Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Public Board Meeting

Conference Rooms A and B, First Floor, Centre for Research and Development, Kingsway Hospital
31 January 2018 13:00 - 31 January 2018 16:00

INDEX

Derbyshire Healthcare NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – WEDNESDAY 31 JANUARY 2017
TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOMENT, KINGSWAY HOSPITAL

	TIME	AGENDA	LED BY
1.	1:00	Chair's welcome, opening remarks, apologies for absence and Declarations of Interest Register	Caroline Maley
2.	1:05	Service Receiver Story – Family First Model	Carolyn Green
3.	1:30	Minutes of Board of Directors meeting held on 29 November 2017	Caroline Maley
4.	1:35	Matters arising – Actions Matrix	Caroline Maley
5.	1:40	Questions from governors or members of the public	Caroline Maley
6.	1:45	Chair's Verbal Update	Caroline Maley
7.	1:55	Chief Executive's Update	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY			
8.	2:10	Integrated Performance and Activity Report	Mark Powell/Claire Wright/Amanda Rawlings/Carolyn Green
9.	2:40	Position Statement on Quality - Mortality Report December 2017	Carolyn Green John Sykes
10.	2:50	Board Committee Assurance Summaries and Escalations: Audit & Risk Committee 14 December, Quality Committee 14 December, Audit & Risk Committee 16 January, Quality Committee 11 January, People & Culture Committee 19 January 2018 *(minutes of these meetings are available upon request)*	Committee Chairs
3:10 B R E A K			
11.	3:25	Deep Dive – Kedleston Unit	Mark Powell
12.	3:40	Board Assurance Framework Update – Fourth Issue	Claire Wright
13.	3:50	Deloitte Well-led Framework Report	Ifti Majid
14.	3:40	Register of Trust Sealings 2017/18	Claire Wright
CLOSING MATTERS			
15.	3:45	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Report from Council of Governors Meeting 28 November 2017			-
2017/18 Board Forward Plan			-

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.turner2@derbyshcft.nhs.uk
The Trust Chair may, under the Foundation Trust's Constitution, request members of the public to withdraw for the Board to conduct its remaining business in confidence as special reasons apply or because of information which is likely to reveal the identities of an individual or commercial bodies.

The next meeting will be held at 1.00 pm on 28 February 2018
in Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ
Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion

Declaration of Interests Register 2017-18

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	Director, Organisation Change Solutions Limited Non-Executive Director, Derwent Living	(a, b)
Geoff Lewins Non-Executive Director	Director, Woodhouse May Ltd Director, Arkwright Society Ltd	(a, b)
Ifti Majid Chief Executive	Board member, North East Midlands Leadership Academy Board Kate Majid (spouse) Chief Executive of the Shaw Mind Foundation which is a UK/USA mental health charity	(a, d)
Caroline Maley Acting Trust Chair	Director – C D Maley Ltd Trustee – Vocaleyes Ltd.	(a) (a, d)
Mark Powell Chief Operating Officer	Chair of Governors, Brookfield Primary School, Mickleover, Derby	(d)
Amanda Rawlings Director of People and Organisational Effectiveness (DHcFT)	Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) Co-optee Cross Keys Homes, Peterborough	(a, d)
Dr Julia Tabreham Deputy Trust Chair and Non-Executive Director	Non-Executive Director, Parliamentary and Health Service Ombudsman Director of Research and Ambassador Carers Federation Leads the Parliamentary and Health Service Ombudsman's contribution to establishing NHS complaints advocacy support in Ireland Husband, Steve Tabreham of Steve Tabreham Inspection Services, also works for Lloyds Register	(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. Sits on the management side of the Trust's Local Negotiating Committee	(e)
Richard Wright Non-Executive Director	Director, Sheffield Chamber of Commerce Chair, The UTC Sheffield Multi Academy Trust Member of Advisory Board of Sheffield National Centre for Sport and Exercise Medicine	(a, d)
Lynn Wilmott-Shepherd Interim Director of Strategic Development	Director of Commissioning and Delivery, NHS Erewash Clinical Commissioning Group	(d)

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

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.
(e) Any connection with a voluntary or other organisation contracting for NHS services.

Family First Model

Partnership working within 0-19 service

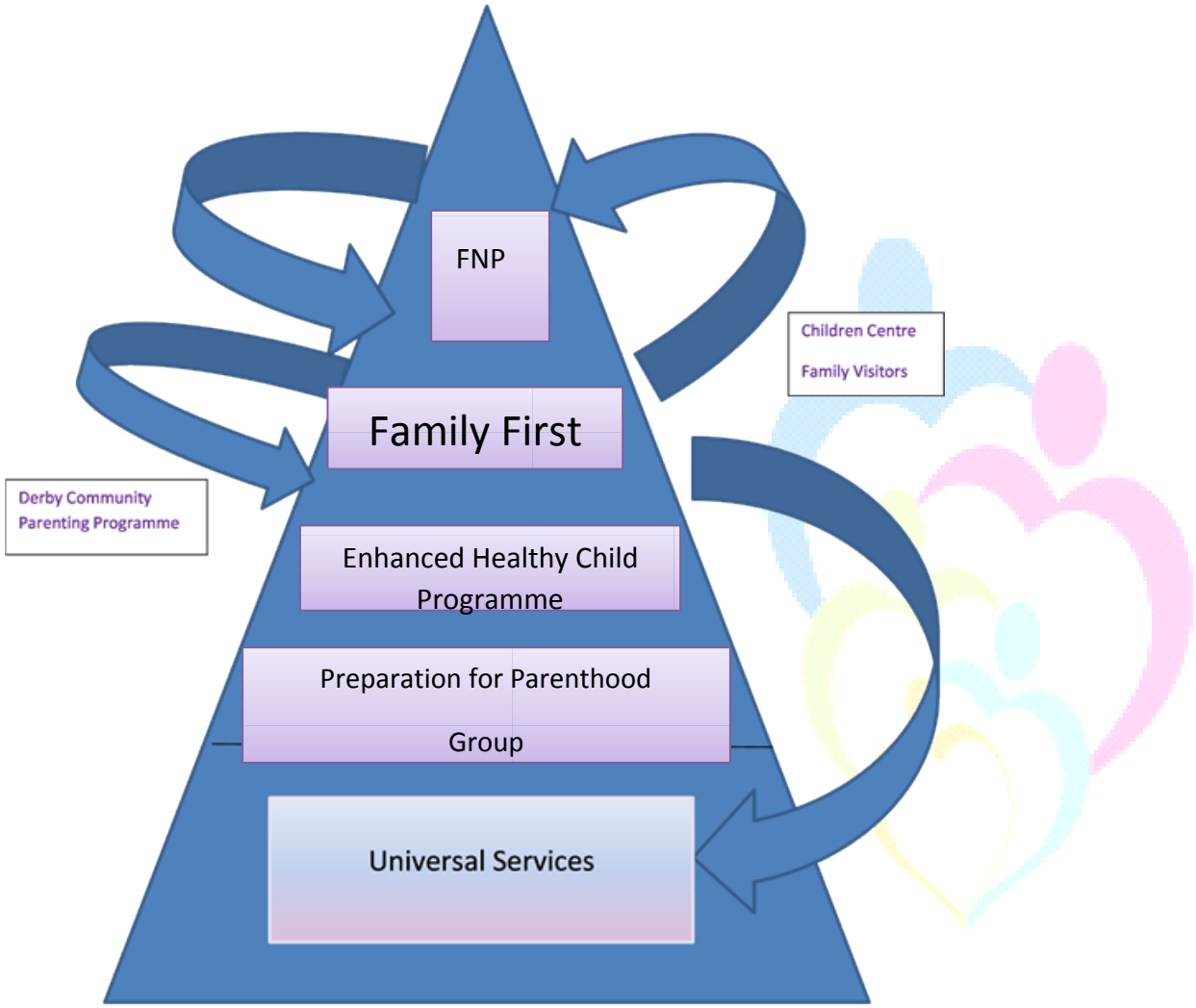
Derby Integrated Family Health Service

Why Family First?

In response to the new Service Specification (SS), it had been identified that there was a gap within Derby City for vulnerable families who did not meet the criteria for Family Nurse Partnership (FNP).

Commissioners wished for more vulnerable families to have access to a specialist Parenting Programme.

Derby City 0 -19 Service Offer Depending on Level of Identified Needs



Family First Aims

- Have a Healthy Pregnancy- providing babies with the best start in life
- Become knowledgeable, sensitive and responsive parent
- Develop positive health, social and economic outcomes for families and their children

Referral Criteria

Automatic Referral → Those with LD (Learning Difficulties), LAC (Looked After Children) and risks of CSE (Child Sexual Exploitation)

Vulnerability Factors →

- Homelessness/sofa surfing
- Mental Health Issues
- Substance Misuse
- Domestic Abuse
- Environmental Risks
- Isolated

Criteria

Under 17's if declined or dis-engaged from FNP in pregnancy

Under 18's with one factor

Over 18's but under 25 with two factors

Concealed Pregnancies to be reviewed on a case by case basis.

