2019) [ACTION OWNER COO]	Compliance reporting to TMT with specific risks identified as part of PAMS reporting (to continue monthly from March 2019)	31/05/2019		

Summary Board Assurance Framework Risks 2019/20. Issue 1.2

Strategic Objective 2. To be a GREAT place to work

Principal risk: There is a risk that the Trust will not be able to retain, develop and attract enough staff to protect their wellbeing to deliver high quality care

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

Root causes:

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

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction 1st issue	Rating HIGH	Likelihood 3	Impact 5	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Resourcing Plan covering wide range of recruitment channels.
Detective – Performance report identifying specific hotspots and interventions to increase recruitment.
Directive – Wellbeing strategy, infrastructure and programmes to support staff health and wellbeing. Workforce plan to grow and develop the workforce.
Corrective – Leadership and Management Strategy and development programmes to build inclusive and engaging leadership and management. Leadership Programme Launch – Core Leaders.

Assurances on Controls (internal):	Positive assurances on Controls (external):
Bi Monthly People Performance Report to Trust Management Team, Executive Leadership Team and People and Culture Committee, includes recruitment tracker Workforce Supply Hot Spot report to Trust Management Team and People and Culture Committee Workforce Plan delivery monitored monthly by the Strategic Workforce Group	Staff survey, high level of participation for 2018 Pulse Checks CQC visits identify caring and engaging staff

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Action review date:	Progress against action:	Action on track:
Gaps in the effective recruitment and retention plan to fill substantive and bank posts	Monthly tracking of People Performance: turnover and recruitment hot spots, with focused actions [ACTION OWNER DP&OE, COO]	Reduction in vacancies in identified hotspot areas to below 10%	30/06/2019		

Fully delivered leadership and management development programme	Roll out of the Leadership Launch and masterclasses (by June 2019) and monitor up take. Move from Pilot to scale for 360 feedback leadership tool [ACTION OWNER DP&OE]	90% of Leaders attend the Leadership Launch 50% update of Management Masterclasses	31/03/2020 31/03/2020		
Gaps in colleagues health and wellbeing provision and infrastructure	Agree investment wellbeing offer by the Executive Leadership Team (Completed March 2019) [ACTION OWNER DP&OE Review Occupational Health contract to include rapid access to musculo-skeletal services. Roll out access to counselling service [ACTION OWNER DP&OE, COO]	Reduction in sickness absence rates to 5% or below (target date tbc as linked to CIP agreement) Increased uptake of staff flu vaccination to 75%	(date tbc) 01/03/2020		
Development of a funded Workforce Plan	Develop and implement Year 1 of the Workforce Plan (by March 2020)	Utilisation of the Apprenticeship Levy Use of CPD, DHCFT Investment decisions (by when and how measured to be determined)	31/03/2020		
Staff reporting being disadvantaged due to their protected characteristics	Action plans to be approved and implemented for staff with protected characteristics (by March 2020). To be monitored by Board	Annual publication of Workforce Race Equality Standard data, identifying an improved position	31/03/2020		
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Action review due:**	**Progress against action:**	
Training compliance in key areas below target set by the Trust	Review and simplify mandatory training requirements to align to an individual's role and contract [ACTION OWNER DP&OE, COO] Improve E-Learning offer, including improvements in terms of ease of use	90% of staff achieve their mandatory training requirements (by March 2020)	31/03/2020		

	[ACTION OWNER DP&OE]				
Evidence of safer staffing levels of suitably qualified staff	Compliance with NHSI Workforce Safeguards requirements (by March 2020) [ACTION OWNER DP&OE, COO/MD/DON]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	30/09/2019		

Summary Board Assurance Framework Risks 2019/20. Issue 1.2

Strategic Objective 3. To make GOOD use of our money

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

Impact: Trust becomes financially unsustainable

Root causes:

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

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

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

Key controls:

Preventative – Budget training, segregation of duties, contract team to manage with commissioning risk, mandatory counterfraud training and annual counterfraud work programme. Project Vision system controls for CIP/CI

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

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

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

Assurances on Controls (internal):	Positive assurances on Controls (external):
Delivery of plan, in-year and forecast outturn for overall Trust financial plan Delivery of Continuous improvement including CIP (through appropriate mix of waste reduction and year-on-year actual cost reduction, productivity improvement and successful budget reduction Delivery of Counterfraud and audit work programme with completed and embedded actions for all recommendations Independent assurance via internal auditors, external auditors and counterfraud specialist that the figures reported are valid and systems and processes for financial governance are adequate Use of Resources report to Trust Board meeting November 2018 evidences	- Internal Audits– significant assurance with minor learning opportunities for internal audits: 2017/18 Expenditure Data Analytics (3 medium, 1 low risk findings) and 2017/18 Payroll Data Analytics (1 medium, 2 low risk findings) - External Audits – strong record of high quality statutory reporting - Grant Thornton audits show good benchmarking for key financial metrics (including liquidity) - NHSI Finance Rating Metrics – shows good performance - National Fraud Initiative – no areas of concern - Local Counterfraud work – Referrals show good counterfraud awareness and reporting in Trust and no material losses have been incurred

strategic approach to effective use of resources	- Deloitte Well Led review – positive affirmation of the effectiveness of the Finance and Performance Committee

Key gaps in control:	Key actions to close gaps in control:	Impact on risk to be measured by:	Action review date:	Progress against action:	Action on track:
Delivery of a continuous improvement (CI) plan that will meet requirements for financial sustainability and quality improvement driven by the Use of Resources top ten	Plans to be finalised before commencement of 19/20 financial year (by March 2019) [ACTION OWNER DBI&T] Reporting of future continuous improvement and 19/20 CIP schemes – plan and actual delivery throughout year [ACTION OWNER DBI&T]	Achievement during year of planned 19/20 CIP savings totalling £5.9m. Quarterly reviews in place for CIP and pipeline Size of pipeline for continuous improvement plans for future years	30/06/2019		
Delivery of specific benefits realisation as described in investment cases, including the Mental Health Investment Standard	CCG Contract sign-off including MHIS investments (by April 2019) [ACTION OWNER DBI&T] Collation of summary of expected benefits to be realised from key investments in 19/20 (by March 2019) [ACTION OWNER DBI&T]	Impact of investments measured and reported in year as part of quarterly updates to the Finance and Performance Committee	30/06/2019		
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Action review due:**	**Progress against action:**	**Action on track:**
Inconsistency of managers' application of appropriate HR policy e.g. secondary employment and working while sick, in order to close practice gaps identified by previous counterfraud referrals	Implementation of group Counterfraud meetings with HR, Finance and LCFS to support targeted training and oversight (meetings in place by end March 2019) [ACTION OWNER DOF]	Reduction in counterfraud findings related to application of relevant HR process	30/09/2019		

Summary Board Assurance Framework Risks 2019/20. Issue 1.2

Strategic Objective 3. To make GOOD use of our money

Principal risk: There is a risk that the Trust fails to influence external drivers (such as the STP and BREXIT) to effectively engage in enhancing service models

Impact: If not delivered could lead to a deterioration of services available to patients and a negative impact on the Trusts financial position, which could result in regulatory action

Root causes:

a) Priority in other parts of the system i.e. A&E
b) Financial constraints nationally and locally
c) Lack of system wide leadership
d) Lack of engagement with staff from other organisations
e) Suddenly changing national directives out with control of the Trust
f) Regulatory bodies imposing different rules and boundaries
g) Move to system wide working causes tension between loyalty to the system v's sovereign organisation
h) Unresolved political decision making regarding BREXIT
i) Political time spent on BREXIT taking time from other priorities

BAF ref: 19_20 3b	**Director Lead**: Ifti Majid. Chief Executive Officer	**Responsible Committee**: Board	Datix ID: tbc

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction 1st issue	Rating LOW	Likelihood 2	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative - Maintenance of strong relationships with commissioners particularly mental health and learning disability SRO (Senior Responsible Officer); Close alignment between emerging CCG QIPP plans and STP workstream objectives; Full involvement with appropriate system wide groups; Maintenance of strong relationships with other providers; service receiver engagement; Working openly and honestly with clear line of sight to impacts on sovereign organisation; CEO representation on national Mental Health Network Board

Detective - Scrutiny of national directives; Translation to local action i.e. are national directives being adhered to?

Directive- Agreed contract with CCG and adherence to Mental Health Investment Standard

Corrective- Ongoing discussions with key stakeholders on proposed changes, progress, establishment of partnerships etc. ; Engagement and consultation with patients, carers, public and staff as appropriate; Interrelationships with other STP workstreams; Active CCG membership and participation in STP Mental Health Delivery Board; Fortnightly CEO and DOF meeting across Derbyshire system

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

- Engagement with staff though managers, staff side, focus groups etc - CEO's Board Report providing strategic scan of national policy landscape					
Key gaps in control:	**Key actions to close gaps in control:**	**Impact on risk to be measured by:**	**Action review date:**	**Progress against action:**	**Action on track:**
National policy and local implementation focuses on organisations in deficit and those that provide urgent care, leading to the Trust not receiving the focus they deserve	Maintain senior open dialogue with commissioners being prepared to escalate through contract mechanisms any failure to deliver national MHIS contract expectations [ACTION OWNER CEO] Have a strong senior leadership presence in system Board and Executive meetings as well as the emerging provider alliance Boards and urgent care strategy forums – this will require re-prioritisation of Executive and next in line capacity [ACTION OWNER CEO] Lead the development of an updated STP mental health system plan ensuring it is approved through Joined Up Care Derbyshire governance [ACTION OWNER CEO]	Maintenance of separate working groups at a system level relating to our core services led by Trust senior leaders Agreed contract in place for 19/20 that does not require external mediation. Delivery of the Mental Health Investment Standard and support to core services within it. Delivery of the STP MH QIPP savings and realise reinvestment of all savings into MH programme spend. Full *Futures in Mind* allocation passed to the Trust by commissioners	30/09/2019		
Lack of full understanding as to the impact to the Trust of leaving the EU in relation to essential supplies, impact on research and development, impact on staffing availability and logistics such as petrol	Maintenance of an up to date EU Exit risk assessment until the risk nationally has deemed to have reduced [ACTION OWNER COO] Ensure colleagues within the Organisation are aware of the key risks and mitigating actions [ACTION OWNER COO]	The lack of major or critical incidents affecting the Trust resulting from risks associated with leaving the EU	30/06/2019		

	Link in with Joined Up Care Derbyshire colleagues to ensure that where actions are needed that can be completed at a system level this is carried out [ACTION OWNER COO] Respond to requests for information from the national leadership team as these could inform changes in actions required of our Trust [ACTION OWNER COO]				
Key gaps in assurance:	**Key actions to close gaps in assurances:**	**Impact on risk to be measured by:**	**Action review due:**	**Progress against action:**	**Action on track:**
Lack of assurance with respect to the impact of national policy, in particular in relation to the: Long Term Plan; Integrated Care Systems, Revisions to the Mental Health Act; Fit and Proper Persons which may impact on the governance mechanisms and or clinical service delivery within our organisation	Continue to utilise opportunities to influence and lobby at a national level through attending MHN Board national and regional CEO and Chair meetings [ACTION OWNER CEO] Development of a stakeholder register including local MP's to ensure they are briefed on risks to and opportunities for our local population relating to proposed policy change [ACTION OWNER CEO] Attendance at regional events such as Regional CEOs meeting as these feed into NHSI/E at a national level and provide a conduit for influencing policy changes [ACTION OWNER CEO]	Trust maintenance of full compliance with regulatory standards Plans for policy and or legislation changes are developed in a timely way to enable effective implementation	30/06/2019		

Summary Board Assurance Framework Risks 2019/20. Issue 1.2

Risk Rating:

The summary score for determining the risk ratings for each risk is shown below. The full Risk Matrix, including descriptors, is shown in the Trusts Risk Management Strategy

Risk Assessment Matrix						
The Risk Score is simply a multiplication of the Consequence Rating x the Likelihood Rating. The Risk Grade is the colour determined from the Risk Assessment Matrix below.						
LIKELIHOOD	**CONSEQUENCE**					
	INSIGNIFICANT 1	**MINOR 2**	**MODERATE 3**	**MAJOR 4**	**CATASTROPHIC 5**	
RARE 1	1	2	3	4	5	
UNLIKELY 2	2	4	6	8	10	
POSSIBLE 3	3	6	9	12	15	
LIKELY 4	4	8	12	16	20	
ALMOST CERTAIN 5	5	10	15	20	25	

Risk Grade/ Incident Potential
Extreme Risk
High Risk
Moderate Risk
Low Risk
Very Low Risk

Action progress:

The previous 'risk to delivery' of the action detailed in the 2018/19 BAF has been changed for 2019/20 to detail if the action is on track to delivery. The colour ratings are based on the following descriptors.

Actions on track for delivery against gaps in controls and assurances:	**Colour rating**
Action completed or on track to completion within proposed timeframe	Green
Action implemented in part with potential risks to meeting proposed timeframe.	Amber
Action not completed to timeframe. Revised plan of action required.	Red

Action owners:

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 April 2019

DHCFT - Preparations for BREXIT

Purpose of Report

To provide Board members with an update on the Trust's current preparations in the event on a no deal BREXIT.

Executive Summary

All provider trusts received a letter (attached) from Professor Keith Willett (EU Exit Strategic Commander) on 20 March requesting the following;

To achieve that readiness we now ask that by next Monday (25 March) provider trusts will have brought together members of their senior executive team with their EU Exit SRO and EU Exit team, and directors or lead managers from key areas (such as pharmacy, estates, facilities and procurement) to scrutinise preparations to operate under the conditions of a no deal. Representatives from your Clinical Commissioning Groups and Local Resilience Forum should also attend where possible. We also recommend that you include non-executive directors to critique that preparation. CCGs should organise similar sessions.

Please ensure your incident management procedures are now in place and are scalable if multiple issues arise, including: NHS England and NHS Improvement-working together for the NHS

- *A single point of contact for local and national partners*
- *Clinical reference points in the event of issues such as supply shortages*
- *A local communication plan is in place*
- *On-call directors understand what is required of them and the escalation routes for problems*

We will require an assurance from your Board of your organisation's plans and preparedness by close of play Monday 25 March, using the attached template.

This request was undertaken on Thursday 21 March by the Trust's EU Exit Senior Responsible Officer along with nominated colleagues from the Trust's EU Exit team. The attached template is what was agreed by the team and submitted to the Trust Chair and CEO for approval on behalf of the Board. Following Chair and CEO approval it was submitted as requested to our regional EU Exit team on Friday 22 March.

This report is for Board members' information.

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.	

Assurances

Board members can take assurance from the preparation that colleagues from across the Trust have undertaken. National guidance is being followed by service areas and being reviewed as further guidance is released.

Consultation

The completed template has not been received by any other group or committee.

Governance or Legal Issues

There are many unknowns relating to a no deal Brexit and therefore there could be specific governance and legal issues that may arise beyond 29th March.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

If there were to be a no deal Brexit, there may be impact not only on our own services but also on wider health and social care services, which, could lead to potential adverse effects on members of those populations with protected characteristics in the REGARDS groups.

As this is an evolving situation it is difficult at this time to fully assess the risk to understand what actions could be taken to minimise this. However, this will need to be kept under review.

Recommendations

The Board of Directors is requested to note the submission

Report presented by: **Mark Powell – Chief Operating Officer**

NHS England
PO Box 16738
Redditch
B97 9PT

Publishing Approval Reference 000370

20 March 2019

Dear colleagues,

Further to my letter of 4th February and the subsequent regional EU Exit events I am writing at the request of the Department of Health and Social Care to update you on progress with the UK's negotiations to exit the European Union. We are grateful for your excellent engagement over the last few months - our NHS plans are well advanced as a result.

As you will no doubt be aware, the House of Commons last week voted against the UK leaving the European Union without a deal, and in favour of extending Article 50. Votes this week mean it is still possible that we can leave on 29 March with a deal, although time is very short.

However, the Department has made clear to us that unless and until a Withdrawal Agreement is ratified by the UK and the European Parliament, or until any extension is agreed by the EU, the legal default in UK and EU law remains that the UK will leave the EU on 29 March 2019 without a deal. We must therefore **continue to plan for a no deal outcome** on 29 March.

The Department of Health and Social Care will continue to implement its no deal plans in full, and we are writing in similar terms to all other organisations in the health and care system to ask they continue with their no deal plans.

Please therefore continue to check that you are as ready as you can be for the possibility of a no deal exit from the EU. This includes working with your system partners to ensure you are on track with your operational and commercial preparations, as set out in the Department's operational guidance and the recent regional NHS events (slides attached).

To achieve that readiness we now ask that by next Monday (25 March) provider trusts will have brought together members of their senior executive team with their EU Exit SRO and EU Exit team, and directors or lead managers from key areas (such as pharmacy, estates, facilities and procurement) to scrutinise preparations to operate under the conditions of a no deal. Representatives from your Clinical Commissioning Groups and Local Resilience Forum should also attend where possible. We also recommend that you include non-executive directors to critique that preparation. CCGs should organise similar sessions.

Please ensure your incident management procedures are now in place and are scalable if multiple issues arise, including:

- A single point of contact for local and national partners
- Clinical reference points in the event of issues such as supply shortages
- A local communication plan is in place
- On-call directors understand what is required of them and the escalation routes for problems

We will require an assurance from your Board of your organisation's plans and preparedness by close of play Monday 25th, using the attached template.

The EU Exit National Coordination Centre in Leeds is fully operational and our regional coordination centres are live and acting as the single point of contact for each area. Your local EU Exit team for return of the Board Assurance and your contact point for issues and questions are as follows:

Region	Email Account
North East	England.euexitnortheast@nhs.net
North West	England.euexitnorthwest@nhs.net
Midlands	England.mids-euexit@nhs.net
East of England	England.eoe-euexit@nhs.net
London	England.london-euexit@nhs.net
South East	England.se-euexit@nhs.net
South West	England.sw-euexit@nhs.net

As a reminder, all EU Exit information published specifically for NHS organisations is available on the NHS England website. Information for the public and patients is available on the nhs.uk website. All information published by DHSC and other parts of Government can be viewed here.

The NHS is well practised in managing operational risk – it's something we all do in daily practice. We will particularly benefit from the extensive planning undertaken to date. But we cannot be complacent and it's essential that we now finalise our preparations in anticipation of a possible no deal.

I will update you again as soon as I have further information.

Yours sincerely,

Professor Keith Willett
EU Exit Strategic Commander
Medical Director for Acute Care & Emergency Preparedness

Questions to support EU Exit Executive meetings

Operational communications

- Is the board sighted on published operational guidance for EU Exit and subsequent publications and information shared at the recent national workshops?
- Have you taken steps to communicate EU Exit preparation actions to front-line staff?
- Have you discussed EU Exit impact across the local health system and through LHRP?

Operational readiness for a response

- Has the organisation established its EU Exit team and planned for the potential to respond out of hours or over a sustained period of time?
- Have you established a single point of contact for EU Exit and communicated the escalation process across the organisation?
- Have you identified local leads for workforce, supply, data, research and medicines?

Supply

- Are national contingency arrangements for supply understood across the organisation and the local actions required in progress?
- Are plans in place to "walk the floor" to escalate any further EU dependent supply issues that are not addressed nationally?
- Are plans in place to manage with longer lead times for supplies, and for potentially receiving deliveries out of hours?

Workforce

- Are systems in place to monitor uptake of the EU settlement scheme?
- Are the key workforce risks of EU exit understood in the organisation and have actions been put in place to mitigate this and monitor impact?

Clinical Trials

- Has information about EU funded clinical trials been sent to eugrantsfunding@ukri.org
- Have study sponsors for Investigational Medicinal Products (IMPs) used by the organisation been approached for assurance on continuity of supply?

Data

- Have the critical data flows affected by EU Exit (including for clinical trials) been assured?

Finance

- Are systems in place to record the costs of EU Exit preparations and impact?
- Do you have any risks or concerns to flag?

- Is any additional support or information required from a national or regional level?

Geography / Health Demand

- Have the wider risks of EU Exit on the local health and care system been assessed? E.g. increased demand, difficulties in accessing key sites.

Template for completion by EU Exit SRO (1 per NHS organisation) to be returned to Regional EU Exit mailbox by 25 March 2019

Topic	Organisation Derbyshire Healthcare NHS Foundation Trust	Comments & risks identified
Operational Communications	*Green*	*Trust Board and front line staff regularly briefed*
Operational Readiness	*Green*	*EU exit team and single point of contact in place* *On-call arrangements in place*
Supply	*Green*	*Generally the Trust is not reliant upon EU supplies. Key risks relate to medicines and food supply. Both of these are known risks and we continue to follow national guidance to mitigate issues in both.*
Workforce	*Green*	*Low risk as less than 2% of workforce are EU nationals*
Clinical trials	*Green*	*No EU risks*
Data	*Green*	*We have no overseas data processing*
Finance	*Green*	*No specific risks to flag at this time*
Health Demand	*Green*	*CCG and LHRP plans in place*

Please RAG rate:

- Red – no preparations made
- Amber – preparation commenced, but some risks outstanding
- Green – organisation fully prepared

Derbyshire Healthcare NHS Foundation Trust
Report to the Board - 2 April 2019

Learning from Deaths - Mortality Report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period April 2018 to March 2019.

Executive Summary

The Care Quality Commission (CQC) has recently published a review of the first year of NHS Trusts' implementation of the national guidance.

The Medical Director attended a conference in March in which Professor Ted Baker, Chief Inspector of Hospitals talked to this and other relevant CQC publications relating to safety. These notes are a reflection on this material.

For decades, the NHS has sought to reassure the public that services are 'safe'. Research however showed that 3.6% of hospital deaths had a 50% chance of being avoided (Hogan et al 2015) and later the NHS England report into how deaths were investigated by Southern Health FT found that learning opportunities were missed and noted the poor experience of bereaved families hence the emphasis on 'learning from deaths'. Many elderly people, however, are in hospital services during the last twelve months of their life and many are frail and suffering from dementia. The concept of 'avoidable' deaths therefore has given way to deaths associated with 'problems in care'. Mortality 'case reviews' are now seen as a hallmark of an open inquisitive culture thought to be essential to ground up quality (or continuous) improvement. Likewise support and encouragement with bereaved families are a hallmark of openness and compassion.

The concept of a safety culture is being developed. There is a danger of an inappropriate tolerance of impaired safety paradoxically taking root in services that are under intense operational pressure dealing with patients with potentially high clinical risk. There can be a general acceptance that in these situations we should run services as safely as possible but that this may fall short of being as safe as they can be. No trust in England has 'outstanding' for safety and 37% of mental health trusts (including our own) have 'require improvement' for this domain (40% of acutes). An airline would never habitually fly overloaded or crew with staff who are not compliant with mandatory (simulation) training and/or who are temporary / not employed directly, yet the equivalent is common place in the NHS.

The State of Mental Health Services 2014/2017 highlights the following as safety concerns:

- Poor environment particularly inpatient wards
- Use of restrictive practices including seclusion
- Sexual safety concerns

- Medication management being suboptimal
- Low staffing levels (and failure to vary according to demand).

Sir Simon Wessely's Review of the Mental Health Act reached much the same conclusions.

Themes identified in other high pressure clinical services are also likely to be relevant:

- Leadership / culture
- Patient flow
- Triage and early identification of a deteriorating clinical state

Issues that impair a safety culture are likely to be:

- Culture and leadership barriers -
  - A top down approach
  - Professional rivalries
  - Externalisation of problems
  - Never ending mergers, eg North versus South, etc

- Strategic barriers -
  - Financial problems
  - Estate legacy
  - Failure to reconfigure

- System barriers -
  - Lack of integration

These therefore, are the factors to consider alongside the reported mortality information when considering whether the Trust has a 'safety culture'. We need to learn all we can from deaths but this is only part of the picture. We must avoid significant incident investigations and mortality reviews becoming a source of excessive anxiety for staff as this can lead to risk avoidance behaviour and decision making that can inadvertently increase clinical risk. This is particularly relevant to patients detained under the Mental Health Act. We need to learn from critical but appreciate analysis of practice and above all foster a culture of curiosity and continuous improvement.

A network of 'medical examiners' is to be established over the next twelve months overseeing mortality / safety in acute hospitals but later covering community and mental health trusts.

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

Assurances

This report provides assurance that the Trust is following recommendations outlined in the National Guidance but that there is a bigger picture to consider related to developing a Safety Culture.

Since April 2018, the Trust has received 1,861 death notifications of patients who have been with our service within the previous six months. 197 (10.5%) were reported through our DATIX system of which 41 (2%) warranted further investigation.

All inpatient deaths are reviewed and quarterly reports received by the Executive Leadership Team (ELT) in addition to coroner's inquest updates. Medical availability for mortality reviews has improved.

Consultation

This report has been received by the Trust's Quality Committee. The Committee asked for an Executive Summary to give the report 'context'.

We are engaged positively with the CQC who gave the following citation in their annual review:

> **Derbyshire Healthcare NHS Foundation Trust**
> Although Derbyshire Healthcare NHS Foundation Trust was rated as requires improvement overall in September 2018, it had strong processes in place for engaging with bereaved families and carers. Feedback from families about support received from the family liaison team was overwhelmingly positive.
>
> The family liaison role has evolved in line with learning from the national learning from deaths guidance. The family liaison team works with families where there has been a serious incident or unexpected death as reported through the trust's reporting system. They also work with families on referral through the process for learning from deaths, serious incident process and the complaints process where concerns have been highlighted about care.
>
> The team start engaging with families after the death of their loved one has been identified. A single point of contact is established, initial condolences

are given and the duty of candour, where applicable, is applied at the first point of contact, which can include providing the clinical team with advice.

Engagement with families is individualised and person-centred, and families are invited to contribute to the investigation's terms of reference and outline any specific questions they want answered about their relative's care and treatment. Monitoring of these actions is done through the Serious Incident Group (SIG) and the family liaison team who can review and see if the report answers the family's questions.

Families are invited to feedback on the care and treatment of their family member, and the family liaison worker meets with the family at the end of the investigation process to explain the outcome of the investigation. The family liaison team will support the family for as long as they need them up until the inquest, then work towards closure. Any additional needs are met through arranging activities such as referral to independent advocacy or psychological services.

There is also a range of information shared with families including details about the Samaritans, Public Health England's 'Help is at Hand' booklet, WAY (Widowed and Young) (if under 50), details of local support groups, and The Compassionate Friends leaflet. The information that is sent to families depends on the circumstances around the death of their loved one.

Governance or Legal Issues

There are no legal issues arising from this Board report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20)

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

There is recognition that nationally mental health services have been under-resourced for decades and that this is now being addressed through commissioning and contract arrangements. The 'bigger picture' of safety culture requires a strategic approach which is being addressed by the Board.

Recommendations

The Board is requested to accept this Mortality Report as assurance of our approach and note its publication on the Trust's website as per national guidance.

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

Report prepared by: **Dr John R Sykes**
Medical Director

Rachel Williams
Lead Professional for Patient Safety and Patient Experience

Tracy Bates and Louise Hamilton
Mortality Technicians

Learning from Deaths - Mortality Report

1. Background

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths[1]'. The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

The Guidance has outlined specific requirements in relation to reporting requirements. From April 2017, the Trust is required to collect and publish each quarter, specified information on deaths. This is through a paper and Board item to a public Board meeting in each quarter, to set out the Trust's policy and approach (by end of Q2) 2017-2018 and publication of the data and learning points by Quarter 3 2017/18. The Trust should include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths, subject to review, we are asked to consider how many of these deaths were judged more likely than not to have been due to problems in care.

The report presents the data so far this financial year from April 2018, incorporating new data for the periods December 2018, January and February 2019.

2. Current Position and Progress

- As a way of accessing a national database for cause of death, our application for NHS Digital continues, and the Trust is currently awaiting an outcome .This continues to be a slow process, to ensure that the Trust meets all of NHS Digital legal requirements.

- The Mortality Review Group continues to undertake regular case note reviews and there have been improvements in medic availability since the implementation of a rota for attendance from the North consultants. A rota incorporating medics from the South of the County is currently been discussed.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary changes made.

[1] National Guidance on Learning from Deaths. National Quality Board. March 2017

3. Data Summary of all Deaths

Month	2018-04-01	2018-05-01	2018-06-01	2018-07-01	2018-08-01	2018-09-01	2018-10-01	2018-11-01	2018-12-01	2019-01-01	2019-02-01
Total Deaths Per Month	164	186	145	183	135	140	200	174	184	224	126
Inpatient Deaths	1	0	2	1	0	0	1	0	1	1	0
LD Referral Deaths	2	5	0	5	4	1	5	0	2	1	0

Note that inpatients and LD are based upon whether the patient has an open inpatient or LD referral at time of death.

Correct as at 01.03.2019

The table above now only shows information for this current financial year, whereas previous reports have outlined number of deaths since January 2017.

Since April 2018, the Trust has received 1,861 death notifications of patients who have been in contact with our service. Initially, the Trust recorded all deaths of patients who had contact within the last 12 months, but this was changed after discussion with Commissioners to contact within the last 6 months. This took effect from 20 October 2017.

4. Review of Deaths

Total number of Deaths from 1 April 2018 – 1 March 2019 reported on Datix	197 (of which 152 are reported as “Unexpected deaths”; 33 as “Suspected deaths”; and 12 as “Expected - end of life pathway”)
Number reviewed through the Serious Incident Group	195 (1 was not required to be reviewed by SI group and 1 pending for a review).
Number investigated by the Serious Incident Group	41 (155 did not require an investigation and 1 pending for a review)
Number of Serious Incidents closed by the Serious Incident Group?	138 (58 currently opened to SI group and 1 pending for a review, as at 01/03/2019)

The Trust has recorded 7 inpatient deaths since April 2018, of all which have been reviewed under the *Untoward Incident Reporting and Investigation Policy and Procedure*. None of these deaths have been due to problems in care.

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*;

Any patient open to services within the last 6 months who has died, and meets the following:

- Homicide – perpetrator or victim.
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / The Ombudsman, or where staff have raised a significant concern about the quality of care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death

Death of a patient with historical safeguarding concerns, which could be related to the death:

- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not

5. Learning from Deaths Procedure

Since April 2018, the Mortality Review Group has reviewed 76 deaths. These reviews were undertaken by a multi-disciplinary team and it was established that of the 76 deaths reviewed, 74 have been classed as not due to problems in care.4 were referred to the Serious Incident Group where 2 required no further action, and a further 2 are currently under further investigation.