First Parenting Experience- (neonatal death)

Some of the support Family First Offers.....

Life course Development

Attachment

Preparation for Parenthood

Being a Positive Parent

Housing

Healthy Living

Relationships

Coping Strategies

What will the visit structure look like…..

Pregnancy

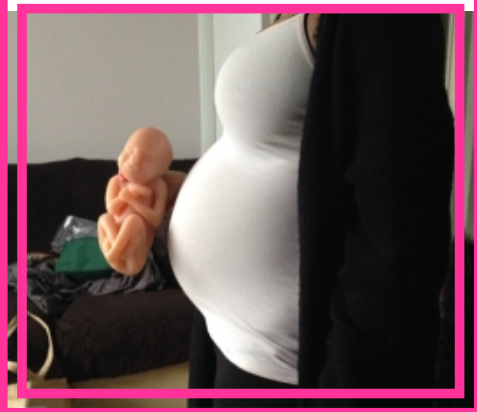
5 Core Visits

Recruitment visit

4 x visits

1 x 36-38 week visit

Introduction to Derby Community Programme (DCPP).



0 to 12 Months
7 Core Visits

Primary Birth Visit
Day 10 - 14

2 x fortnightly visits

6 – 8 Week Review
Joint visit with Family Visitor

4 Months

8 Months

12 Months

1 to 2 and a half years

3 x CoreVisits

18 Months

2 Years

2 and a half Years

Additional to home visits will be telephone support, Children's Centre joint contact and possible group support

My journey with family first….Why?

- I have been a HV champion for the family first team since November 2016.
- Enhance my skills as a Public Health Nurse
- Explore different ways of working
- Frustration with limited tools and I wanted to explore a delivery of health promotion in a less directive style, moving away from leaflets.
- Experience a more therapeutic relationship with clients, within my HV role.

Impact on practice for me

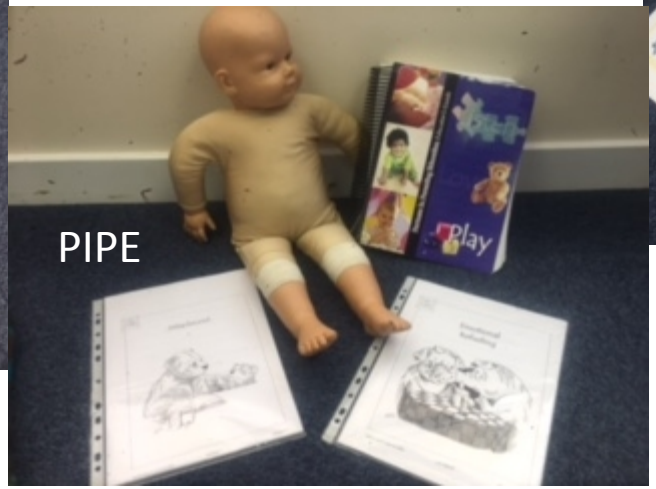
- Change in delivery style for not only my FF Clients but my universal contacts
- Increased moral and job satisfaction
- Professional development and Increased Learning Opportunities
- New group work initiated within the children's centre for antenatal contact which has improved partnership working.
- Better understanding and relationships of specialised services within 0 -19 partnerships
- Supervision- using the new tools (vulnerability matrix and the 7 Ps) has enhanced supervision sessions. Directly impacting on the positive outcomes for families.
- Child protection contacts have more focus with the use of pipe tools.
- Positive feedback and engagement from clients

Tools


Breastfeeding box


Baby Brain box


Contraception Box


PIPE


Lullaby Trust safe sleep

Clients involvement in the development of FF

- **Involvement in interview process for recruitment of HV FF champions**
- **Discussions with Family Nurse Partnership National Unit around model development**
- **Focus groups around development of Family First- Quarterly**
- **Involved in Derby University Evaluation of Model**

Any Questions?

Client Focus Group

Family First Model

12th December 2017

Client Focus Group Report for Family First

The aim of the focus group was to discuss the clients' experiences of the Family First Model, explore what changes could be made to enhance the service and their thoughts of being a young parent in Derby City.

Six Clients from all stages of the Family First Programme (Pregnancy, Infancy and Toddlerhood) were invited to the Focus Group. These included two fathers.

The information obtained from this focus group will support practitioners in the development of the Model, ensuring it is meeting the needs of service users and also support the academic evaluation of the model by Derby University.

It was decided that these groups would be helpful to hold every three months, looking at different themes and development of the Model.

What was liked by clients

- Parents not told what to do
- Options available / choice given
- Really relaxing, feels like a partnership
- Feel I have lots of support – my questions get answered
- Identified my needs; felt well supported; feel more confident around parenting
- Able to get to know my Family First Nurse and build a relationship
- Familiar face – don't have to keep re-telling my story, which is not easy to do
- Able to trust my Nurse
- Really like having the same worker, get used to them
- Like the different tools and not being told how to do things, or given a load of leaflets

Changes to service

- Need to make fathers more aware that the service is for them too
- Visiting Pattern went from seeing every week to large gaps - How can you support us with this change in visit frequency?

What is it like being a parent in Derby City

- What is there to do in Derby City in the winter that is not expensive?
- Really enjoy the Young Parents Group at the Quad; lovely staff and great activities
- Need more knowledge of what is available and how to access
- More groups please
- Went to a good group at Monmouth Street – but no one else other than staff there, so not much point
- Sad that the Children's Centre at West End has shut down
- Very little available for parents that is cost effective
- Parks aren't great

What do parents aspire for their children

- My child to go to university
- To never go without
- Feel safe
- Have safe places to play in
- To pursue their dreams
- More support groups and opportunities to meet other parents
- More information relating to Family Services
- To never feel neglected, or like they missed out on having a Dad

Derbyshire Healthcare
NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

Held in Conference Rooms A&B
Research and Development Centre, Kingsway, Derby DE22 3LZ

Wednesday 29 November 2017

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4.25pm

PRESENT:	Caroline Maley	Trust Chair
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director
	Dr Anne Wright	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Director of Finance & Deputy Chief Executive
	Dr John Sykes	Medical Director
	Carolyn Green	Director of Nursing & Patient Experience
	Mark Powell	Chief Operating Officer
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
	Lynn Wilmott-Shepherd	Interim Director of Strategic Development
IN ATTENDANCE:	Geoff Lewins	Incoming Non-Executive Director
	Anna Shaw	Deputy Director of Communications & Involvement
	Hollie Cowan	Senior Communications Officer
	Sue Turner	Board Secretary (minutes)
For DHCFT 2017/171	Nicola Fletcher	Acting Assistant Director of Clinical Professional Practice
	Daniel Pidkorczemny	Engagement Officer, Healthwatch Derbyshire
APOLOGIES:	Barry Mellor	Non-Executive Director
VISITORS:	John Morrissey	Lead Governor and Public Governor, Amber Valley South
	Carole Riley	Deputy Lead Governor and Public Governor, Derby City East
	Shelley Commery	Public Governor, Erewash North (part)

DHCFT 2017/170	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** Trust Chair, Caroline Maley, opened the meeting, welcomed everyone and introduced incoming Non-Executive Director (NED), Geoff Lewins, who was attending today's meeting as an observer and would be replacing Barry Mellor as Chair of the Audit and Risk Committee. Barry Mellor had offered his apologies for today's meeting and thanks were extended to him in his absence for the contribution he has made to the Trust as a NED and Chair of the Audit and Risk Committee as his appointment would finish at the end of December 2017. Caroline Maley congratulated Mark Powell on his appointment as Chief Operating Officer which took effect on 20 November. The Register of Declarations of Interest would be updated in respect of the entries under