The Mortality Group reviewed the deaths of patients who fall under the following 'red flags' from 1 November 2018:

- Patient referred to services, then assessed and, discharged without referral onto other mental health services (including liaison team)
- Patient diagnosed with a severe mental illness
- Patient only seen as an Outpatient
- Patient taking an Anti-psychotic medication

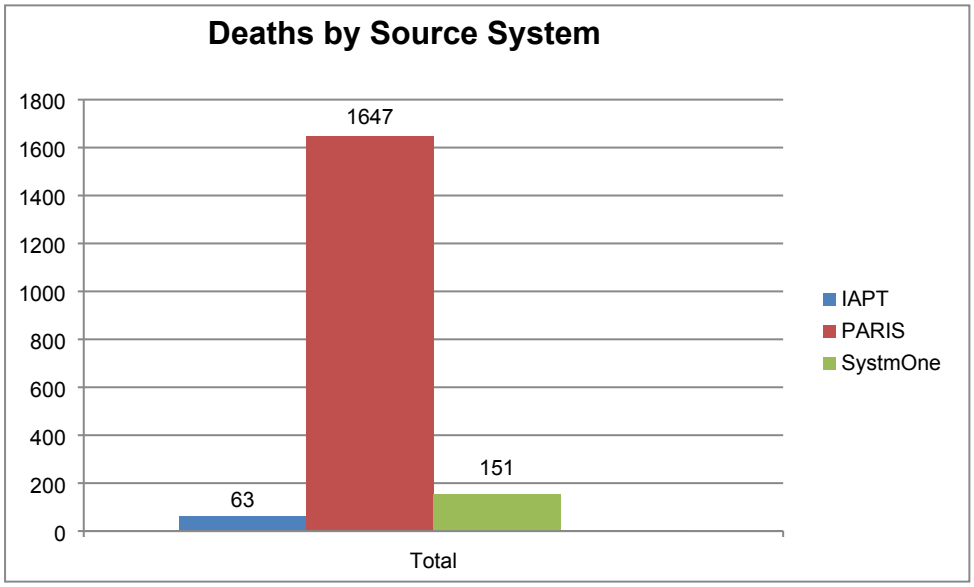
We have received 9 cause of deaths since April 2018, of these, initial analysis of death notification information shows the most prevalent causes of death are:

- Bronchopneumonia
- Heart disease
- Dementia

Undertaking Case Note Reviews of deaths has improved from the previous quarter due to the North Consultant rota which has meant that only 3 reviews have had to be cancelled due to lack of medic availability. We will be scoping the implementation of a South Consultant rota to further improve the availability of the medics.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 April 2018

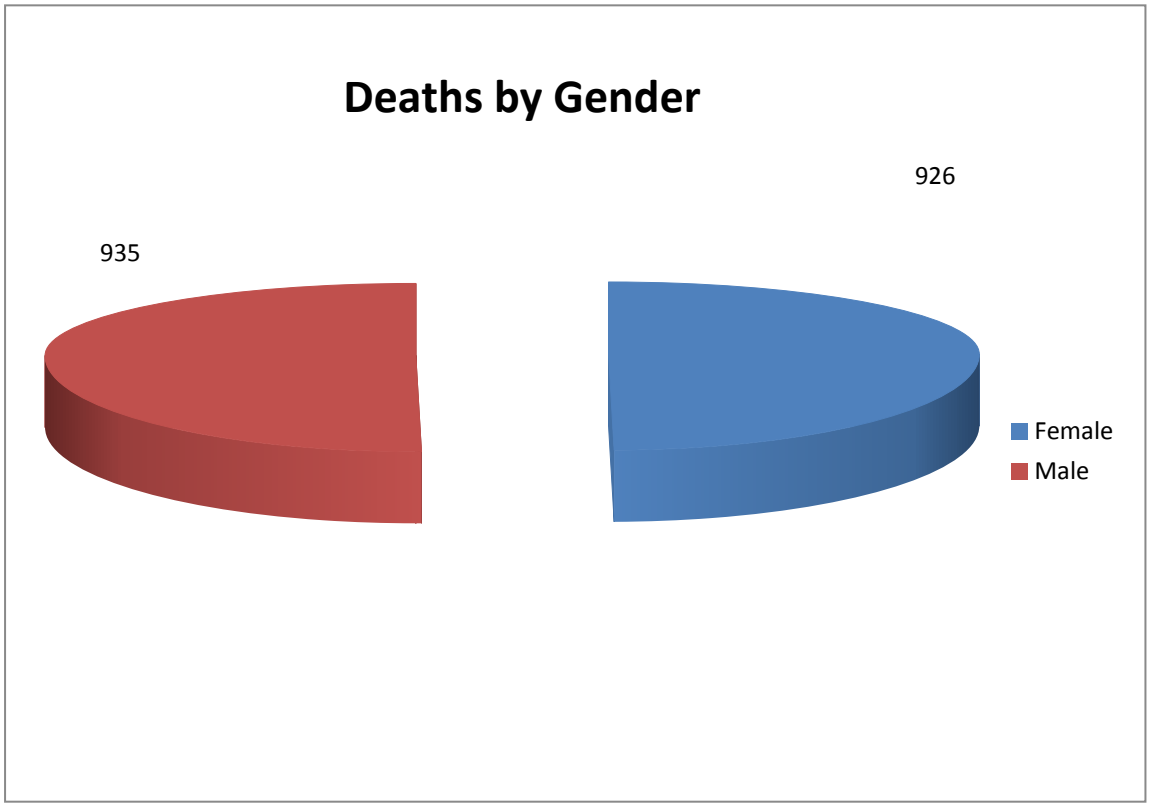


	IAPT	PARIS	SystmOne	Grand Total
Count	63	1647	151	1861

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care. 151 death notifications were extracted from SystmOne and 63 death notifications were extracted from IAPT.

6.2 Deaths by Gender since 1 April 2018

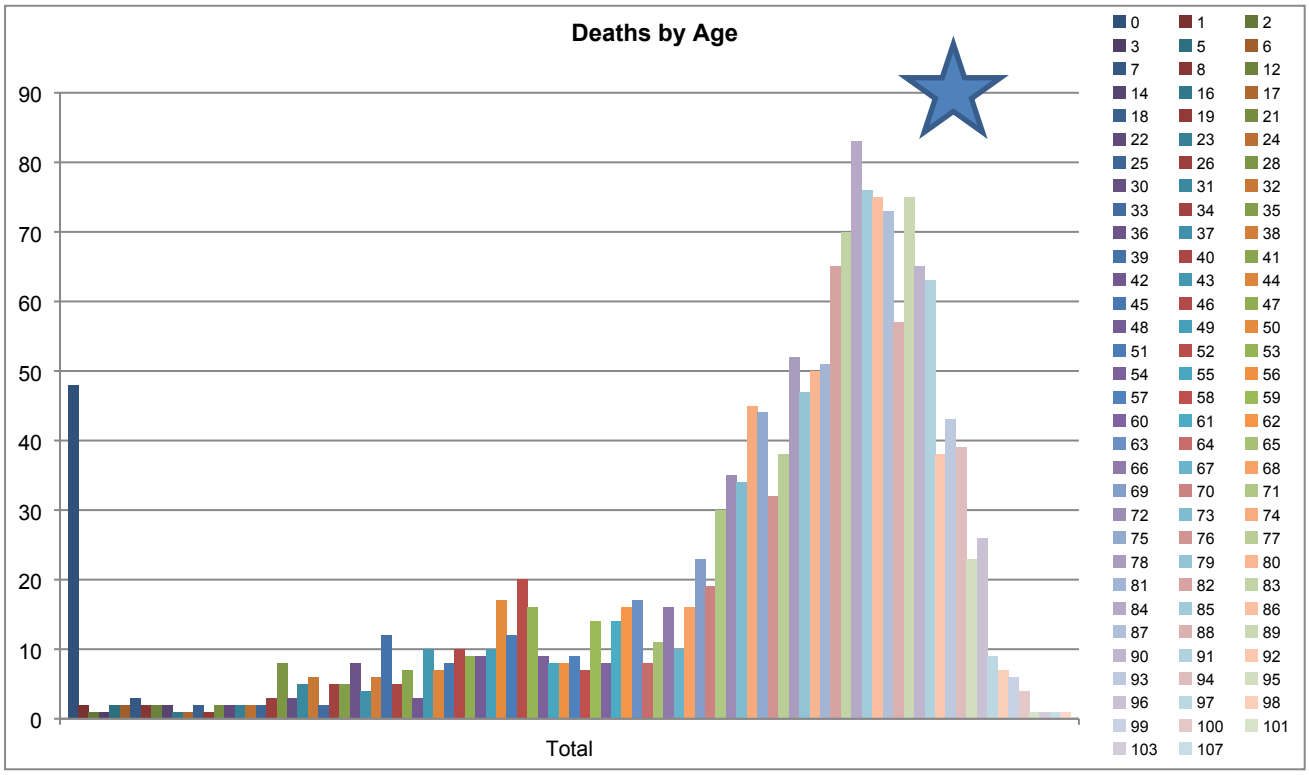
The data below shows the total number of deaths by gender since 1 April 2018. There is very little variation between male and female deaths; 935 male deaths were reported compared to 926 female.



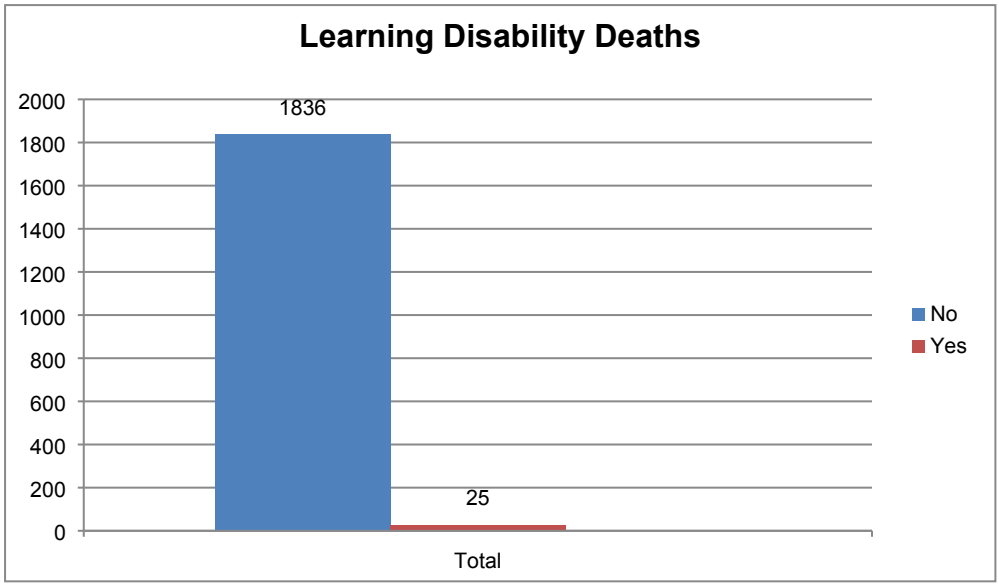
	Female	Male	Grand Total
Count	926	935	1861

6.3 Death by Age Group since 1 April 2018

The youngest age was classed as 0, and the oldest age was 107 years. Most deaths occur within the 83-87 age groups (indicated by the star). In the last report, most deaths occurred between 85-89 age groups.



6.4 Learning Disability Deaths since 1 April 2018



The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) Programme. However, we are unable to ascertain how many of these deaths have been reviewed through the LeDeR process, as LeDeR only looks at a sample of overall deaths. Currently the Lead Professional for Patient Safety and Experience is working closely with LeDeR so that the Trust can be involved moving forward in the review process. Since the last report, the Trust is now sharing relevant information with LeDeR which is used in their reviews. Since April 2018, the Trust has recorded 25 Learning Disability deaths.

The Trust now receives a quarterly update from LeDeR which highlights good practice and identified learning.

6.5 Death by Ethnicity since 1 April 2018

White British is the highest recorded ethnicity group with 1,389 recorded deaths, 323 deaths had no recorded ethnicity assigned, and 19 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Count
White - British	1389
Not Known	323
White - Any other White background	41
Other Ethnic Groups - Any other ethnic group	37
Not stated	19
Caribbean	13
Indian	11
White - Irish	9
Asian or Asian British - Pakistani	6
Pakistani	3
Mixed - Any other mixed background	3
Asian or Asian British - Indian	2
Mixed - White and Asian	2
Mixed - White and Black Caribbean	2
Asian or Asian British - Any other Asian background	1
Grand Total	**1861**

7. Recommendations and Learning

Below are examples of the recommendations that have been undertaken following the review of deaths either through the *Untoward Incident Reporting and Investigation Policy and Procedure* or *Learning from Deaths Procedure.* These recommendations are monitored by the Patient Safety Team and are allocated to a specific team, and individuals to be completed. This is not an exhaustive list.

7.1 Action Log

- Observation Policy and Procedure to be reviewed.
- Medication changes which are likely to impact upon the risk of falls should be recorded in the Multi-Disciplinary Team process and care plans updated accordingly.
- New Crisis Assessment and Home Treatment Operational Policy to be updated.
- To develop standard operating policy/procedures for Hepatitis A, B and C, HIV testing and vaccinating against Hepatitis A and B.
- The consideration of relapse reduction model including relapse signature to be a continuous quality improvement priority for mental health service in 2018.
- Clarify protocols with NHS England surrounding gatekeeping assessments for low secure services.
- Collateral information should be sought from families wherever possible to add to the clinical assessment and understanding of the presentation.
- A clinical supervision framework that ensures clinicians have routine access to professionals with clinical expertise in forensic care.
- Review of Liaison Team South's documentation / risk assessment against expected standards.
- Site visits to be organised for junior doctors during induction.
- Community Team Learning Disability Teams to review Triangle of Care action plans with Multi-Disciplinary Team members & carers champions.
- Non-recent sexual abuse reporting process to be discussed with ward staff and all staff to be forwarded link to the Trust procedures.
- To explore the development of Eating Disorder awareness training package to the relevant Trust teams
- Development of a new standard operating procedure in the acute care pathways in the North and South for all complex case clinical reviews.
- To consider the Clinical Safety Plan becoming part of the main PARIS tree index so that it is more easily accessible to all agencies involved.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 April 2019

Board Effectiveness Survey Feedback Including Review of Policy for Engagement between the Trust Board and Council of Governors

Purpose of Report

This report provides the Board with the results of the Board Effectiveness Survey conducted in September/October 2018.

Executive Summary

Board Effectiveness Survey

As part of the Deloitte review of Trust governance arrangements in January 2016, a Board Effectiveness Survey was undertaken. After Board discussions it was agreed that the Board would continue to use the survey in order to assess improvements and also gauge how effective the Board believes itself to be. Further surveys were undertaken in September, and presented to the Trust Board in September 2017. From November 2017 this survey was developed to include opportunity for free comments.

This report outlines the results from the fifth survey undertaken in September 2018. The survey was completed by 11 of the 14 current Board members (79%). Comments have been incorporated into the summary presented for each question.

Q1 All Board members act as Corporate Directors, demonstrating the ability to think strategically and contribute to areas outside their specialist field

There is unanimous agreement with this statement with 100% of respondents saying they either strongly agree or agree. This is the same result at the November 2017 survey and an increase from 93% in the Spring 2017.