	Deputy Trust Chair, Julia Tabreham, Medical Director, John Sykes and Mark Powell and would be brought to the next meeting of the Board.
DHCFT 2017/171	**SERVICE USER STORY** Assistant Director of Clinical Professional Practice, Nicola Fletcher, introduced Daniel Pidkorczemny, from Healthwatch Derbyshire who presented a summary of a service user story that was previously presented to the Derbyshire Health and Wellbeing Board on 5 October 2017. Trust Chair, Caroline Maley had asked for this story to be heard at today's Board meeting to allow the Board to obtain learning from this service user's experience of accessing health and social care services. Daniel explained how Healthwatch provides an independent voice for users of health services. He gave an overview of the series of events caused by a lack of support and communication from mental health services and social care services that resulted in a service user's downward spiral of their mental health. This led to their mental health deteriorating and a restriction being put on their access to mental health services and an eventual prison sentence. The report set out the history about this individual who was diagnosed with Borderline Personality Disorder (BPD) and made it clear that if the right interventions had been in place earlier and access to the right treatment had been available a prison sentence could have been avoided. The report also described how this service user suffered delays in access to the correct treatment and the problems they experienced having to repeat their medical history to different professionals within the psychological therapy service and multi-disciplinary team. There was lack of communication and transparency with regard to referrals and mistakes were made. However, Daniel was pleased to report that as a result of receiving counselling and treatment this person has since recovered from their negative experiences and is actively trying to set up a support group for people with a personality disorder. The Board was sincerely sorry that this person had not received a good experience from health and social care services. Deputy Trust Chair, Julia Tabreham, wondered when this had all happened as the National Institute for Health and Care Excellence (NICE) have carried out a lot of work to improve the care and treatment of offenders and she asked how closely the Trust was adhering to the new NICE guidelines and whether they are helpful. Executive Director of Nursing and Patient Experience, Carolyn Green, clarified that we are applying the principles and are dealing with concepts of treatment but there is no defined pathway for people diagnosed with personality disorder. The outcomes of this particular case were not due to the clinical effects of this condition. When dealing with this person's trauma and experiences we would need to assess whether we were compliant with NICE guidelines, in this particular case it would appear that we may have been fully compliant with our expected standards of practice. We should and will explore whether we could work differently with people who are released from prison. We will review the personality disorder NICE guideline and review compliance this year. It was clear that this individual felt that their expectations had been raised and that they had received broken promises. Medical Director, John Sykes, explained that personality disorder pathway is not fully defined and commissioned along a full pathway approach in Derbyshire. He suggested implementing support plans for individuals leaving prison who are known to have mental health conditions to help them with practical issues so they understand how to access the services they need. This would enable individuals to understand what can be covered by their treatment and would ensure people's expectations are filled. He outlined how the development of EPR (Electronic Patient Record) has helped to improve our services. Having this system means service users only have to tell their story once and this information is recorded which allows more time for practitioners to take care of the family and carers. The Board understood that this case involved a complex set of circumstances and

	touched upon the lived experience of our services and brought attention to the risks of our current commissioning landscape and the impact it has on the people we support. The Board pledged to improve the transparency between medical staff and service users. Other actions will include further work to develop EPR to reduce the likelihood of actions not being completed, and e-prescribing. We will continue to develop the access point that directs people through to help which will address some of the earlier confusion around accessing support and will work with Healthwatch in its form as watchdog and holding the contract for involvement to ensure they are involved in the development of our care pathways. Caroline Maley thanked Daniel for presenting the Healthwatch report. This case enabled the Board to obtain learning as well as the opportunity to improve the services of the people we support. **ACTION: Review the NICE personality disorder guidelines and review the Trust's compliance** **ACTION: Explore whether we could work differently with people who are released from prison** **ACTION: Further work to be undertaken to develop EPR to reduce the likelihood of actions not being completed, and e-prescribing** **ACTION: Further develop the access point that directs people through to help** **ACTION: Continue to work with Healthwatch to ensure their involvement in the development of our care pathways** **RESOLVED: The Board of Directors Board obtained learning from the series of events described in this case and pledged the actions outlined above in response to the recommendations made by Healthwatch Derbyshire**
DHCFT 2017/172	**MINUTES OF THE MEETING DATED 1 NOVEMBER 2017** The minutes of the previous meeting, held on 1 November were agreed and accepted as an accurate record.
DHCFT 2017/173	**ACTIONS MATRIX AND MATTERS ARISING** The Board agreed to close all completed actions. Updates were provided by members of the Board and were 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 2017/0174	**CHAIR'S VERBAL REPORT** Caroline Maley updated the Board on the outcome of the meeting of the Remuneration and Appointments Committee meeting held earlier in the day. The Committee discussed the continuing secondment of Amanda Rawlings as Director of People and Organisational Effectiveness and agreed that a report would be brought to the next meeting in February that will allow the Committee to confirm practical considerations of the ongoing secondment arrangements. The Committee reviewed Executive Director remuneration and agreed that no increases would be made to their salaries. Executive Director remuneration would be further reviewed once appraisals have taken place with the Executive Directors next year. The BAF (Board Assurance Framework) risk relating to potential loss of Board members was considered and due to the recent substantive appointments that have been carried out this risk is to be reduced from moderate to low.

	During November Caroline Maley was involved in the recruitment and appointment of the Trust's substantive Chief Operating Officer. She was also involved in the Well-led self-assessment process. Appraisals were carried out for two NEDs and their performance over the past year was reviewed. . A combined training event with NEDs and the Council of Governors took place on 8 November which enabled an understanding of their mutual roles and responsibilities and how best they can be exercised in ensuring the Trust moves forward. Executive Directors also undertook leadership training that day that focussed on empowering, engaging and inspiring our colleagues and enabled them to consider their priorities for the next 6 – 18 months to deliver the Trust's mission. There have been a number of new appointments within the Council of Governors. These included an appointed governor from Derbyshire County Council and we have moved ahead in appointing voluntary sector governors, all of whom are undergoing the induction process for newly appointed governors. An effective meeting of the Council of Governors took place last week. Caroline continues to meet with Lead Governor, John Morrissey, Deputy Lead Governor, Carole Riley, and Chair of the Governance Committee, Gillian Hough on a regular basis. Caroline has continued her visits to services that have been arranged through the quality visit programme. She enjoyed talking to the teams and saw how essential it is to have good working relationships between the people who work in administrative roles and those on the front line and how important it is to promote our Trust values in working together and having respect for one another. The Trust's Delivering Excellence Awards were held on 15 November. This was an excellent opportunity to see the extent of the day to day work of the Trust's staff and to celebrate their outstanding achievements. Caroline also attended a dinner with Mental Health Chairs and was interested to hear their ideas for improving funding and pooling resources in terms of research and development. She also attended the STP (Sustainable Transformation Partnership) Board meeting where discussions focussed on financial challenges. **RESOLVED: The Board of Directors noted the activities of the Trust Chair throughout the month of November**
DHCFT 2017/175	**<u>CHIEF EXECUTIVE'S REPORT</u>** The Chief Executive's report provided the Board of Directors with an update on developments occurring within the local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as commissioners and feedback from staff. The report was used to support strategic discussion on the delivery of the Trust strategy. Ifti Majid outlined how the changes NHS Improvement (NHSI) has made to the Single Oversight Framework (SOF) would affect the Trust's reporting metrics. Now that these changes have been clarified the metrics used through the Integrated Performance Report (IPR) could be aligned with them and improvement plans developed as needed. From a local context, Ifti Majid was pleased to report that the Nottinghamshire and Derbyshire Quality Surveillance Group (QSG) rating system had agreed that the Trust should remain on Routine Surveillance. This gave good assurance to the Board and demonstrated continued quality compliance with expected standards. Ifti also talked about the engagement event that was held across all ten organisations and primary care in Derbyshire relating to the mental Health STP Workstream and how the Trust meets the requirements of the Mental Health 5 Year Forward View. These

	requirements are captured in a specific national mental health workforce strategy and will provide us with an opportunity to highlight risks around achieving the Mental Health Five Year Forward View and will help towards achieving workforce needs. The Board joined Ifti Majid in congratulating Consultant Psychiatrist, Dr Subodh Dave, on being awarded the psychiatric trainer of the year by the Royal College of Psychiatrists which is a great accolade and testament to the commitment Subodh has shown to his education roles. Attention was drawn to the 'Ifti on the road' drop in engagement sessions. Two have been held so far and he is delighted with the response and attendance by staff. He has observed some themes arising from these sessions around how we use our data and information particularly around HONOS (Health of the Nation Outcome Scales) and clustering. He also heard ideas about practicalities involving access to rooms to see patients in and having the right environment to work in. These discussions have inspired Ifti especially when he heard people quoting the Trust's vision and values during conversations. The Board was asked to note that the Executive Team is focussed on actions resulting from feedback received from staff and he has already fed back to individuals the action that has been taken to improve the environment that staff work in. Margaret Gildea asked if, when issues are raised regarding equipment, is there anything that enables managers to have resolved these issues themselves. Ifti replied that he is always interested to know why these issues are being raised with him because it usually means people have not been able to resolve them locally and this allows him to engage with middle managers to check that processes we have in place have been utilised. Ifti talked about how he continues to meet with MPs to discuss the business of the Trust and raise the challenges faced by people who use our services. He had recently met with Toby Perkins (MP for Chesterfield) to discuss opportunities for funding. He was pleased to report that following their meeting Toby wrote to the Secretary of State to raise the profile of lack funding into the mental health sector and the Trust and the letter he had received from Toby and the letter he sent to the Secretary of State were appended to his report. He explained that the letter arose from discussions Toby Perkins had with North Derbyshire Clinical Commissioning Group (NDCCG). He thought it important that the Board should acknowledge the lack of investment from NDCCG and welcomed the opportunity to include the letter in the public domain. Ifti and Caroline regularly meet with MPs and Caroline will be meeting with Pauline Latham MP for Mid-Derbyshire on 9 February 2018. The Delivering Excellence Awards event was also highlighted and Ifti thanked everyone from the communications, catering, estates and learning and development teams who made the afternoon such a great success. Attention was drawn lastly to the specific work being carried out on mentor training in relation to reverse mentoring for equality and inclusion which was launched on 3 November. The organisation also celebrated Black History Month when representatives from the Trust's BME network shared their thoughts and reflections which was a good lead in to this year's Equality and Diversity grading review that focussed on our Children's service which will be reported to the Board in January. Ifti thanked everyone who attended and contributed to the honest appraisal of the Trust's services. **RESOLVED: The Board of Directors noted and scrutinised the Chief Executive's update**
DHCFT 2017/176	**<u>TRUST VISION AND VALUES</u>** The Trust has identified staff engagement as its priority for the coming year. This paper updated the Board on how this will be achieved and the new mechanisms that will be put in place across the Trust to engage with staff.

	Ifti Majid outlined how this new focus on staff engagement will be led by a multi-disciplinary team working across the Communications Team and People and Organisational Effectiveness (POE) directorate. The Board recognised that it is vital that improvements are made to the culture of the organisation and was pleased to see from the report that the new 'TEAM Derbyshire Healthcare' programme has been designed to promote two-way communication and opportunities to receive feedback from staff. This will allow staff to engage and receive information through a clear two-way mechanism for communication between leaders and staff. It was emphasised that this has already started through an increased visibility of the Board and from Ifti's on the road drop in engagement sessions, Staff Forum sessions which have commenced and further initiatives that are planned. The specific engagement activities and how they will be delivered through a co-ordinated programme of work was set out in the report. The Board discussed the importance of emphasising the use of key words to strengthen the Trust's revised values and approved the changes to the Trust's Vision, Values and Strategic priorities and agreed the new internal communications and engagement approach known as Team Derbyshire Healthcare. The focus and plan for staff engagement will be reflected in the new forthcoming Communications Strategy and will be supported through actions identified in the People Plan. Amanda Rawlings informed the Board that during December she would start consulting with staff so they understand that the People Plan would be the forerunner of the People Strategy which will be fed through the Executive Leadership Team (ELT) and the People and Culture Committee. Wider corporate work is currently underway to support this approach. This will include a refreshed Trust Strategy and associated strategic priorities which build upon our current objectives. These will be reflected through the divisional business plans for 2018/19. Ifti Majid felt that the Trust had reached a pivotal point in understanding how the levels of connectivity flow through the organisation to understand what drives people and this was captured in the Team Derbyshire Healthcare infographics. The revised values are something that staff can identify with and the proposed changes to the vision make it much simpler for all Trust colleagues to recognise and support which will make a difference to people's lives and improve their health and wellbeing. **RESOLVED: The Board of Directors** **1) Approved the updated vision, values and mission statement** **2) Noted the new staff engagement approach for TEAM Derbyshire Healthcare** **3) Authorised an update of the Trust Strategy to include the revised vision, values and updated strategic priorities**
DHCFT 2017/177	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)</u>** The IPR provided the Trust Board with an integrated overview of performance as at the end of October 2017 that focussed on workforce, finance, operational delivery and quality performance. The report showed that 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, highlighted the key issues. As explained previously in the Chief Executive's Report, the new Single Oversight Framework (SOF) which was published in mid-November has replaced the "data completeness priorities metrics" and "data completeness identifiers metrics" indicators with a single "data quality maturity index – mental health services data set score" indicator. The Trust has been compliant against all Single Oversight Framework operational standards, except for Priority Metrics. The proposed target for the new indicator is 95%. In the latest published national data the Trust scored 98.9% and therefore would expect to be compliant with this target in the future.

Within the NHSI financial metrics the agency metric continues to be challenging, both in terms of the ceiling and the medical staff cost reduction target. Mark Powell was pleased to report that work undertaken has enabled the Trust to keep agency spend within the 50% agency threshold due in part to the aggregated impact of data cleanse on accruals.

Following the Inpatient Model report presented at the previous meeting DNAs (Did Not Attend) levels have reduced as a result of the action that was implemented. If patients do not attend appointments, they are telephoned by medical staff to establish the reason for non-attendance and a telephone appointment is then conducted with the agreement of the patient. Mark Powell was confident that this action should lead to a reduction in future DNA rates and he also expects clinical cancellations will also be reduced.

The Board heard how some challenges were raised at the Finance and Performance Committee on 27 November around the way clustering is delivered within the organisation. Mark Powell and John Sykes have commissioned an action plan to achieve the identified performance standards of clustering to deliver savings. Chair of the Finance and Performance Committee, Richard Wright, emphasised the need to focus on establishing the efficiency benefits of clustering that could be driven through the Trust as part of continuous improvement and informed the Board that a report on clustering will be received at the Committee's January meeting.

Mark Powell was pleased to report that progress has been made to staffing levels at the Hartington Unit. This has resulted in greater stability in the overall workforce across the Unit. Amanda Rawlings added that overall the vacancy rate has reduced and turnover of staff has also reduced. Although substantial improvements have been seen in staffing levels at the Hartington Unit she was not expecting improvements to be seen in the Radbourne Unit staffing trajectories until the new year. This is due to the Radbourne Unit's work being challenging and the majority of staff choose to work in other areas.

Julia Tabreham observed that quality is being maintained despite huge pressures on hotspots in our services. She asked how the Trust supported staff when they become ill due to the pressure of work. Carolyn Green responded that we continue to support our colleagues and have recruited heads of nursing and invested in clinical skills tutors to help staff to improve practice and do well and have invested heavily in training facilitators to support newly qualified staff and raise support and supervision levels to reduce turnover. We have also invested in practice investigation facilitators to reduce pressure arising from investigations and complaints management. In addition we have restarted Schwartz rounds to reduce stress and isolation of staff and to increase safety. We continue to target hotspot areas and provide these areas with suitable leadership.

Mark Powell emphasised the need to seek assurance on the delivery of the Workforce Plan which would re-evaluate our hotspot areas. The People Plan is being scrutinised by the Executive Leadership Team and the People and Culture Committee and will be submitted to the February Board meeting.

Caroline Maley acknowledged that the IPR showed encouraging signs that good progress is being made, particularly in outpatient areas, out of area placements and staffing. Some challenges still remain such as following up actions around SIs (Serious Incidents). The report showed that SIs have reduced considerably and that the CCGs (Clinical Commissioning Groups) are satisfied with the headway we have made.

As agreed, the financial section of the report was streamlined this month. The position largely stayed the same. The Trust is ahead of plan year to date by £1.1m and the forecast remains to achieve the control total at the end of the financial year. Director of Finance and Deputy Chief Executive, Claire Wright, alerted the Board to an emerging escalation of risk around our anticipated 0.5% CQUIN reserve income (Commissioning for Quality and innovation). She assumed that the Trust would achieve this income but if it is withheld this would have a significant impact on our financial performance.

In this context, Caroline Maley concluded that in terms of levels of assurance on current

	performance the Board could obtain limited assurance on the contents of the report. Further assurance will be received once the People Plan has been scrutinised by ELT and the People and Culture Committee. **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained limited assurance on current performance across the areas presented.**
DHCFT 2017/178	**QUALITY POSITION STATEMENT** Carolyn Green provided the Board of Directors with an update on the organisation's continuing work to improve the quality of services that are provided in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives. This month the theme of the report was 'how do we know?' and NHS benchmarking. This data indicated that the Trust's investment programme in ligature reduction has been successful and effective. The Board was pleased to see that training in suicide prevention has had some impact on in-patient suicide prevention which is a result of our Suicide Prevention Strategy having a positive impact. The report showed that we are in the highest quartile of community caseloads per population and our teams are under significant pressure, but that staff continued to provide a good quality service to our community. The report showed that the Crisis team is underfunded for the population it is serving and although activity has reduced to a level more akin to the size of the team the challenge of meeting the demands of the community remains unchanged. The learning from the Care Quality Commission (CQC) comprehensive visit continues and is closely monitored by the Quality Committee. The Board was pleased to see that progress is being made to ensure that all recommendations and final actions are fully delivered. The Board noted the information in this position statement and agreed that a significant level of assurance was obtained from the mental health benchmarking data contained in the report. **RESOLVED: The Board of Directors receive the Quality Position Statement and gained significant assurance from the benchmarking data and was advised on safety**
DHCFT 2017/179	**REPORT ON PEER REVIEW OF HOMICIDES AND REVIEW OF SECTION 41 PATIENTS IN THE COMMUNITY** A small cluster of homicides took place earlier this year and this report presented by John Sykes was produced to provide the Board with assurance that lessons have been learnt and crucially that there is evidence that changes have been embedded. In order to provide the scrutiny and assurance necessary a peer review of a cluster of homicides has been commissioned and a review of Section 41 cases already completed. A full action plan will be formulated by the Mental Health Act Operational Group and a re-audit will be completed by January 2018. John Sykes outlined how a thematic learning review of homicides and a review of seven recent suicides concluded that most homicides cannot be predicted and are non-preventable and that safety relies on having systems and thorough processes that are well-applied across the Trust's services to help with the prevention of homicides. The Board reviewed the Terms of Reference for the Peer Review of Homicides 2017 and agreed they would be amended so that they focus on the importance of having the right systems in place to ensure safety and risk towards others and that workers are enabled