Q2 As a Board we have considered our future skills requirements and succession planning is in place

There has been an increase in positive response with successive surveys. When first surveyed in January 2016 the majority of Board members, 83%, neither agreed nor disagreed and the remaining 17% disagreed. In 2017 there was 100% agreement (either strongly or agree) that this is under consideration and either in place or taking place. The latest survey however highlights that one respondent (9%) neither agrees nor disagrees. Comments relating to potential to improve Executive Director succession planning in the free text may be a driver for this. The Board continues to review skill requirements and training and development opportunities through undertaking a comprehensive Board Development programme. This has continued through 2018/19 and plans for the 2019/20 programme are being finalised.

Q3 We operate as a Unitary Board

100% of respondents felt that the Trust Board operated as a Unitary Board - where all directors are collectively and corporately accountable for organisational performance.

Q4 As a Board we have established clear values for the Trust and Q5 – Values for this Trust are consistently role modelled by the Board members and senior managers

100% positive response to Q4. Notably 8/11 respondents strongly agreed with this statement with the comments that this has improved significantly in year.

100% positive response for Q5. Although agreeing, comments include reference to role modelling of values by senior managers, which was also noted as feedback in the November 2017 survey.

Q6 I am confident we have systems to ensure that inappropriate behaviours and performance are identified and responded to

100% of respondents supported this statement reflecting confidence in the systems in place.

Q7 The Board does not operate in an 'ivory tower'– it proactively engages staff and staff feel able to approach Board members to discuss concerns they might have

100% positive response to this question. This reflects increasing levels of confirmation of this as seen in the survey over the last two years. The comments reflect the increased levels of engagement the Board has undertaken.

Q8 There are sufficient levels of engagement between the Board and the Council of Governors

100% of respondents agreed or strongly agreed with this statement. Comments reflect the high levels of satisfaction including noting that this is an area of real strength for the Trust. When compared with the results of the Council of Governors' most recent survey, undertaken in September 2018 (see below), it is notable that 100% of governors that responded stated they agreed or strongly agreed that there was sufficient opportunity for contact and good communication with the Board of Directors. This was reflected in comments from the CQC in their report following our comprehensive inspection in 2018.

The Council of Governors have sufficient opportunity for contact, and good communication, with the Board of Directors:

	Strongly agree	Agree	Don't know	Disagree	Strongly disagree	Response Total
Sept 2018 With the Executive Directors	35.7% 5	64.3% 9	0.0% 0	0.0% 0	0.0% 0	14
Sept 2018 With the Non-Executive Directors	42.9% 6	57.1% 8	0.0% 0	0.0% 0	0.0% 0	14
Sept 2017 With the Executive Directors	8.3% (1)	50.0% (6)	33.3% (4)	8.3% (1)	0.0% (0)	12
Sept 2017 With the Non-Executive Directors	38.5% (5)	46.2% (6)	7.7% (1)	7.7% (1)	0.0% (0)	13
Sept 2016 With the Executive Directors	0.00% (0)	6.7% (6)	0.00% (0)	33.3% (3)	0.00% (0)	9
Sept 2016 With the Non-Executive Directors	0.00% (0)	88.9% (8)	11.1% (1)	0.00% (0)	0.00% (0)	9

Q9 After a decision has been made by the Board it is clear who is responsible for implementing it and by when

Repeat score of 2017 survey of 92% either agree/strongly agree with one respondent disagreeing alongside a comment that this is an area where further improvement is required.

Q10 There is minimal duplication between the work of the various Board Committees

A positive response of 91% of the Board agrees/strongly agrees with this statement which may be linked to work of the Board Committee chairs to focus on this area during the year. As a reminder, this question links to the 2016/17 GIAP recommendation *Review the operation of all committees seeking to minimise duplication*.

Q11 We routinely invite members of staff and other key stakeholders to present to the Board

100% of respondents agreed or strongly agreed with this statement. Comments reflected the positive step of inviting staff to shadow Board members with increase in clarity of purpose of staff invited to Board being welcomed.

Q12: When corrective action is taken, changes made are embedded. It is rare for our Trust to have issues that reoccur

There was a mixed response to this question again as in previous years. There is an increase from the 2017 survey to those who neither agree nor disagree, and one member disagreeing (total of 64% giving a negative response). Comments include referring pace of implementation and embedding work. This has been further reflected through comments and discussion at both Board meetings and Board Development sessions throughout 2018/19 and pace of implementation and embedding work is a key theme for Board focus going forwards.

Review of Policy for Engagement Between the Trust Board and Council of Governors

The Policy for engagement between the Trust Board and the Council of Governors was recommended by the Council of Governors in September 2016 and approved by the Trust Board on 5 October 2016. The policy was introduced in January 2017 and it was agreed to evaluate annually.

The policy outlines the commitment from the Trust Board and the Council of Governors to develop engagement opportunities to carry out their respective roles effectively. The policy was initially produced as part of the Governance Improvement Action Plan requirement and as part of implementation of good governance practice (NHS Improvement, NHS Foundation Trust Code of Governance recommendation).

Initiatives that have been maintained and undertaken during the year include:

- Induction and ongoing training provided to Trust Board and the Council of Governors on their respective roles through Board Development sessions and governor training programme respectively.
- Formal questions/concerns have been raised to the Trust Board by the Council of Governors. Escalations from the Governance Committee are working well in this respect.
- The Chair has successfully met with the Lead Governor and Deputy Lead Governor and welcomes the opportunity for 1:1 meetings with individual governors on an ongoing basis (as publicised on 'Governor Connect' weekly/biweekly newsletter.
- Non-Executive Directors have presented on their work including their Committee Chair responsibilities during the year and there is a schedule for this to continue on an ongoing basis.
- There has been a good level of Executive Director attendance at Council of Governors meetings during the year – linking in with respective Committee chair leads.
- The Lead Governor role has continued effectively during the year with the Deputy Lead Governor role providing support across the range of duties of this post.
- The Lead Governor has worked with the Senior Independent Director on the appraisal of the Trust Chair and overseen the appraisal of Non-Executive Directors through the Governors' Nominations & Remuneration Committee.
- Governors were actively involved in the appointment of External auditors during September-November 2019
- There have been no concerns as defined within the context of this policy (performance of the Trust Board, compliance with the licence or the welfare of the Trust as item 4.1) during the year.

At a meeting of the Governance Committee, governors noted the initiatives undertaken in year and agreed that the policy had worked well with a range of engagement opportunities carried out and which were now embedded as business as usual.

The Chair and Lead Governor were invited to present the Trust's work on development and implementation of the policy at the regional NHS Providers governance conference on 26 February 2019. This was very positively received.

Board members are asked to reflect and discuss their perspectives on implementation of the policy during the last year.

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

Assurances

This paper should be considered in relation to key risks contained in the Board Assurance Framework.

Consultation

The Board Effectiveness Survey results reflect the input from 11 out of 14 Board members requested to complete the survey.

Governance or Legal Issues

This paper links directly to the NHS improvement enforcement action and associated licence undertakings, having been used in the Deloitte review February 2016.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks – there is no direct impact on those with protected characteristics arising from this report

Recommendations

The Board of Directors is requested to:

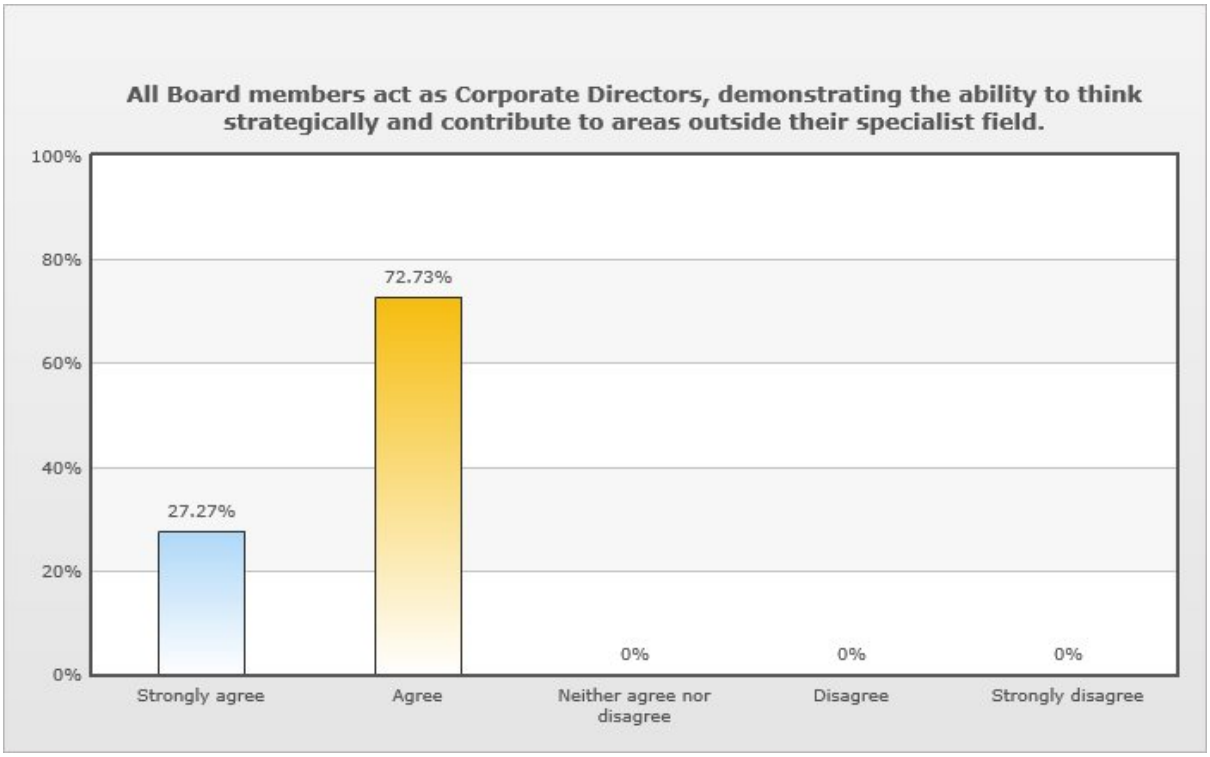
1. Note the outcome of the Board Effectiveness Survey October 2018.
2. Consider the responses including how further improvements can be taken forward as part of planned action by either the Board itself, Board Committees or the wider Trust.
3. Agree that the survey should be completed again in October 2019.
4. Note the activity to positively implement the Policy for Engagement between the Trust Board and Council of Governors which has been presented to the Council of Governors in November 2018.

Report presented by: **Caroline Maley**
Trust Chair

Report prepared by: **Samantha Harrison, Director of Corporate Affairs & Trust Secretary**

Sue Turner
Board Secretary

Q1 All Board members act as Corporate Directors, demonstrating the ability to think strategically and contribute to areas outside their specialist field

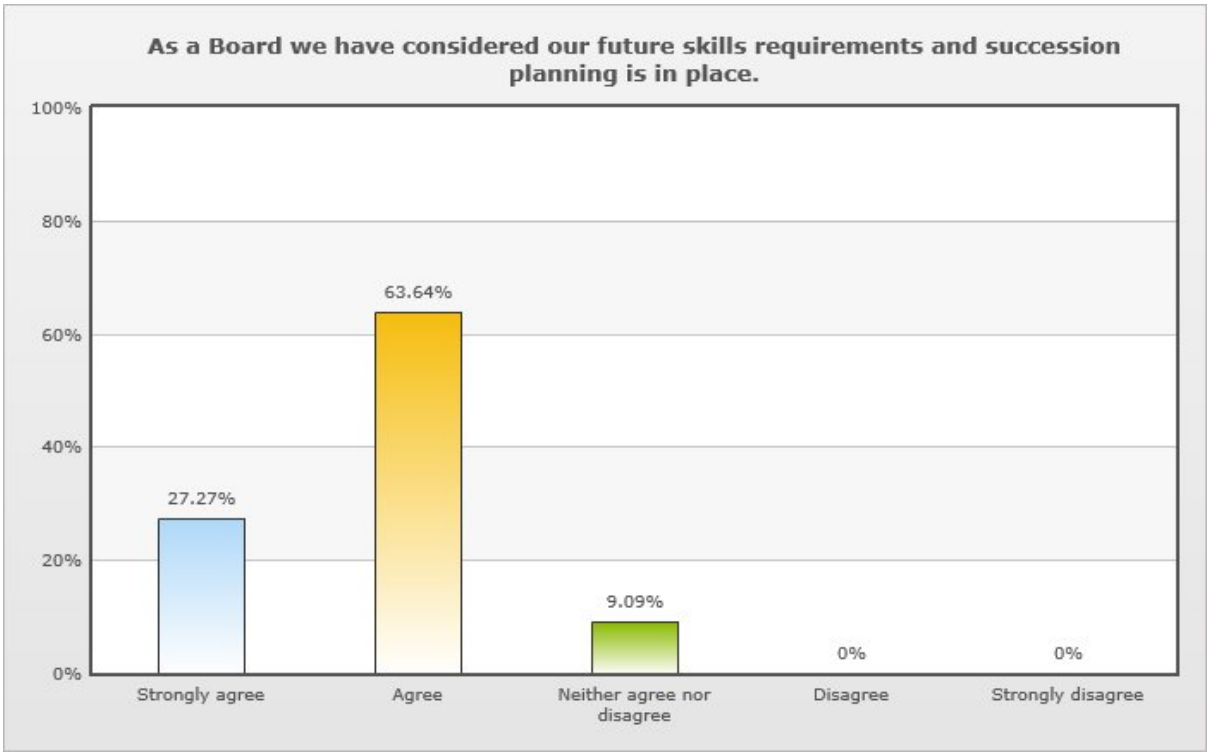


Question 1		Sep 2018	Nov 2017	Mar 2017	Sep 2016	Jan 2016
1	Strongly agree	3	3	2	0	0
2	Agree	8	9	12	8	9
3	Neither agree nor disagree	0	0	0	0	3
4	Disagree	0	0	1	2	1
5	Strongly disagree	0	0	0	0	0
Total Responses		**11**	**12**	**15**	**10**	**13**

Comments – Question 1

- I agree although it would be better if everyone fully participated in assurance seeking at Board
- As always I think we could do more around strategy and strategic thinking. There has been more cross specialism debate

Q2 As a Board we have considered our future skills requirements and succession planning is in place