	and supported to address all safety issues without losing sight of the areas that are under pressure. In addition, they are to be updated to encompass the need to consider the human factors in regard to whether staff are enabled and supported to address all safety issues. **ACTION: Peer Review of Homicides 2017 Terms of Reference to be amended** **RESOLVED: The Board of Directors:** **1) Noted the terms of reference and proposed they would be amended as outlined above** **2) Acknowledged the resource implications facing our services to ensure that we have organisational memory of the issues going forwards**
DHCFT 2017/180	**<u>BOARD ASSURANCE SUMMARIES & ESCALATIONS</u>** Assurance summaries were received from the meetings of the Mental Health Act Committee held on 26 October, Safeguarding Committee held on 3 November, Quality Committee held on 9 November and the People and Culture Committee held on 16 November. Committee Chairs summarised the escalations that had been raised and these were noted by the Board as follows: **Mental Health Act Committee:** Committee Chair, Anne Wright, reported that the structure of the Committee is changing and is now supported by the Mental Health Act Operational Group. This group has met twice which allowed discussions at the Committee to focus on assurance rather than operational issues. The Committee's Terms of Reference are being refreshed to take into account the set-up of the operational group. The Committee's BAF risks are the main point of reference at each meeting and discussions took place on the highest risk which is the failure to achieve training targets in applying the Mental Capacity Act and Mental Health Act. Due to the fact that the Committee meets on a quarterly basis and the next meeting will not be until February, the People and Culture Committee has oversight of training momentum and is endeavouring to resolve the difficulty in releasing staff to attend training due to workload pressures. CQC actions resulting from the 2016 inspection visit are mostly completed and are on target to be completed in 2017. **Safeguarding Committee:** Committee Chair, Anne Wright, informed the Board that as with the Mental Health Act Committee, the Safeguarding Committee is aiming to set up an operational sub-group that will address operational issues. This Committee will continue to meet quarterly with the operational group meeting the month before so that action plans and reporting can provide the Committee with assurance of their adequacy. Training passports have been revised to reflect the more focussed approach to safeguarding training needs. Safeguarding Level 3 training is to be inter-agency and is run by the Safeguarding Adults Board. The Trust Management Team (TMT) has been requested to prioritise attendance at Prevent training and raise the percentage of attendance at Safeguarding Adults level 3. The level of work carried out by the Safeguarding Children team is increasing due to the different types of communities within Derbyshire. Specific wards in Derby City have a seen a significant level of activity in children meeting safeguarding thresholds. This was one of the escalating issues arising from the Safeguarding Committee and it is also reflected in the BAF. **Quality Committee:** Committee Chair, Julia Tabreham reported that the Quality Committee is driving to remove unnecessary material from papers to maintain a high level of analysis to ensure more effective meetings with a streamlined attendance. The structure of the agenda items are clustered to enable people to only attend for their items to be discussed so they can get back to their duties. The Quality Dashboard continues to develop and is an increasingly valuable tool. Areas of operation remain under pressure and assurance levels are limited due to significant challenges. The Chair's biggest concern is the pressure on community mental health teams. In October the Committee

	took consideration of an action plan to identify high risk individuals waiting for services. The implementation of the Quality Strategy and framework is challenging especially around physical healthcare. Although there is a level of confidence in terms of service, pressure and acuity, the Committee has significant confidence in Executive Director focus. **People and Culture Committee:** Committee Chair, Margaret Gildea, expressed concern that there is inadequate representation on the Committee from the medical and nursing teams and commented that meetings have developed as a type of HR forum. Two staff governors and a union representative attend the meetings and now that the Staff Forum has been set up this would be the right environment to ensure HR issues can be heard. This would allow the Committee to have a streamlined membership that will concentrate on providing assurance. The real item of focus is the BAF risk relating to attracting and retaining staff. The Committee received full assurance on the amount of activity that is taking place to reduce this risk but has limited assurance on the timeline as to whether this is working and achieving results and when the results will be seen. Retention of our medical workforce is a challenge despite efforts to support medical staff and it is apparent that the size of caseloads has caused a number of staff to leave. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries and Escalations**
DHCFT 2017/181	**<u>BUSINESS PLAN 2017/18 MONITORING</u>** The Trust's Business Planning Process was developed for 2017/18 to include a 'plan on a page' summary for each clinical division, corporate areas and clinical support services. Each plan on a page was turned into an action matrix, which could be monitored through the Trust Management Team (TMT) as part of the divisional performance reviews and is summarised to the Board on a quarterly basis to provide an update of delivery against plans, and ultimately delivery of the Trust's strategy. This summary report produced and presented by Interim Director of Strategic Development, Lynn Wilmott-Shepherd, is reflective of the process that was outlined and agreed at the July Board meeting and this is being addressed through TMT (Trust Management Team) meetings by Mark Powell, Director of Corporate Affairs and Trust Secretary, Sam Harrison and Lynn Wilmott-Shepherd to ensure that work is progressed by the divisional teams. It was noted that future reports should state whether actions are completed/on-track/off-track and provide an assessment of any major areas of risk. Lynn Wilmott-Shepherd explained that the plan on a page reporting process is currently being reviewed to ensure that it is embedded within the Trust's performance reporting framework. The next plan on a page report to be received by the Board will be seen as a key output from the business planning process for next year and will provide assurance that it is fully embedded operationally. Performance for next year will link in with the Trust's new vision and values and will be more specific to achieving the Trust's strategic objectives. **RESOLVED: The Board of Directors:** **1) Noted the content of the paper** **2) Gained assurance from the performance management mechanisms that have been put in place** **3) Noted that future reports should state whether actions are completed/on-track/off-track and provide an assessment of any major areas of risk**
DHCFT 2017/182	**<u>EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL REPORT</u>** This report presented by Mark Powell provided the Board with the Annual EPRR Report setting out progress against the EPRR Core Standards, delivery of the 2017 work

	programme and assurance from the CCG (Clinical Commissioning Group) of full compliance. Mark Powell was pleased to report that significant progress has been made in delivering the EPRR Core Standards. Following last year's self-assessment the Trust moved from 'non-compliance' to 'partial compliance' in the year. The Board noted that following this year's self-assessment and subsequent CCG 'confirm and challenge' process it has been confirmed that the Trust is now rated as having 'full compliance'. This was a significant achievement and was commended by the Board. Work is taking place to continue to sustain this position and achieve continued compliance with regular review and oversight by the Trust EPRR Steering Group and will also be monitored by the Quality Committee for the foreseeable future. Caroline Maley congratulated Mark Powell and his team for their outstanding work that resulted in the Trust meeting the full compliance standard and was pleased to see that learning from this programme would be shared as good practice across the Trust. **RESOLVED: The Board of Directors acknowledged the progress made and took assurance from the CCG confirm and challenge process that the Trust meets the required 'full compliance' standard**
DHCFT 2017/183	**LGBT+ COMMITMENTS** Claire Wright presented this report and asked the Board to sign up to evidencing its commitment to strengthen the focus on improving the Trust's LGBT+ inclusion. She outlined the Board's ambition to not only meet the statutory requirements, but to provide the best experience possible for Lesbian, Gay, Bisexual and Transgender colleagues and service receivers. The Board recognised that this commitment explicitly supports the Trust's refreshed vision and values for Team Derbyshire Healthcare and will give confidence to LGBT+ colleagues and service receivers that genuine positive change will happen and saw that it will also give confidence in LGBT+ colleagues to speak up if they have concerns. Sam Harrison pointed out that the Foundation Trust membership is another element of this initiative and informed the Board that a further piece of work is being carried out to ensure the Trust's membership reflects the whole community which reinforces the work we are doing in engaging the community. The Board welcomed the opportunity to commit to improving LGBT+ inclusion and signed up to improving our LGBT+ inclusion through actively delivering three commitments that include demonstrating a zero tolerance for homophobia, biphobia and transphobia. In so doing, the Board also made a commitment to keep up to date with LGBT+ issues and learning from colleagues and people who use our services to provide a more inclusive working experience or service experience. **RESOLVED: The Board of Directors:** **1) Discussed the LGBT+ Board commitments and the difference they will make** **2) Signed up to the LGBT+ Board commitments** **3) Agreed to receive regular updates on LGBT+ issues**
DHCFT 2017/184	**JOINT VENTURE AGREEMENT COVERING JOINT WORKING BETWEEN DCHS AND THE TRUST** This paper was received by the Board for information and contained drafts of the Joint Venture Agreement documents that will be received by Derbyshire Community Health Services NHS Foundation Trust (DCHS). Following agreement at the 1 November Board meeting held in confidential session, the

	membership of the Joint Venture Leadership Team (JVLT) has been agreed between the two organisations and is relevant to the People and Organisational Effectiveness Services. The JVLT will consist of the Deputy Chief Executive and Director of Finance, the Chief Operating Officer and the Interim Director of Strategic Development. The Director of People and Organisational Effectiveness will be an attendee at all JVLT meetings. The Board noted that ELT have been given authority to sign the final documents and that the financial aspects and the final Customer Contract will be included in the final version. **RESOLVED: The Board of Directors accepted this paper for information and acknowledged that the Executive Leadership Team have approved all documents which have been developed after taking legal advice and have undergone rigorous scrutiny.**
DHCFT 2017/185	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** It was noted that Safeguarding training compliance has been added to the BAF. The following issues will be included in the next iteration due to be presented to the Board in January: • EPRR reduced risk rating will be included in the BAF • The risk rating for BAF risk 3e 'potential turnover of Board members' would be reduced.
DHCFT 2017/186	**2017/18 BOARD FORWARD PLAN** The forward plan was noted by the Board and would be updated in line with today's discussions.
DHCFT 2017/187	**MEETING EFFECTIVENESS** The Board considered that appropriate items for discussion were included in today's agenda. The refreshed vision and values and the important decisions made at today's meeting would impact our strategic priorities and will set the culture of the organisation.

The next meeting of the Board to be held in Public Session will take place at 1pm on Wednesday, 31 January 2017.

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

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - JANUARY 2018			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
1.11.17	DHCFT 2017/163	Governance Improvement Action Plan Six Month Update	Sam Harrison	Further review of the GIAP is to take place in March 2018 and is to be captured in the forward plan	28.3.2018	Agenda item for 28 March 2018 meeting	Yellow
29.11.2017	DHCFT 2017/171	Service User Story	Carolyn Green	Review the NICE personality disorder guidelines and review the Trust's compliance. NICE review group / named lead for NICE personality disorder	31.1.2018	NICE review group and COAT to review and report to QC by June 2018	Amber
			Carolyn Green	Explore whether we could work differently with people who are released from prison. Neighbourhood COAT team (clinical and operational lead) specifically developing community forensic team offer	31.1.2018	In development – DICE model and mapping of community forensic offer has commenced.	Green
			John Sykes	Further work to be undertaken by lead for medicines optimisation and e-prescribing to develop EPR to reduce the likelihood of actions not being completed	31.1.2018	Medicines optimisation strategy drafted. This will be a long piece of work to be completed over 2 to 18 months	Amber
			Carolyn Green	Patient Experience team to further develop the access point that directs people through to help and advertise this guidance on the website and patient information	31.1.2018	In development with Patient Experience team to be completed by June 2018	Amber
			Carolyn Green	Neighbourhood Community Development Group to continue to work with Healthwatch to ensure their involvement in the development of our care pathways	31.1.2018	Request submitted for Mental health together/ Healthwatch to join neighbourhood review group, At this time no formal confirmation of Mental health together that this has been prioritised by commissioners. Requested and completed	Green
29.11.2017	DHCFT 2017/179	Peer review of homicides and review of Section 41 patients in the community	John Sykes	Peer Review of Homicides 2017 Terms of Reference to be amended	31.1.2018	Terms of Reference were amended and review is being conducted	Green

Resolved	**GREEN**	**3**	**43%**
Action Ongoing/Update Required	**AMBER**	**3**	**43%**
Action Overdue	**RED**	**0**	**0%**
Agenda item for future meeting	**YELLOW**	**1**	**14%**
		7	**100%**

Chief Executive's Report to the Public Board of Directors

Purpose of Report:

This report provides the Board of Directors with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within our local Derbyshire health and social care community. The report also updates the Board on feedback from external stakeholders such as our commissioners and feedback from our staff. The report should be used to support strategic discussion on the delivery of the Trust strategy.

National Context

1. Firstly let me wish all Board members and members of the public the best wishes for 2018. As part of those best wishes I thought I would remind you that The National Health Service is turning 70 on 5 July 2018. It's the perfect opportunity for our Trust individually and in conjunction with others to celebrate the achievements of one of the nation's most loved institutions, to appreciate the vital role the service plays in our lives, and to recognise and thank our colleagues who are there to guide, support and care for us, day in, day out. Our Trust will be releasing specifics of our own celebrations in due course.

2. December saw the release of the annual NHS Workforce Race Equality Standard (WRES). The WRES was introduced to enable employees from black and minority ethnic (BME) backgrounds to have equal access to career opportunities and receive fair treatment in the workplace. This is vital as the evidence shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety; it also leads to more innovative and efficient organisations. For our Trust this clearly resonates with our revised values and adds weight to our strategic priority around focussing on people. Two years on, data submission against the nine indicators again this year has been 100% and the third WRES data analysis report has been completed. This 2017 report shows that the low baseline we started off from in 2015 has improved, albeit with room to improve further. The key points to note from the 2017 report include:

    - White shortlisted job applicants are 1.60 times more likely to be appointed from shortlisting than BME shortlisted applicants, who continue to remain absent from senior grades within Agenda for Change (AfC) pay bands.
    - An increase in numbers of BME nurses and midwives at AfC Bands 6 to 9 is observed once again in 2017; this pattern has persisted since 2014.
    - The number of very senior managers (VSMs) from BME backgrounds increased by 18% from 2016 to 2017 it should be noted that this is 7% of all VSMs, which remains significantly lower than BME representation in the overall NHS workforce (18%) and in the local communities served (12%).
    - BME staff are 1.37 times more likely to enter the formal disciplinary process in comparison to white staff. This is an improvement on the 2016 figure of 1.56.

- BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers compared to white staff, at 14% and 6% respectively.
- There is no significant difference in white or BME staff experiencing harassment, bullying or abuse from the general public.
- The overall percentage of BME staff experiencing harassment, bullying or abuse from other colleagues in the last twelve months dropped from 27% to 26%. BME staff remain more likely than white staff to experience harassment, bullying or abuse from other colleagues in the last twelve months.
- There is a steady increase in the number of NHS trusts that have more than one BME board member. There are now a total of 25 NHS trusts with three or more BME members of the board; an increase of nine trusts since 2016.

Whilst there are some encouraging signs progress remains slow nationally. The next step in our Trust is for us to analyse the data and understand our own year on year performance as well as how we benchmark with other Organisations. In addition we will continue with the initiatives we have in place including the continuation of our refocussed BME Network. Our reverse mentoring initiative and some joint training and development between our BME Network and our senior leaders meeting *#TeamDerbyshireHealthcare Leaders*.

3. There has been lots of stories in the papers about NHS performance over recent weeks and the pressure of winter related activity – so just how bad is it. I have included below some of the key national facts and figures that do confirm what many are saying on the frontline, the pressures this winter are severe and that demand for services continues to rise inexorably.

   It's not all bad news:

   - The focus since the start of the financial year on delayed transfers of care has seen a significant reduction and this continued in November 2017; with the average number of delayed beds 5.8% lower than the previous month and 19.8% lower than November 2016
   - By the end of November 2017 59.3% of frontline healthcare workers had been vaccinated against flu, up from 55.6% the year before
   - Performance against the key cancer targets has been relatively stable over the past few months.
   - Mental Health core targets have been largely unaffected by winter pressure.
   - By the end of November 2017 59.3% of frontline healthcare workers had been vaccinated against flu, up from 55.6% the year before

   There are some serious pressures however:

   - A&E performance in December 2017 was seriously compromised. The month saw both the highest ever number of emergency admissions – over 520,000 – and the lowest ever performance against the 4-hour standard for type 1 (major) attendances – 77.3%.
   - The number of flu cases is rising, with 7.38 hospitalised cases of influenza per 100,000 of the population this week, up from 1.55 two weeks ago. Of the 758 hospitalisations, 240 were admitted to intensive level care.
   - Despite an extra 2000 national acute beds being open, bed occupancy levels have increased, peaking at 95.8% on 3 January with 88% of hospitals reporting occupancy of over 92% that day

Locally performance is variable, Chesterfield Royal Hospital were exceeding the national 95% A&E target at 96.06% year to date though during December performance dipped to 93.95% whist Derby Teaching Hospitals reported 73.7% against the type 1 A&E target.

Local Context

4. The Nottinghamshire and Derbyshire Quality Surveillance Group (QSG) has carried out its November review of our Organisation. As per national QSG guidance a surveillance rating system is in place which monitors ongoing, new and closed concerns. After due consideration and based on the discussion during the meeting, the QSG agreed that we as a Trust should remain on Routine Surveillance. This is good news and demonstrates continued quality compliance with expected standards.

5. As part of Joined up Care Derbyshire our system has submitted the Derbyshire GPFV (General Practice Forward View) STP (Sustainability Transformation Plan (Joined Up Care Derbyshire)) Workforce plan which was reviewed by the Directors of Commissioning operations in NHS England (DCO) (NHSE) Assurance panel and given an initial score of 48% and a rating of "partial assurance" (the pass score is 50%). The comments received from NHSE were addressed and a revised version submitted on 15 November 2017. Feedback from NHSE North Midlands is that they will be recommending an improved score of 59% to the regional team. This score represents a rating of assured with conditions" as opposed to full assurance, however the improved position is welcome.