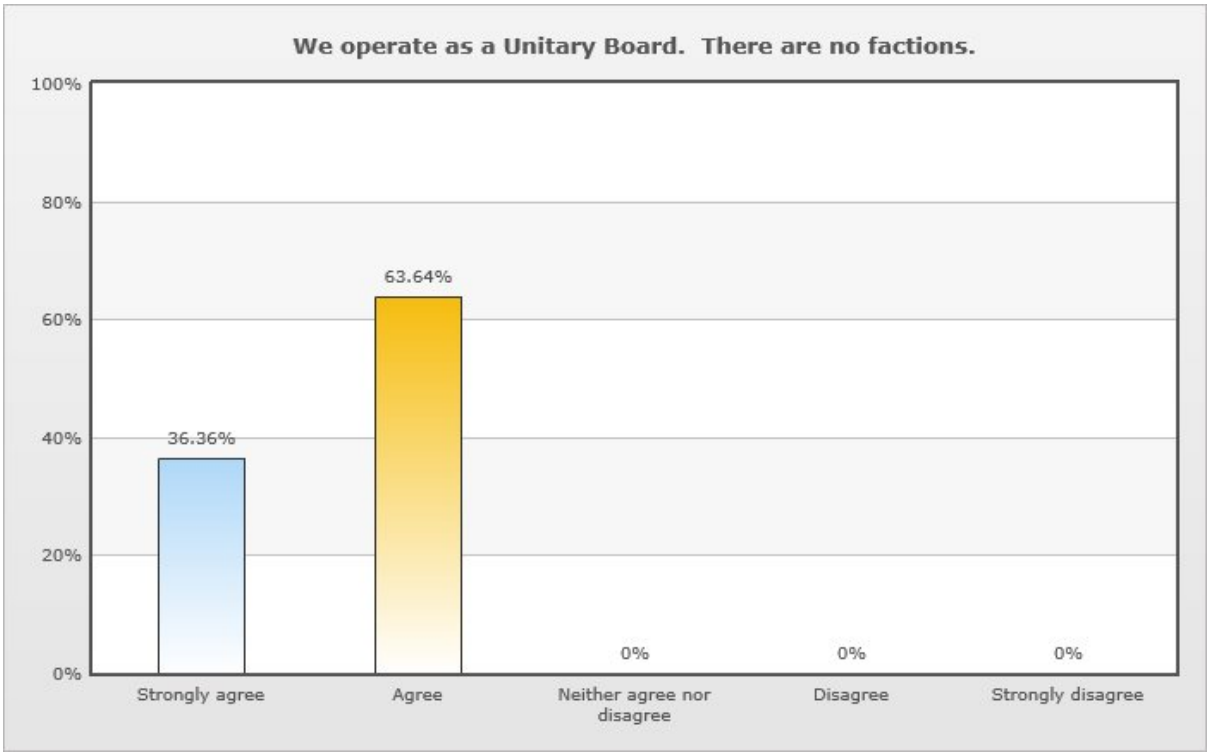


Question 2		Sep 2018	Nov 2017	Mar 2017	Sep 2016	Jan 2016
1	Strongly agree	3	3	1	2	0
2	Agree	8	9	9	1	0
3	Neither agree nor disagree	1	0	3	3	10
4	Disagree	0	0	2	3	2
5	Strongly disagree	0	0	0	1	0
Total Responses		**11**	**12**	**15**	**10**	**12**

Comments – Question 2

- This has emerged as a real strength of our Board, evidenced by papers to both Council of Governors and Remuneration and Appointments Committee
- We have reviewed Non-Executive Director skills and at present there is a stable group. Executive Director succession planning is getting better but may still need some consideration

Q3 We operate as a Unitary Board



Question 3		Sep 2018	Nov 2017	Mar 2017	Sep 2016	Jan 2016
1	Strongly agree	4	3	1	2	0
2	Agree	7	9	9	1	0
3	Neither agree nor disagree	0	0	3	3	10
4	Disagree	0	0	2	3	2
5	Strongly disagree	0	0	0	1	0
Total Responses		**11**	**12**	**15**	**10**	**12**

Comments – Question 3

- I believe that there is a unitary board approach to the Trust's business

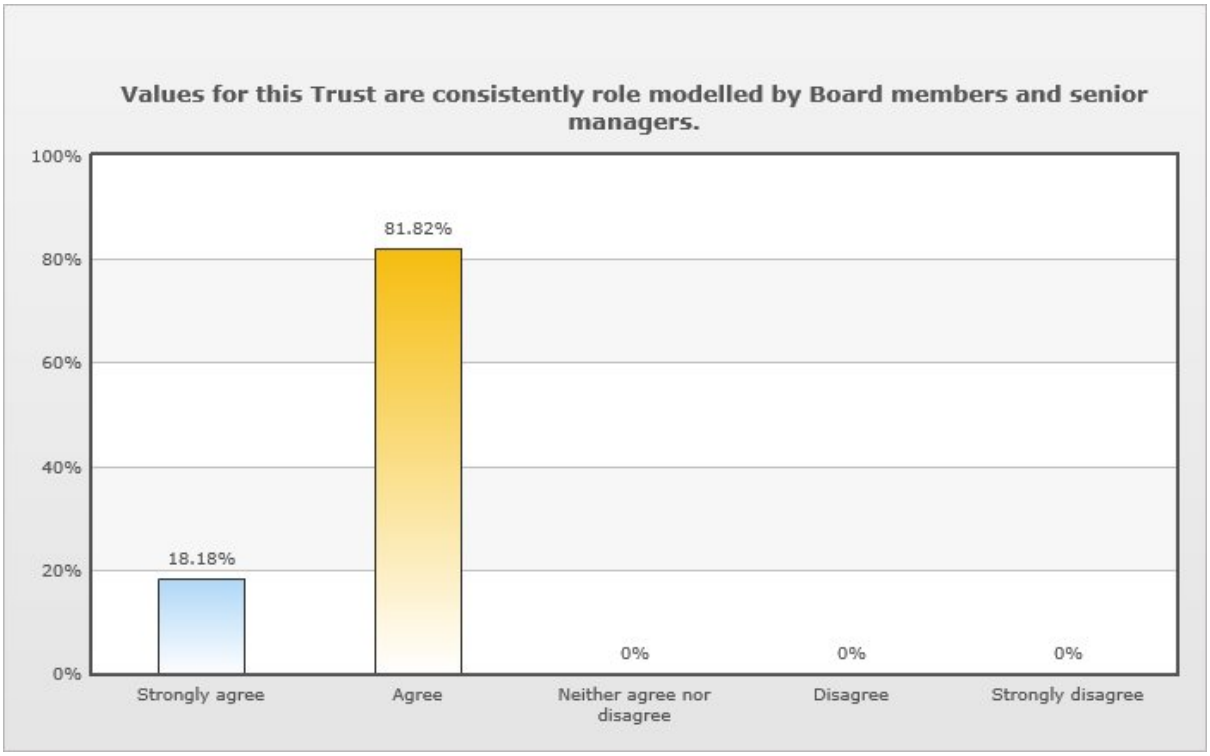
Q4 As a Board we have established clear values for the Trust

Question 4		Sep 2018	Nov 2017	Mar 2017	Sep 2016	Jan 2016
1	Strongly agree	8	3	1	2	0
2	Agree	3	9	9	1	0
3	Neither agree nor disagree	0	0	3	3	10
4	Disagree	0	0	2	3	2
5	Strongly disagree	0	0	0	1	0
Total Responses		**11**	**12**	**15**	**10**	**12**

Comments – Question 4

- Values relaunched, development sessions held for Board and senior leaders to understand values
- This has moved on leaps and bounds this year

Q5 Values for this Trust are consistently role modelled by Board members and senior managers

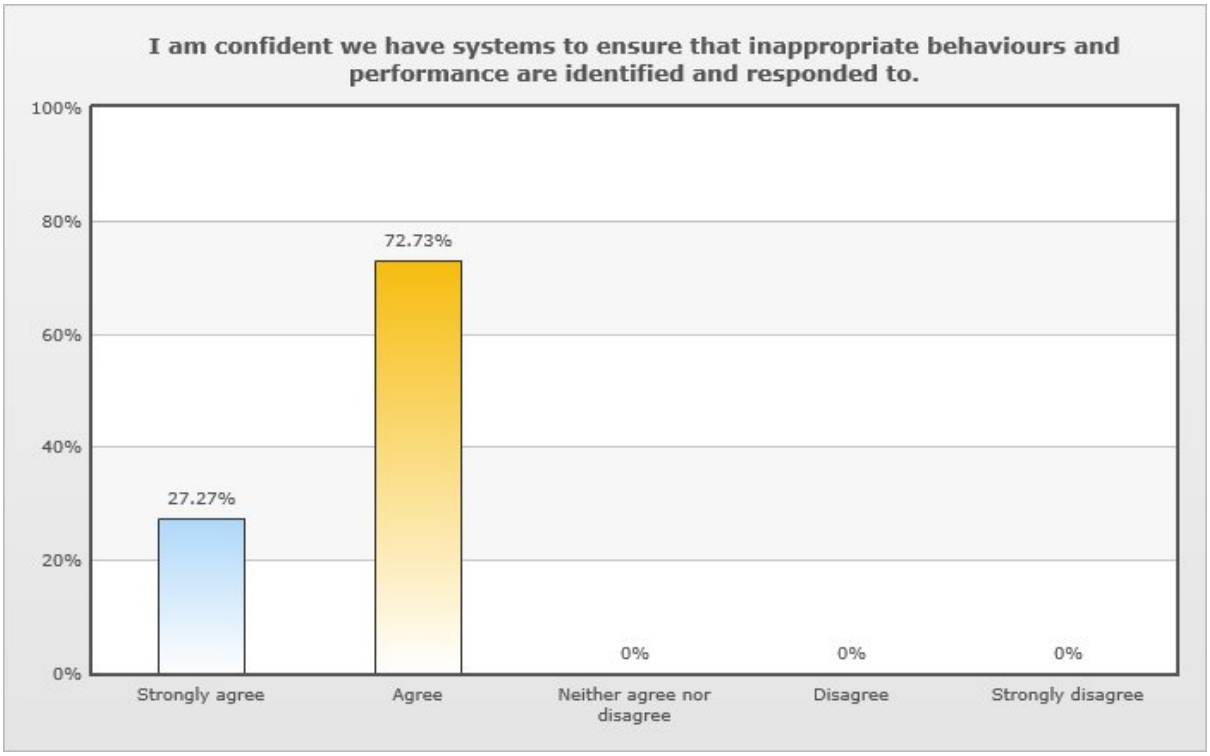


Question 5		Sep 2018	Nov 2017	Mar 2017	Sep 2016	Jan 2016
1	Strongly agree	2	3	1	2	0
2	Agree	9	9	9	1	0
3	Neither agree nor disagree	0	0	3	3	10
4	Disagree	0	0	2	3	2
5	Strongly disagree	0	0	0	1	0
Total Responses		**11**	**12**	**15**	**10**	**12**

Comments – Question 5

- Strongly agree for Board members, more difficult for senior managers as there is ongoing leadership work addressing some pockets of difficulty
- I certainly try to live the values and to use them in my work in the Trust. There may be a little more needed for the Board to be clear on how it models the values as a Board

Q6 I am confident we have systems to ensure that inappropriate behaviours and performance are identified and responded to

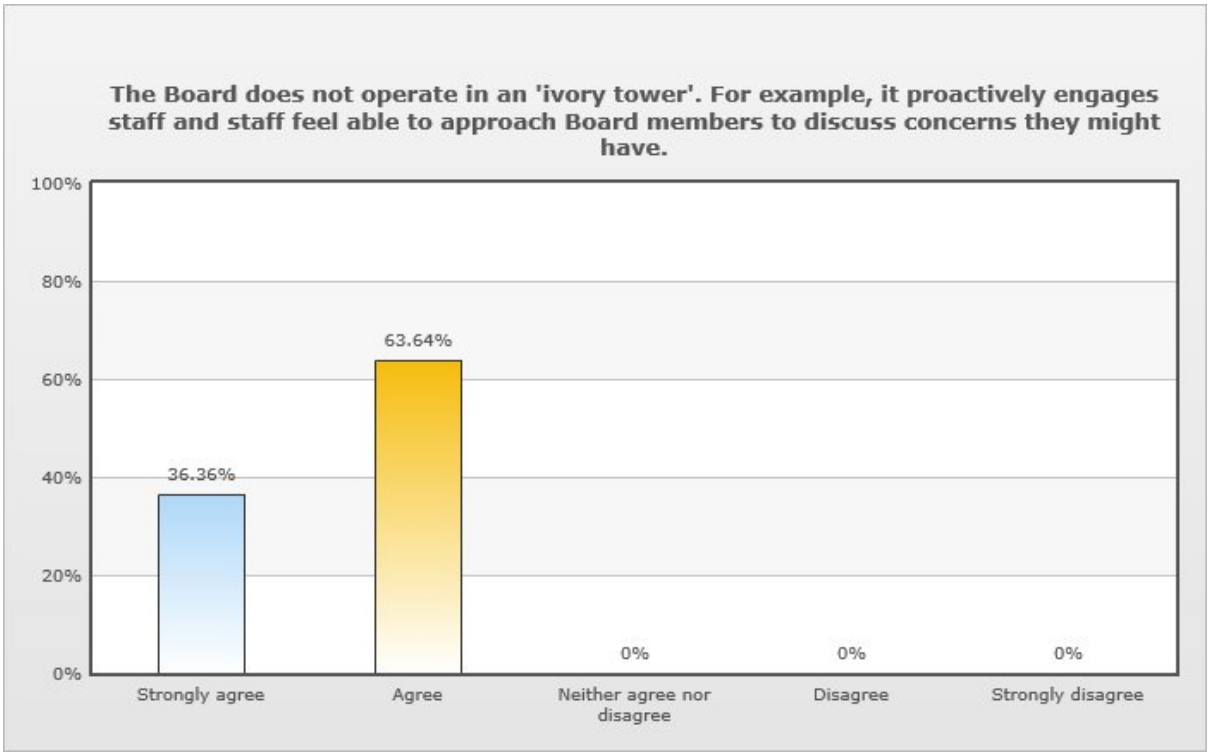


Question 6		Sep 2018	Nov 2017	Mar 2017	Sep 2016	Jan 2016
1	Strongly agree	3	3	1	2	0
2	Agree	8	9	9	1	0
3	Neither agree nor disagree	0	0	3	3	10
4	Disagree	0	0	2	3	2
5	Strongly disagree	0	0	0	1	0
Total Responses		**11**	**12**	**15**	**10**	**12**

Comments – Question 6

- Performance conversations form an integral part of 360 degree feedback and appraisals
- With the Board I believe that we have the right approach in place. However I do think that there remains an issue further down in the Trust. Whilst better, there are still gaps

Q7 The Board does not operate in an 'ivory tower' – it proactively engages staff and staff feel able to approach Board members to discuss concerns they might have

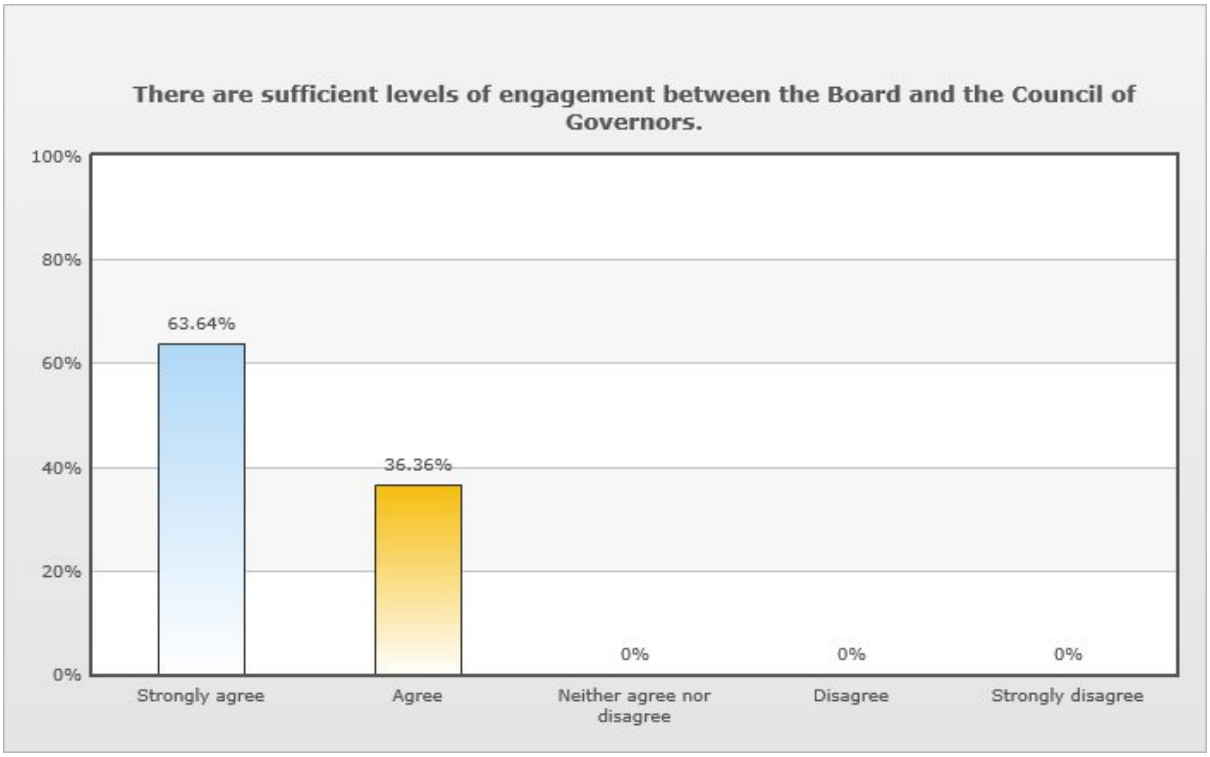


Question 7		Sep 2018	Nov 2017	Mar 2017	Sep 2016	Jan 2016
1	Strongly agree	4	3	1	2	0
2	Agree	7	9	9	1	0
3	Neither agree nor disagree	0	0	3	3	10
4	Disagree	0	0	2	3	2
5	Strongly disagree	0	0	0	1	0
Total Responses		**11**	**12**	**15**	**10**	**12**

Comments – Question 7

- Will be good to see all Board members actively engaging not just via quality visits
- Much better now and some obvious ways in which to reach the wider Trust – my visits, Ifti on the Road, quality visits, NED informal visits in due course. Executive meetings around the Trust.
- Can always do more but certainly efforts are being made.

Q8 There are sufficient levels of engagement between the Board and the Council of Governors

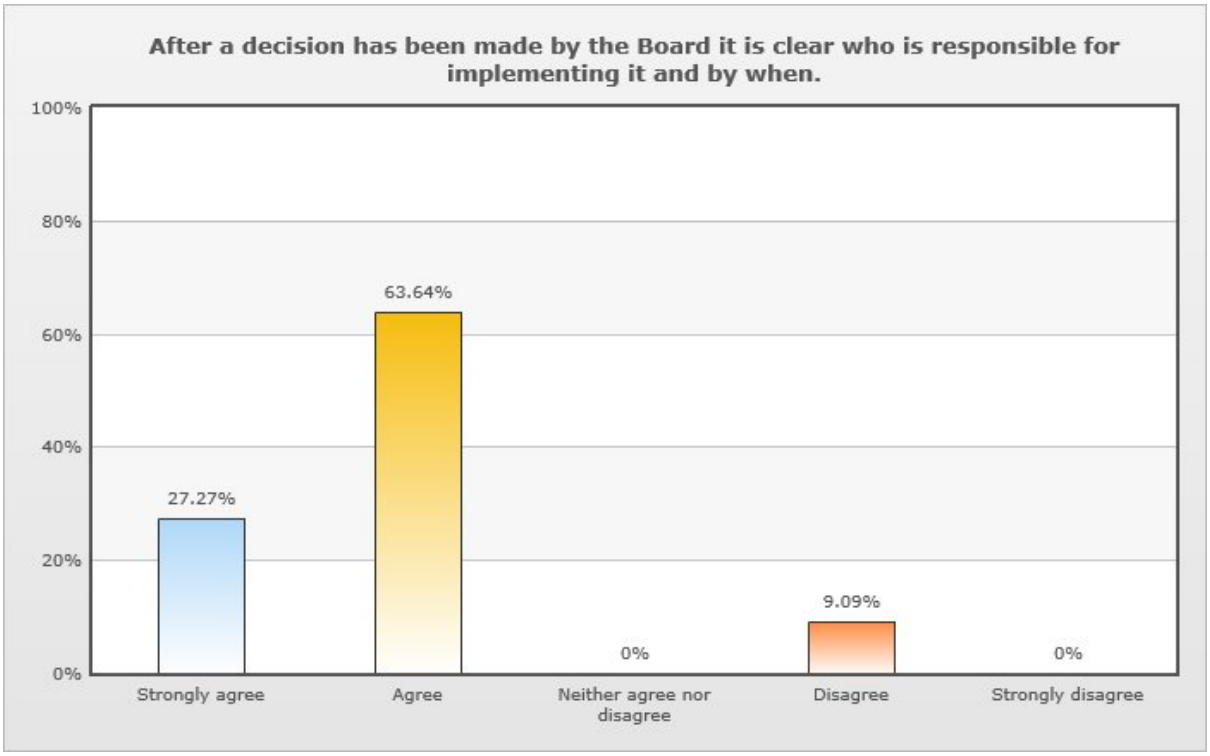


Question 8		Sep 2018	Nov 2017	Mar 2017	Sep 2016	Jan 2016
1	Strongly agree	7	3	1	2	0
2	Agree	4	9	9	1	0
3	Neither agree nor disagree	0	0	3	3	10
4	Disagree	0	0	2	3	2
5	Strongly disagree	0	0	0	1	0
Total Responses		**11**	**12**	**15**	**10**	**12**

Comments – Question 8

- Remains real strength
- Again this has moved on substantially over the past few years. Some might argue that we should reduce the number of meetings
- I thought last December's workshops were very well timed and managed

Q9 After a decision has been made by the Board it is clear who is responsible for implementing it and by when

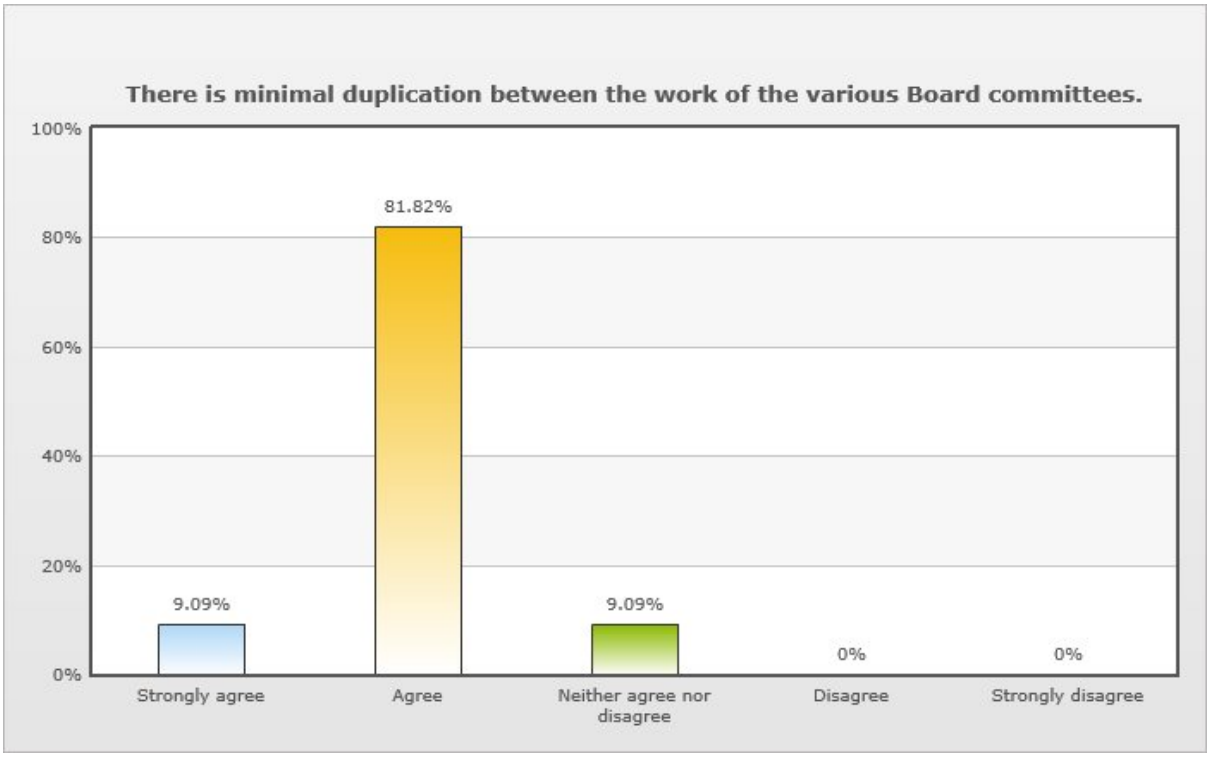


Question 9		Sep 2018	Nov 2017	Mar 2017	Sep 2016	Jan 2016
1	Strongly agree	3	3	1	2	0
2	Agree	7	9	9	1	0
3	Neither agree nor disagree	0	0	3	3	10
4	Disagree	1	0	2	3	2
5	Strongly disagree	0	0	0	1	0
Total Responses		**11**	**12**	**15**	**10**	**12**

Comments – Question 9

- I think that we could still be better on this, but on the whole I think we have improved in this area
- This could be improved

Q10 There is minimal duplication between the work of the various Board committees



Question 10		Sep 2018	Nov 2017	Mar 2017	Sep 2016	Jan 2016
1	Strongly agree	1	3	1	2	0
2	Agree	9	9	9	1	0
3	Neither agree nor disagree	1	0	3	3	10
4	Disagree	0	0	2	3	2
5	Strongly disagree	0	0	0	1	0
Total Responses		**11**	**12**	**15**	**10**	**12**

Comments – Question 10

- No comments submitted

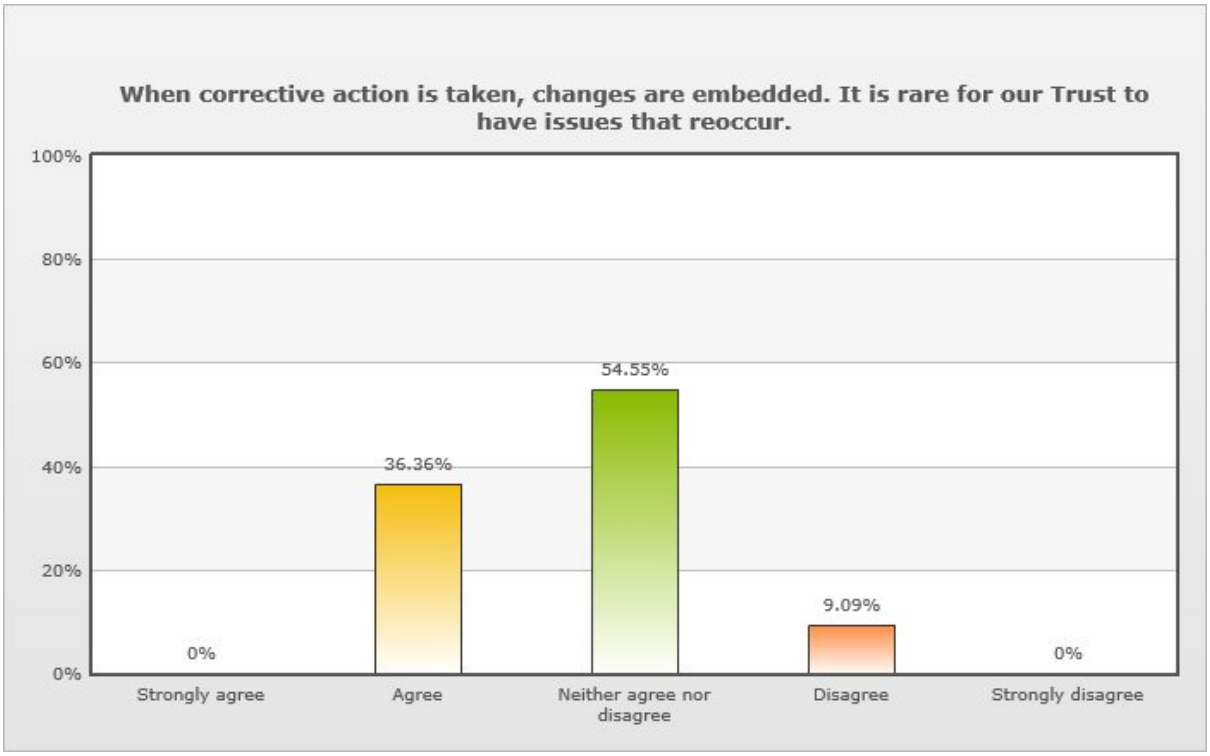
Q11 We routinely invite members of staff and other key stakeholders to present to the Board

Question 11		Sep 2018	Nov 2017	Mar 2017	Sep 2016	Jan 2016
1	Strongly agree	4	3	1	2	0
2	Agree	7	9	9	1	0
3	Neither agree nor disagree	0	0	3	3	10
4	Disagree	0	0	2	3	2
5	Strongly disagree	0	0	0	1	0
Total Responses		**11**	**12**	**15**	**10**	**12**

Comments – Question 11

- Increased clarity over year on purpose of engagement has been helpful
- We now have a lot of staff shadowing Executive Directors and me. We are not inviting as many for deep dives or patient story?