   In addition the mental health workstream (led by myself) submitted an 'initial commentary' against the national workforce expectation associated with the delivery of the mental health workforce strategy to support the delivery of the mental health five year forward view. We have not to date had any feedback on our initial commentary that clearly flags up a gap in expectation between the resources available to fund the national strategy and how those resource are materialising locally. The initial commentary is attached as appendix 1 for information

6. Our STP has taken part in a Kings Fund event to learn more about what has supported improvements in those areas leading the move towards more integrated working:

   - The need to have aligned clinical operating model and business operating model over all the system
   - System architecture must enable the model of care to be delivered.
   - The need to understand what primary care can and cannot offer to contribute to the system model
   - Focus on cost rather than price or income – North Cumbria noted that this has transformed relationships and ways of working within their STP's footprint.
   - Digital technology and workforce – demonstrable link of the cultural change needed to support and enable our workforce to respond to the efficiency opportunities generated through technological advancements.
   - A need to track, analyses and monitor general practice data

   The next STP stocktake meeting led by Dale Bywater, Regional Director for NHS Improvement, has been confirmed and will take place in March. This meeting will provide an opportunity to showcase some of the good work that has taken place across Derbyshire. It will also provide an opportunity to identify any areas where we

feel that we would benefit from some additional support from regulators.

It is positive to note that all system triangulation issues have now been understood and resolved for 2017/18 however there is more work to do to define and mitigate the risks associated with 2018/19:

- Commissioners need to describe the extant 2017/18 QIPP (Quality, Innovation, Productivity Programme) schemes and how these will roll into 2018/19.
- Providers need to work on their own CIPs (Cost Improvement Programme) to understand the potential surplus/deficits and how these compare with 2018/19 control totals.
- STP workstream leads and SROs need to specify where they may need more financial and/or contractual support to value the potential impact of the financial mitigation that their workstream should deliver in 2018/19.
- The Capped Expenditure Process ideas are being valued by DoFs (Directors of Finance) as approaches to further mitigate the expected financial position.

Senior clinicians in the Derbyshire System have been working together to develop principles and standards that will support development and delivery of all clinical pathways. Those standards include:

- Consistency with national and local strategic direction and plans; so that that improvements in population health are achieved in an integrated way, with all parts working together with collective ownership of delivery as one Derbyshire system (Triple Integration – Health and Social Care, Community and Specialist Care, Physical and Mental Health)
- Improved delivery of care which maximises the potential benefits for the people of Derbyshire to improve their experience of care in a way which is safe, effective and person centred (addresses the care and quality gap)
- Measurable improvements in population health and reduced inequalities (addresses the health and wellbeing gap)
- Reduction of the per capita cost of care by driving more efficient and effective use of resources (addresses the finance and efficiency gap)

The Derbyshire system has now agreed a joint estates strategy that augments the strategies of all individual organisations. There are five key priorities noted in the strategy:

- Acute hospital optimisation;
- Community Hospital optimisation through Better Care Closer to Home in the north part of the county and projects in Heanor and Belper;
- Links to 'One Public Estate' initiatives to help with rationalisation of surplus property and to enhance partnership working on estate utilisation;
- Review the utilisation of buildings and develop new ways of working (e.g. increase agile working through the use of technology) to help improve efficiency of use
- Identify joint priorities for new capital investments

7. In January the Mental Health Workstream leadership team combined with HealthWatch Derbyshire to undertake a days facilitated training around co-production and in particular co-production in the context of statutory consultation. The key learning I took from the session was that 'continuous engagement' is the key to ensuring co-production that support a formal consultation process. This resonates with

the approach we are now starting to take with colleagues within the Trust and I have undertaken to ensure we develop mechanisms in association with HealthWatch Derbyshire to develop local stakeholder groups that we are able to engage with both as a workstream and as a Trust to get continuous feedback from our local communities

Within our Trust

8. In December I met with Guy Freeman who is the Refugee Support Coordinator at the British Red Cross in Derby. It was very helpful to get an understanding of the role of the British Red Cross as well as understanding the wider issues and resources associated with supporting individuals and families who are dispersed to Derby as part of the 'no choice accommodation' section of the asylum seeker process. I was also able to have some first-hand feedback about the new 'initial accommodation centre' due to open imminently. During the meeting I agreed with Guy a quid pro quo arrangement whereby we would provide some mental health awareness training to his team and he would provide some training to some of our local teams around the asylum seeking process – real local partnership in action!

9. The Christmas period is always difficult for those individuals and their families who need to be in hospital. I would like to applaud the efforts of our staff, that I saw first-hand in my pre-Christmas ward visits, to make the environment as festive as possible. Trust Chair, Caroline Maley and I had the pleasure of judging the Christmas decorations at the Radbourne Unit and whilst the decorations themselves were fantastic I was particularly impressed with the involvement of people who use our services. I would also like to note the commitment of all of our colleagues who worked over the Christmas and New Year period to ensure the safety of people in Derbyshire who needed the support of our services.

10. Since our last Board meeting on 29t November I have been fortunate to visit a number of teams as part of our 'Ifti on the Road' initiative including:

    - Hartington Unit
    - St Andrews House (all teams)
    - Dynamic Psychotherapy Service
    - Radbourne Unit

    I have been delighted at how many colleagues have come along at these sessions to share thoughts, ideas and concerns. There has been a real mixture of people raising individual and personal issues along with teams attending 'en masse' to discuss issue that were important to all team members.

    Common themes included:

    - Access to car parking, desk space and a sense of overcrowding in some of our buildings
    - Unhappiness with the safety planning process in particular how we need to ensure it is adaptable to different service user groups
    - Consultation around change, timeliness, style and approach
    - Opportunities for personal development in particular gaining new skills not necessarily associated with promotions.

All feedback has been captured and actions are in place to understand more about the issues raised and where appropriate specific actions have been taken, for example a review of the usage of car parking at St Andrews and limiting its use by non-Trust staff. In addition our communications and engagement team are developing feedback mechanisms using a number of media to help colleagues to understand what actions have been taken following their raising issues.

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 other stakeholders is being reported into the Board

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

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

Internal Trust and wider system transformation schemes all need to involve an appropriate equality impact assessment in order to mitigate any risks that are identified in actions being proposed. For example when defining schemes associated with the system estates strategy a full equality impact assessment will need to be completed on all parts of the change programme.

That 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.

Highlighting to the Board the national WRES finding and then moving that to benchmarking our performance against it is an example of where the Trust is adopting best practice in monitoring available data and importantly moving from understanding to action.

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

Appendix 1

DELIVERY PARTNERS – STAKEHOLDER MANAGEMENT & COMMUNICATIONS

The Derbyshire wide STP has appointed a Workforce Lead to co-ordinate the whole system workforce plan and its component parts. The workforce plan is based around three key objectives which have been agreed by the 11 organisations that form the STP Board. The objectives are:

- Workforce Optimisation
  - Identifying and reducing/eliminating inefficiencies
  - Health & wellbeing, vacancy management, roster management, training, employment practices
- Workforce Planning and Modelling
  - Understanding the baseline workforce profile
  - A common methodology to model the future workforce
- Workforce and Organisational Development
  - Training and interventions to support new roles and ways of working
  - Developing the culture towards seeing ourselves as one health and social care system

The vision for our STP wide workforce plan is:

> "Our workforce strategy will help to create our vision for the delivery of care in an integrated place based care system, and will also encourage and empower citizens to be personally resilient and to share decision making about their care. This will be driven by a commitment to prevention and to reduce the incidence and impact of disease, and to deliver proactive, preventative health and well-being services, through integrated place based delivery models which transcend organisational boundaries. Staff will provide person centred care involving and engaging people, their families and carers as partners in their care"

The Mental Health System Deliver Board is led by the SRO for the Mental Health Workstream, Ifti Majid, CEO of DHcFT. The Board consists of representatives from all organisations in Derbyshire and has been in existence since July 2017. In November 2017 a workshop was held to look at the workforce needs across the four programmes – MH Primary Care; Responsive Communities; Rehabilitation and Forensics; Dementia and Delirium. Over 70 people participated, including representation from Healthwatch and voluntary sector organisations and this helped to understand the roles that will be required for new models of care. Key themes were:

- Need to look at non-medical/clinical roles – not all have to be from statutory organisations
- Population needs should inform the workforce models
- The workforce needs to work to 'the top of their licence'
- We need to build resilience across the workforce
- We need to cut across current organisational boundaries

Our workforce plan will need to take into account the above factors.

RESOURCES

The waterfall diagram presented shows the requirement for an additional 311 posts which at an average of £40K per annum would require an investment of approximately £12.4m. In the letter from Andy Gregory, Accountable Officer, Hardwick CCG to Wendy Saviour, NHSE on 24th February 2017 it was made quite clear that whilst our STP MH plans were strong, there was not sufficient investment money available at the current time to fund the business cases which would help deliver the FYFV. The majority of investment required was for staff. The position if anything has worsened.