Q12 When corrective action is taken, changes made are embedded. It is rare for our Trust to have issues that reoccur



Question 12		Sep 2018	Nov 2017	Mar 2017	Sep 2016	Jan 2016
1	Strongly agree	4	3	1	2	0
2	Agree	7	9	9	1	0
3	Neither agree nor disagree	0	0	3	3	10
4	Disagree	0	0	2	3	2
5	Strongly disagree	0	0	0	1	0
Total Responses		**11**	**12**	**15**	**10**	**12**

Comments – Question 12

- This relates to the issue of pace – during implementation of agreed solution/strategy issues do reoccur and this implementation and embedding phase can be too long
- We have worked hard on embedding the changes in the Trust. It still needs to be a conscious mind set though
- There do seem to be a number of sticky issues that are not going away
- Mainly

APPENDIX 2

BOARD COMPOSITION AT TIME OF BOARD EFFECTIVENESS SURVEY

January 2016		September 2016		March 2017		November 2017		September 2018	
Richard Gregory	Interim Chair	Richard Gregory	Interim Chair	Caroline Maley	Trust Chair	Caroline Maley	Acting Chair	Caroline Maley	Trust Chair
Maura Teager	Non-Executive Director	Maura Teager	Non-Executive Director	Julia Tabreham	Non-Executive Director	Maura Teager	Non-Executive Director	Julia Tabreham	Non-Executive Director
Caroline Maley	Non-Executive Director	Caroline Maley	Non-Executive Director	Margaret Gildea	Non-Executive Director	Julia Tabreham	Non-Executive Director	Margaret Gildea	Non-Executive Director
Tony Smith	Non-Executive Director	Jim Dixon	Non-Executive Director	Barry Mellor	Non-Executive Director	Margaret Gildea	Non-Executive Director	Geoff Lewins	Non-Executive Director
Jim Dixon	Non-Executive Director	Ifti Majid	Acting Chief Executive	Richard Wright	Non-Executive Director	Richard Wright	Non-Executive Director	Richard Wright	Non-Executive Director
Phil Harris	Non-Executive Director	John Sykes	Medical Director	Anne Wright	Non-Executive Director	Barry Mellor	Non-Executive Director	Anne Wright	Non-Executive Director
Ifti Majid	Interim CEO	Carolyn Green	Director of Nursing	Ifti Majid	Chief Executive	Anne Wright	Non-Executive Director	Ifti Majid	Chief Executive
John Sykes	Medical Director	Claire Wright	Director of Finance	Claire Wright	Deputy Chief Exec/FD	Ifti Majid	Acting Chief Executive	Claire Wright	Deputy Chief Exec/FD
Carolyn Green	Director of Nursing	Carolyn Gilby	Acting Director of Operations	Mark Powell	Chief Operating Officer	John Sykes	Medical Director	Mark Powell	Chief Operating Officer
Claire Wright	Director of Finance	Mark Powell	Director of Business Development	John Sykes	Medical Director	Carolyn Green	Director of Nursing	John Sykes	Medical Director
Carolyn Gilby	Acting Director of Operations	Sam Harrison	Director of Corporate Affairs	Carolyn Green	Director of Nursing & Patient Experience	Claire Wright	Director of Finance	Carolyn Green	Director of Nursing & Patient Experience
Mark Powell	Director of Business Development	Jayne Storey	Director of Workforce & OD	Sam Harrison	Director of Corporate Affairs & Trust Secretary	Mark Powell	Acting Chief Operating Officer	Sam Harrison	Director of Corporate Affairs & Trust Secretary
Jayne Storey	Director of Workforce & OD			Amanda Rawlings	Director of People & Organisational Effectiveness	Sam Harrison	Director of Corporate Affairs & Trust Secretary	Amanda Rawlings	Director of People & Organisational Effectiveness
Jenna Davis	Interim Director of Corporate & Legal Affairs			Lyn Wilmott-Shepherd	Interim Director of Strategic Development	Amanda Rawlings	Interim Director of People & Organisational Effectiveness	Gareth Harry	Director of Business Improvement and Transformation
						Lynn Wilmott-Shepherd	Interim Director of Strategic Development		
14 Board Members, 13 responders, 93%		12 Board Members, 10 responders, 83%		15 Board members, 100% response		14 Board members, 12 responses, 86%		13 Board members, 11 responses, 85%	

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Summary Report to Trust Board
Mental Health Act Committee (MHAC) - meeting held 8 March 2019

Key items discussed:

- **Matters Arising:**

  S12 doctor availability
  - Paediatrics not appropriate for S12 training. Discussions planned between CAMHS services north and south regarding combined rota
  - Some assessments taking longer than 12 hours to complete but not necessarily due to doctor availability – Local authorities (LA) collecting further data
  - Medical Director meets with AMHPs (Approved Medical Health Professional) and LA leads on regular basis – recent initiative agreed to improve availability of psychiatrist who is most familiar with patient
  - Medical Director has met with commissioners regarding project to decrease number of MHA (Mental Health Act) assessments. Commissioners decided not to proceed but to realise saving by cutting fee for MHA work
  - There will be further reports to MHA Operational Group

  Compliance with "patient rights" following audit results
  - Pilot in play to test automated reminders to Responsible Clinicians for CTOs (Community Treatment Orders) and for inpatients

- **Minutes of MHA Operational Group and Actions Matrix**
  - Importance of key members to attend meeting noted and timely papers stressed. Governance leads are currently embedded in acute inpatient units which are compromising their availability. Likewise local authority leads need to attend. To escalate to Executive Leadership Team (ELT).
  - S136 suites – 100% achieved re physical health checks
  - CQC visits – good progress re "Big %" on some units/wards but not in wards under pressure/high occupancy where low morale is evident. To escalate to ELT with report to Trust Board. Rationale for extended deadlines required from general managers
  - Slow improvement in training noted. Local target of 85% noted. JRS to discuss with Amanda Rawlings
  - Community capacity assessments have "hit ceiling" at 67% approximately. Improvements being made to EPR. Already escalated to ELT. Suggested that Performance Review Meeting needs to confirm Quality Improvement Plan at Trust Management Team

- **Review of Mental Health Act Committee BAF Risks -** Acceptable levels of compliance not achieved in some areas although situation significantly improved. Some evidence of improvement "levelling off" therefore no change to risk rating.

- **Mental Health Act Committee Year-end Effectiveness Report including Terms of Reference Review and Committee's effectiveness survey results**
  - Excellence of Medical Director's reports noted but Director of Nursing and Patient Experience also required for full picture.
  - More strategic approach will be required going forwards in view of:

    - Mental Health Act Review
    - Liberty Protection Safeguards (DoLS) changes with Royal Assent expected Spring 2019 and implementation next year

- Mental Health Units (Use of Force) Act 2018 – there will be a need to develop the approach to assurance in keeping with CQC guidance to:

  (1) Determine how good performance is
  (2) Benchmark against others
  (3) Identify local variation
  (4) Determine rate of improvement
  (5) Apply quality improvement techniques
  (6) Emphasise the importance of people factors, kindness and curiosity

  Reverse commissioning agenda could become submerged under all the other "hot issues". **CEO to confirm approach at Trust Board.**

- **Mental Health Act Manager's Report -** An increase in the number of seclusions over 8 hours was noted. It was decided to develop the report in keeping with the CQC guidance outlined above.

- **Monitoring of Compliance with MHA related CQC Actions -** The variance across inpatient units and wards was described – escalate to ELT with a view to considering different approaches to improve performance.
  - **Implications of the MHA review recommendations** – verbal update
    The pressing concerns are the changes to Liberty Protection Safeguards (DoLS):

    - Hospital Managers will become the Responsible Body
    - Our clinical teams will conduct the assessments
    - Information will be collected by the Trust for scrutiny by CQC

  - The MHA review points to a significant clinical and cultural change:
    - Less risk averse and restrictive practice
    - Fewer detentions including CTOs
    - Emphasis on person centred therapeutic approach
    - More safeguards for those detained including statutory care planning and increased access to tribunals and Second Opinion Doctors

  - It follows that without a shift in clinical practice there would be a significant increase in medico-legal work for inpatient clinicians and the Mental Health Act office.

  - The Mental Health Act Units (Use of Force) Act 2018:

    - Director of Nursing is the responsible officer and a Positive and Safe Group has been formed reporting to the Quality Committee (with briefings to the MHA Operational Group).
    - The issue of body cameras for inpatient nurses is under review

- **Restrictive Interventions -** The CQC national report "Monitoring the MHA 2017/18" highlights the high use of restrictive interventions, the high number of assaults on patients and staff and:
  - The poor fabric of many wards
  - Problems with staffing – numbers and expertise
  - Lack of therapeutic interventions "and not just medications"

  - A quality improvement approach to tackling restrictive practice was welcomed with overview by the Positive and Safe Steering Group, Campus COAT and with annual reporting to the Quality Committee

  - The Regional Medical Director has emphasised that "understanding and training staff in human factors is a key element to building safe patient systems" and "multi-disciplinary simulation training can be particularly helpful in this regard"

- The Trust Board will experience simulation training for themselves on a Board Development Day to assess:

  - impact of simulation training versus e-learning
  - potential for creating a joyful work environment
  - potential for team building

- **Associate Hospital Managers verbal update -** Two AHMs have resigned and two hearings cancelled as a result. Interim AHMs will be used whilst recruitment is in progress if appropriate checks are made. Recruitment will commence for up to 7 AHMs

- **MHA Associate Hospital Mangers Report to include model for AHM Appraisals -** Appraisals have been replaced by a peer review system and the policy was agreed.

- **Section 37/41 Review -** A multiagency panel is reviewing all S37/41 cases in the light of the recent Supreme Court judgement. This has replaced the planned audit of cases.

Policy Review - The following policies were ratified following pre-existing consultation:

- Seclusion and Long Term Segregation Psychiatric Emergency Policy and Procedures
- Joint Policy for Derbyshire on the Operational S136 of Mental Health Act 1983
- Mental Health Act 1983 S17 Leave Policy and Procedure
- Advance Decisions to Refuse Medical Treatment Advance Statements and Lasting Power of Attorney
- Mental Health Act 1983 Section 4 Emergency Application for Detention Policy and Procedure
- Mental Health Act 1983 Hospital Managers Scheme of Delegation Policy and Procedure

Issues escalated to Board or transferred to other committees

To Board:

CEO to report to Board on outcome of Reverse Commissioning and its strategic importance

To ELT:

- Poor levels of assurance from wards/units under intense operational pressure/activity
- Drawing of resource from clinical governance teams as a result
- Unless there is a different strategic direction taken for areas under pressure assurance levels are unlikely to change and risk will remain unmitigated
- Need for strategic review of implications of recently passed/proposed legislative changes

Decisions made

As above plus:

- Medical Director to report on S12 issues to MHA Operational Group
- Medical Director to discuss training approach with Amanda Rawlings
- BAF risk or equivalent in new system to remain high
- To develop strategic approach at MHAC
- Develop a new approach to assessing assurance based on latest CQC best practice guidance
- Agreed approach to facilitate positive and safe practice

Committee Chair: **Anne Wright**	**Executive Lead:** **John Sykes, Medical Director**

Derbyshire Healthcare NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
Quality Committee meeting held 12 March 2019

Key items discussed

- **BAF Risks for Quality Committee** – it was noted that there were no updates against the Physical Healthcare Strategy.

- **Quality Priority -** Minimum Standards for Quality Improvement Report. A self-assessment against the standards was completed. The criteria was reviewed and confirmed as a developing approach to quality improvement. Current level of assurance is limited. The Trust has a plan to reach a good rating service into the more mature element of self-assessment.

- **2018/19 Year-end Quality Committee Effectiveness Report.** There was a review of the effectiveness and graphs. The questionnaire and feedback was reviewed. The effectiveness overall confirmed compliance against the standard as set against the existing terms of reference.

- **Draft Quality Account –** A formal review of the draft Quality Account was undertaken. Statement review concluded it is fair and representative.

- **Quality Dashboard (bi-monthly) -** Overall the CQC actions are overdue regarding a specific element of supervision. Lack of progress on supervision and alternative ideas to increase performance is being escalated. Wider strategic discussions took place on the impact of sustained pressure in the acute service and on the wider Trust strategy. The impact, issues and solutions for further improvement will be taken through Board Development.

- **NHS Resolutions Detailed Report -** The action plan was agreed and was devolved to Trust Management Team and relevant Executive Director.

- **Update report on Infection Control –** Confirmed. Full assurance received based upon escalation of concern to all Trusts in the region to review compliance with the Hygiene code.

- **Learning from Deaths Mortality Report -** A comprehensive submission of mortality reviews was submitted. Report will be reviewed under bi-monthly scrutiny with an executive lead. The executive lead is to increasingly improve analysis of the impact of preventative and improving practice for the future to improve the prevention of any future mortality wherever possible in our services.

- **Physical Healthcare Strategy -** Strategy implementation plan has been drafted and will be scheduled for Physical Healthcare Executive Committee and the Executive Leadership Team (ELT). Limited assurance due to the need to improve pace.

- **Medicines Optimisation and Pharmacy interim assurance report -** Significant assurance received on excellent work undertaken.

- **Clinical Audit Annual Report and Clinical Audit Plan 2019/20**- was not received

- **NICE Guidelines Update** - Limited assurance obtained due to the need for improvement work.

- **Patient Experience Quarter 3 Report -** Limited assurance on overall outcome and the governance systems. The wider themes of this report were the warning signs of capacity and

demand. The key triangulation of this report was noted as issues relating to the capacity and demand issue as well as the possible cultural changes of empowering patients to make choices and improve our care planning.

- **EDS 2 Update Report –** The quality improvements to Children's services relating to equalities were commended.
- **Clinical Audit Framework Policy and Procedures -** was not submitted to the Committee – deferred to April.
- **Handling Patient Feedback Comments Concerns Complaints Compliments Policy and Procedures** - ratified
- **Consent to Examination and Treatment Policy and Procedures** - ratified

Assurance/Lack of Assurance Obtained

- The Quality Improvement Strategy self-assessment showed limited assessment of progress to become a mature service
- Significant assurance was achieved for the production of the draft Quality Account, Infection Control Position Statement, Learning from Deaths Mortality Report, Medicines Optimisation and Pharmacy interim assurance report and EDS 2 Update Report on compliance
- Limited assurance was achieved for Quality improvement, Quality Dashboard – CQC and supervision performance, Physical Healthcare strategy implementation plan, NICE Guidelines and Patient Experience Quarter 3 Report.
- NHS Resolutions Detailed Report was provided and delegated to the Trust Management Team.

Meeting Effectiveness

- The Committee reviewed all papers, the detail, assurance and the required improvements covered in all papers. The Committee was successful in its outcomes.
- Members fed back that the Committee was feeling increasingly strategic.

Decisions made

- The Quality Improvement self-assessment and review of implementation plan has been scheduled for June 2019.
- At the next meeting the Committee will review the good care model and review the assurance metrics and achievement.

Escalations to Board or other committee

- The executive leadership team have escalations to review on Physical healthcare implementation plan and wider plans to impact upon capacity and demand management based upon triangulation of the Quality dashboard, supervision levels and dips in quality associated with pressure.

Committee Chair: Dr Julia Tabreham, Current Margaret Gildea.	**Executive Lead: Carolyn Green, Director of Nursing & Patient Experience**

Derbyshire Healthcare
NHS Foundation Trust

HELD IN CONFIDENCE

Board Committee Assurance Summary Report to Trust Board
Finance & Performance Committee – Meeting held 19 March 2019

Key items discussed

- **Board Assurance Framework – F&P risks** - Acknowledged the closing position of 2018/19 BAF risks, noting need to ensure audit trail of residual risk into the 2019/20 BAF. Contextual discussions on impact of actions, risk appetite and risk tolerance.

- **Commissioning Interface and Contract Update** - Discussion of current position with contract negotiations with CCG and NHSE. Committee appraised of key issues in preparation for further discussion at plan sign-off meeting. Discussed potential for significant financial impact of estates requirements in near future.

- **Operational Performance and KPI Achievement** – Discussed persistent issues eg out of areas, gaps in equalities monitoring data and challenge of GP data completeness in referrals. Also discussed delayed transfers of care discussed and Royal Derby ED 12 hour breaches.

- **CIP Delivery and Continuous (Quality) Improvement Delivery Programme** – Impact of discussions with commissioners and size of CIP, the size of non recurrent and levels of risk to delivery

- **IM&T Update (patient record update)** - Progress of discussions on consultancy. Need to see articulation of benefits realisation, even if not yet quantified. Need combined reporting covering technical and transformational update.

- **Sustainable Management Delivery Plan (SDMP)** - Discussed recent changes to Annual Governance Statement requirements. Requires further clarification of priority order of actions and those already undertaken. Acknowledged it is a live plan and will be reviewed regularly

- **2018/19 Financial Performance and 2019/20 Planning Update** - Key drivers and risks anticipated achievement of 18/19 control total and risks into next year. Discussed the main movements at year end that will drive the in-month deficit and cash reduction in March. Noted excellent result with rating of 1 at year end.

- **Reference Costs Process Sign Off** - Greater scrutiny now required by NHSI ahead of mandatory introduction of PLICS (patient level costing). Discussed resources and systems for compiling reference costs and the increasing priority of accurate data capture (including clusters) for the benefit of demonstrating quality and value in services as well as for correct costing and pricing

- **Year-end review of F&P Committee's effectiveness** (aligned to TOR, including structured qualitative review) – Positive report of the work of the Committee and future objectives.

Assurance/lack of assurance obtained

- **Commissioning interface** – Limited assurance due to the financial size of unresolved issues and the timescales remaining
- **Operational Performance** – Limited assurance due to some persistent issues

- **Continuous Improvement and CIP delivery 2019/20** – Limited assurance due to lack of full recurrent pipeline and future programme
- **IM&T records update** – Limited assurance – need to articulate the benefits
- **2018/19 Financial Performance** – Significant assurance for 2018/19 delivery given the forecast end result and the risks successfully managed in year

Key risks identified

- Commissioner governance approval timeframes creating risk to contract and MHIS sign off for 21 March deadline
- Non-alignment of planning: The operational plan has to be collated prior to concluding contract negotiations and contract sign off therefore assumptions in plan will not fully triangulate with commissioner (CCG) assumptions.
- Lack of sight of due diligence information for PICU proposal (and operational resilience to deliver)
- Requirement for significant future funding for costs and impact of estate requirements (capital and revenue)
- Lack of full recurrent CIP and longer term continuous improvement programme
- Capacity to deliver full range of priorities/non-mandatory items

Decisions made

- Sustainable Development Management Plan - approved
- Reference Cost process – approved
- F&P Committee 2018/19 year-end report - approved
- Terms of Reference slight amends - approved
- Committee objectives for 2019/20 – approved (subject to speaking up item discussion at next Committee chairs meeting)
- Forward plan for 2019/20 – approved

Escalations to Board or other committee

- None (noting action for committee chairs' discussion on ED&I and Speaking up objectives, and expectations of deputies in quoracy/attendance of Committees)

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

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Summary Report to Trust Board
Audit & Risk Committee – Meeting held 21 March 2019

Key items discussed

- Board Assurance Framework 2018/19 Issue 5 and draft 2019/20 Issue 1
- Implementation of internal and external audit recommendations progress report
- Annual Report and Accounts 2018/19 update including timetable and response to Grant Thornton Benchmarking survey 2017/18
- Draft Annual Governance Statement
- Draft Committee Year-End Effectiveness Review
- External Audit Progress Report – including confirming Council of Governors' identification of quality indicators
- Internal Audit progress report
- Lessons Learned from Counter Fraud and Bribery cases and action taken by People Services on allegations of Counter Fraud

Assurance/lack of assurance obtained

- Significant assurance received on process followed to update and finalise 2018/19 BAF and develop and manage 2019/20 BAF
- Significant assurance on follow up of actions arising from internal audit, external audit and counter fraud recommendations
- Assurance on progress to planned timetable for annual report and accounts, annual governance statement and quality account
- Significant assurance received that 2017/18 annual report prepared in line with requirements as per the Grant Thornton benchmarking report.
- Full assurance of Grant Thornton programme of work
- Full assurance that Committee fulfilled its role effectively as evidenced through year-end report
- Significant assurance that internal audit programme and counter fraud plan on track for completion 2018/19 and draft plans in place for 2019/20
- Significant assurance with minor improvements opinion on Data Security and Protection audit and Data Quality audit
- Significant assurance received on lessons learned on counter fraud and bribery cases – including actions taken on follow up of issues raised as part of historic review of sickness absence. Concluded sufficient control and management mechanisms in relation to counter fraud bribery and corruption, in line with Counter Fraud Authority Standards.

Key risks identified

- BAF risks as outlined on the 2018/19 BAF and as mapped to 2019/20 BAF. Risk relating to Mental Health legislation compliance which remains high at the close of 2018/19 to be further reviewed and reflected in the 2019/20 BAF as part of ongoing development and management of the BAF

Decisions made

- Matters Arising – agreed that overarching report on Data Quality, to include review of actions relating to internal audit recommendations, and to provide assurance on the implementation of the Trust's Data Quality policy, be presented to April or July meeting. Mark Powell to attend.
- Agreed BAF subject to amendments and comments from Committee members. Comments to include further emphasis on patient safety and compliance to be included in next iteration
- Updated draft of the Annual report to be submitted to 30 April Committee meeting. To include reflecting Suzanne Overton-Edward's attendance at recent Committee meetings.
- Draft Annual Governance Statement to be updated to reflect Committee debate, including comment from auditors to acknowledge staff survey feedback relating to patient safety risk. Subject to this, agreed document was balanced and gives accurate reflection of Trust's position. Updated draft to be brought to 30 April Committee meeting.
- Agreed Committee objectives for 2019/20 to be incorporated into final draft of the year-end report.
- To circulate Internal Audit programme to Non-Executive Directors for awareness following update by 360 Assurance to reflect 2019/20 BAF risks. Agreed follow up activity to include sample check of Trust's completed actions report.
- Committee forward plan to be further reviewed and shared with the Committee chair for 30 April meeting. Routine Data Quality reporting to be added.

Escalations to Board or other Committee

- Escalation to Executive Leadership Team to review internal audit programme contingency days to consider use for high risk areas such as patient safety audit and/or other issues arising from work up of BAF assurances/gaps.

Committee Chair: Geoff Lewins **Non-Executive Director**	**Executive Lead: Sam Harrison** **Director of Corporate Affairs**

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 2 April 2019

Register of Trust Sealings 2018/19

Purpose of Report

This report provides the Trust Board with a six month update of the authorised use of the Trust Seal since the last report to the Board on 2 October 2018.

Executive Summary

In accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors the Trust Seal is affixed to legal transactions, including deeds, transfer and letting of contracts over £100,000.

All contract documents, up to the value of £100,000, shall be signed on behalf of the Trust by an Executive Director (voting or non-voting) or nominated officer. Every contract value which exceeds £100,000 shall be executed under the Common Seal of the Trust and be signed by the Trust Secretary and an Executive Director (voting or non-voting) duly authorised by the Chief Executive and not from the originating department (as set out in the Board's Standing Financial Instructions point 8.18).

These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates and Agile Working Strategy. In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

A six month report on use of the seal from 1 April - 2 October 2018 was made to the Board on 2 October 2018. Since 2 October the Trust Seal was affixed as follows:

1. DHCFT58 contract with Oxehealth £131,519 for HD (Human Activity Detection) RVS (Remote Vital Signs) LRW (Location Risk) systems
2. DHCFT59 Lease of first floor, Ripley Library, 17 – 23 Grosvenor Road, Ripley
3. DHCFT60 contract with 360 Assurance for internal audit services, counter fraud and well-led governance
4. DHCFT61 contract with Grant Thornton LLP for external audit services, counter fraud and well-led governance
5. DHCFT62 licence for alterations Ward 2, London Road Community Centre between University Hospitals of Derby & Burton (UHDB) NHS Foundation Trust and Derbyshire Healthcare Foundation Trust (DHCFT)
6. DHCFT63 under lease Ward 2, London Road Community Centre between UHDB and DHCFT
7. DHCFT64 Deed of variation Ward 2, London Road Community Centre between UHDB and DHCFT
8. DHCFT65 Service Line Agreement with Arden GEM CSU
9. DHCFT66 Rent review memorandum, St Andrew's House Trillenium Property Trading Limited and DHCFT

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.	
4) We will **transform** services to achieve long-term financial sustainability.	X

Governance or Legal issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Financial Instructions and Standing Orders of the Board of Directors.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks – there is no direct impact on those with protected characteristics arising from this report.

Recommendations

The Board of Directors is requested to note the authorised use of the Trust Seal since October 2018 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Report presented by: **Justine Fitzjohn**
Incoming Trust Secretary

Report prepared by: **Sue Turner**
Board Secretary

2019-20 Board Annual Forward Plan

Exec Lead	Item	2 Apr 19	7 May 19	2 Jun 19	2 Jul 19	3 Sep 19	1 Oct 19	5 Nov 19	3 Dec 19	4 Feb 20	3 Mar 20
	Paper deadline	**26 Mar**	**29 Apr**	**28 May**	**24 Jun**	**27 Aug**	**23 Sep**	**28 Oct**	**25 Nov**	**27 Jan**	**24 Feb**
Trust Sec	Declaration of Interests	X	X	X	X	X	X	X	X	X	X
CG	Patient Story	X	X	X	X	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X	X	X	X	X
CM	Board Forward Plan (for information)	X	X	X	X	X	X	X	X	X	X
CM	Board review of effectiveness of meeting	X	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE											
CM	Chair's Update	X	X	X	X	X	X	X	X	X	X
IM	Chief Executive's Update	X	X	X	X	X	X	X	X	X	X
MP/CW	NHSI Annual Plan - timing to be confirmed							X			
Trust Sec	NHS Improvement Year-End Self-Certification		X								
AR	Staff Survey Results										X
AR	Equality Delivery System2 (EDS2)							X			
AR	Workforce Race Equality Standard (WRES)				X						
AR	Workforce Disability Equality Standard (WDES)				X						
AR	Gender Pay Gap Report										X
AR	Public Sector Duty Annual Report									X	
AR	Pulse Check Results and Staff Survey Plan					X					
Trust Sec	Corporate Governance Framework							X			
Trust Sec	Trust Sealings (six monthly)	X					X				
Trust Sec	Annual Review of Register of Interests	X									
Trust Sec	Board Assurance Framework Update	X		X		X		X		X	
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)				X						X
Committee Chairs	Board Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance Committee - Mental Health Act Committee - - Quality Committee - People & Culture Committee - Safeguarding Committee	X	X	X	X	X	X	X	X	X	X
Trust Sec	Fit and Proper Person Declaration		X								

Exec Lead	Item	2 Apr 19	7 May 19	2 Jun 19	2 Jul 19	3 Sep 19	1 Oct 19	5 Nov 19	3 Dec 19	4 Feb 20	3 Mar 20
MP	Emergency Planning Report (EPPR)							X			
Trust Sec	Board Effectiveness Survey Report Policy for Engagement between the Board and COG	X							X		
Trust Sec	Report from Council of Governors Meeting (for information)	X		X		X	X		X	X	
GH	Business Plan Monitoring close down of 2018/19 and proposal for 2020/21 (May)		X					X			
GH	Measuring the Trust Strategy		X								
AR	Flu Campaign for 2019/20							X			X
OPERATIONAL PERFORMANCE											
CG/CW/AR/ MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard		X	X	X	X	X	X	X	X	x
CG/JS/AR/ MP	Workforce Standards Formal Submission/Safer Staffing										X
QUALITY GOVERNANCE											
CG/CW/MP/ GH/JS	Quality Report - focus on CQC domains	X	X	X	X	X	X	X	X	X	X
JS	Learning from Deaths Mortality report (quarterly publication of specified information on death) Apr/Jul/Oct/Feb/Apr	X			X		X			X	
CG/JS	Safeguarding Children & Adults at Risk Annual Report					X					
JS	NHSE Return on Medical Appraisals sign off					X					
CG	Control of Infection Report				A						
JS	Re-validation of Doctors				A						
CG	Annual Review of Recovery Outcomes								X		
CG	Treat Me Well Campaign Update				X						
CG	Annual Looked After Children Report							X			

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 April 2019

Report from the Council of Governors Meeting Held on Tuesday 5 March 2019

The Council of Governors met on Tuesday 5 March 2019 at the Centre for Research and Development, Kingsway Hospital site, Derby. The meeting was attended by 15 governors.

Briefing on NHS Long Term Plan

Ifti Majid provided a presentation on the NHS Long Term Plan. It was agreed that the NHS Long Term Plan will be a standing item on the agenda for the Council of Governors meetings.

Selection of Quality Indicators/Arrangements for production of Governor Statements on the Quality Report

As part of NHS Improvement's (NHSI) requirement, foundation trusts are required to produce an annual Quality Account, which gives a clear understanding of the Trust's performance and assurance of the steps the Trust is taking to improve patient safety, experience and outcomes. The Trust's External Auditors, Grant Thornton, attended the meeting to guide governors through the choice available to them in choosing an indicator as part of the Trust's internal and external audit of data quality checks to measure data completeness and accuracy. A number of governors had already discussed the options in a pre-meeting. Following further debate governors agreed to select the following indicator from the three available core options:

1) **Option 2:** 100% enhanced Care Programme Approach patients receiving follow up contact within seven days of discharge from hospital during the reporting period.

Arrangements to gain governors' feedback on the first draft of this year's Quality Report

It was agreed that a governor discussion would take place at the Governance Committee meeting on 9 April 2019. Darryl Thompson will be in attendance and following the discussion Darryl will draw up the statement and circulate for comment and agreement to be submitted prior to the 30 April consultation deadline. The finalised statement will be presented to the Council of Governors at its 7 May meeting for formal receipt.

Non-Executive Director deep dive

Caroline Maley, Trust Chair, gave an update on the range of activities that she carries as out as Chair for the Trust.

Staff Survey

Margaret Gildea presented details of the staff survey results based on the 2018 staff survey, which showed a positive increase across all domains. More staff have taken

part in this survey than in previous years; a number of hotspots have been identified and there is focus on these.

Integrated Performance Report

The Integrated Performance Report was presented to the Council of Governors to provide an overview of performance as at the end of January 2019. The Non-Executive Director Board Committee Chairs reported on how the report had been used to hold Executive Directors to account in their respective Board Committees for areas with regards to workforce, finance, operational delivery and quality performance.

Escalation Items to the Council of Governors

Three items were escalated to the Council of Governors from the Committee. Geoff Lewins, Chair of the Audit and Risk Committee, responded to a question relating to inpatient staff pressures. Margaret Gildea, Chair of People and Culture Committee, responded to a question seeking assurance that recruitment processes and interview scoring systems ensure that the best appointment for the role is made. Anne Wright, Chair of Mental Health Act and Safeguarding Committee responded to a question seeking assurance that an effective strategy for physical and mental healthcare is in place, especially for the management of an ageing population with multiple co-morbidities.

Governance Committee Report

Kelly Sims, Chair of the Governance Committee presented a report of the meeting held on 12 February 2019. Kelly Sims asked for governors to approve the revisions to the Governor Code of Conduct following discussion and recommendation for approval from the committee, and to agree the governor training and development programme for 2019/20. Both were approved.

Review of Governors' Engagement Action Plan

Angela Kerry gave an update of the actions and it was agreed that the plan would be reviewed annually.

RECOMMENDATION
The Trust Board is asked to note the summary report from the Council of Governors.

Derbyshire Healthcare
NHS Foundation Trust

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAT	Drug Action Team
DBS	Disclosure and Barring Service
DfE	Department for Education
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DPA	Data Protection Act
DRRT	Dementia Rapid Response Team
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FSR	Full Service Record
FT	Foundation Trust
FTN	Foundation Trust Network
F&P	Finance and Performance
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GMC	General Medical Council

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
GP	General Practitioner
GPFV	General Practice Forward View
H	
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health & Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System (formerly ACS)
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
IM&T	Information Management and Technology
IPP	Imprisonment for Public Protection
IPR	Individual Performance Review
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
M	
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
MCA	Mental Capacity Act
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFF	Market Forces Factor
MHA	Mental Health Act
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSI	National Health Service Improvement
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OP	Out Patient
OSC	Overview and Scrutiny Committee
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
Q	
QAG	Quality Assurance Group
QC	Quality Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS	
NHS Term / Abbreviation	**Terms in Full**
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SI	Serious Incidents
SLA	Service Level Agreement
SLR	Service Line Reporting
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
S(U)I	Serious (Untoward) Incident
T	
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TMT	Trust Management Team
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
TMAC	Trust Medical Advisory Committee
W	
WTE	Whole Time Equivalent