We are led to believe from the workshop on 10th November that approximately 70% of investments are expected to be funded locally, with 30% from new national money. In recent discussions with commissioners we have little confidence that money will be available locally owing to pressures elsewhere in the system. ***This is a significant risk.***

With regard to IAPT growth the education providers in the East Midlands are currently operating at maximum capacity, with no spare capacity to run another PWP or HIT programme before March 2018. Although we need to increase this workforce across Derbyshire, there are challenges around the reduced caseloads and the requirement for high level supervisions for high intensity trainees. Derbyshire leads will need support from HEE to move this forward, as we continue to attempt to balance service delivery and increase this workforce. If further places were available and if additional supervision costs were covered we estimate that X trainees would be required to satisfy demand for IAPT service.

WORKFORCE PLANNING AND DIAGNOSTICS

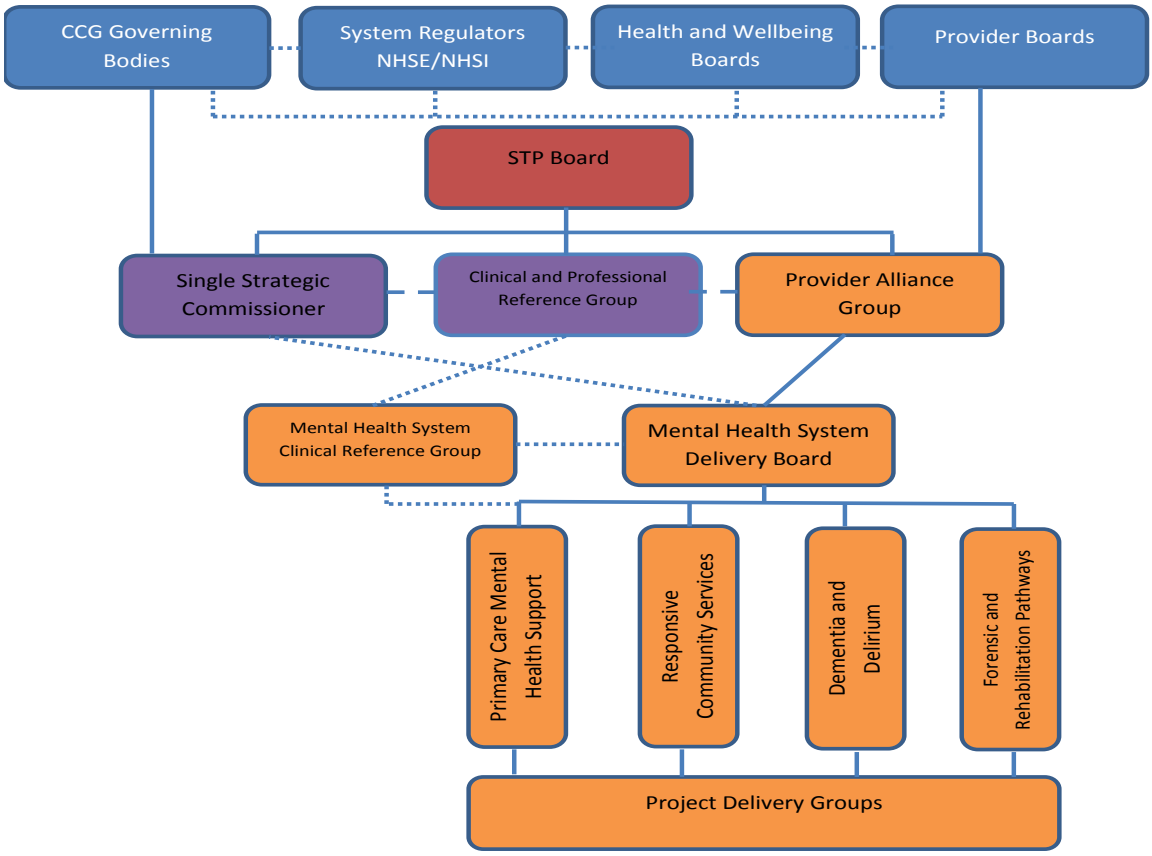
With regard to the waterfall diagram we are unable to verify the numbers as these are not easily recognisable to the health organisations in Derbyshire. This has been discussed with Andrew See at HEE, who has confirmed that at this stage we are unlikely to recognise the numbers as they have been taken from national information and a weighted capitation applied. We understand that further assistance to understand the diagram and to do further work will be available in the New Year. We will engage with key people throughout January and February so that the March submission shows fully validated and understood workforce numbers.

In addition, in order to understand the composition of the workforce we will use the ‘SWIPE’ methodology which is being used across the Derbyshire STP to ascertain the resources required and the numbers within each category i.e. Foundation, Core, Enhanced and Advanced

ASSURANCE

The MH STP is part of a system wide governance process shown below:

Mental Health System Delivery Board Governance Chart



The workforce plan for MH will be overseen by the MHSDB who will provide assurance to the STP Board. The latter will have overall responsibility for producing an aggregated plan for the whole Derbyshire workforce.

Challenges for the Mental Health Workforce in Derbyshire

The following diagram illustrates the key challenges and risks within the Derbyshire MH workforce:

These are all areas which the workforce plan will seek to address.

KEY WORKFORCE AREAS AND ASSOCIATED ISSUES

1. **Psychiatrists**

Recruitment of career grade psychiatrists is a high risk for Derbyshire mental health services (http://www.bbc.co.uk/news/health-41860343) due to the national shortages. This is further exacerbated by the inflation of locum rates which provides less incentive for medical trainees to opt for substantive employment. The mental healthcare recruitment markets appear to be driven by constrained supply of substantive medics and increasing demand for services from a growing and ageing population. Hence, in recruiting from the national pool, we are in direct competition with other local/regional NHS Trusts. This is coupled with the increasingly attractive healthcare career opportunities outside the NHS and the immediate Derby/Derbyshire localities. Moreover, it takes up to 15 years to train a psychiatrist.

2. Psychiatric Nurses

Of significant risk with mental health nurse recruitment is the volume of vacancies arising from core services, with Band 5 posts constituting majority of the vacancies on inpatient services and Band 6 nursing posts in the community services.

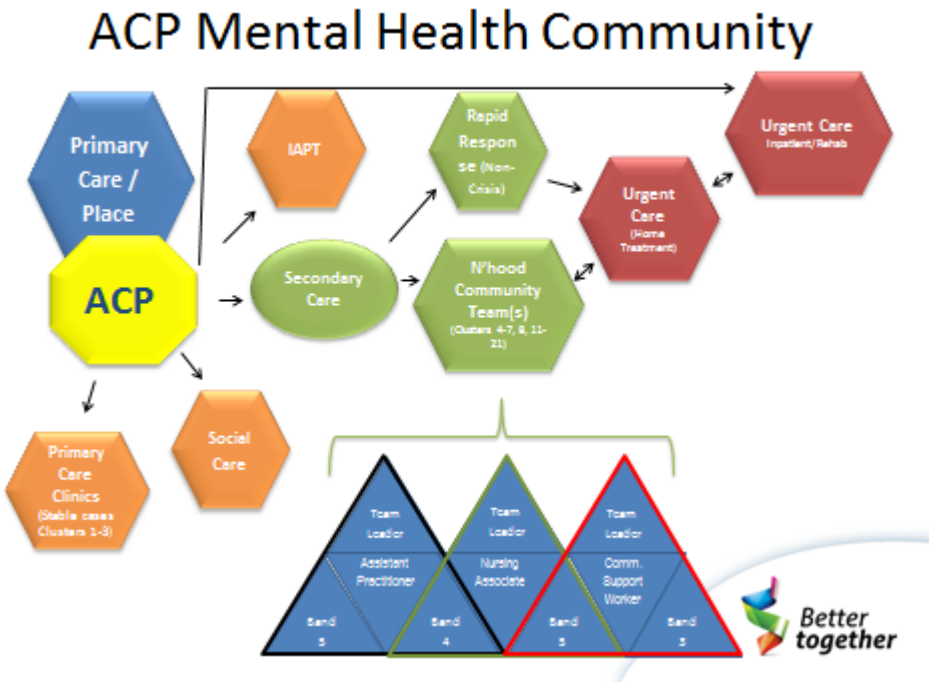
Although the mental health nurse training course has been well subscribed at the University of Derby in September 2017, with a high number of nursing students, it is premature to predict student attrition rates that could partly arise from students' unaffordability to self-finance their tuition fees, which is currently £9,000 per year, due to abolition of the bursary scheme. This is coupled with an ageing workforce as well as rising vacancy and attrition rates across our local health economy.

In addition, the emergence of bridging roles and innovative models of care in new and cross-clinical settings depends on sufficient skilled healthcare staff, who needs to be upskilled in order to enable them to work in roles that span across traditional professional boundaries. This will require us to use mental health staff differently and embrace the new roles to support both the medical and nursing workforce.

3. Workforce Development - Advancing the Mental Health Workforce

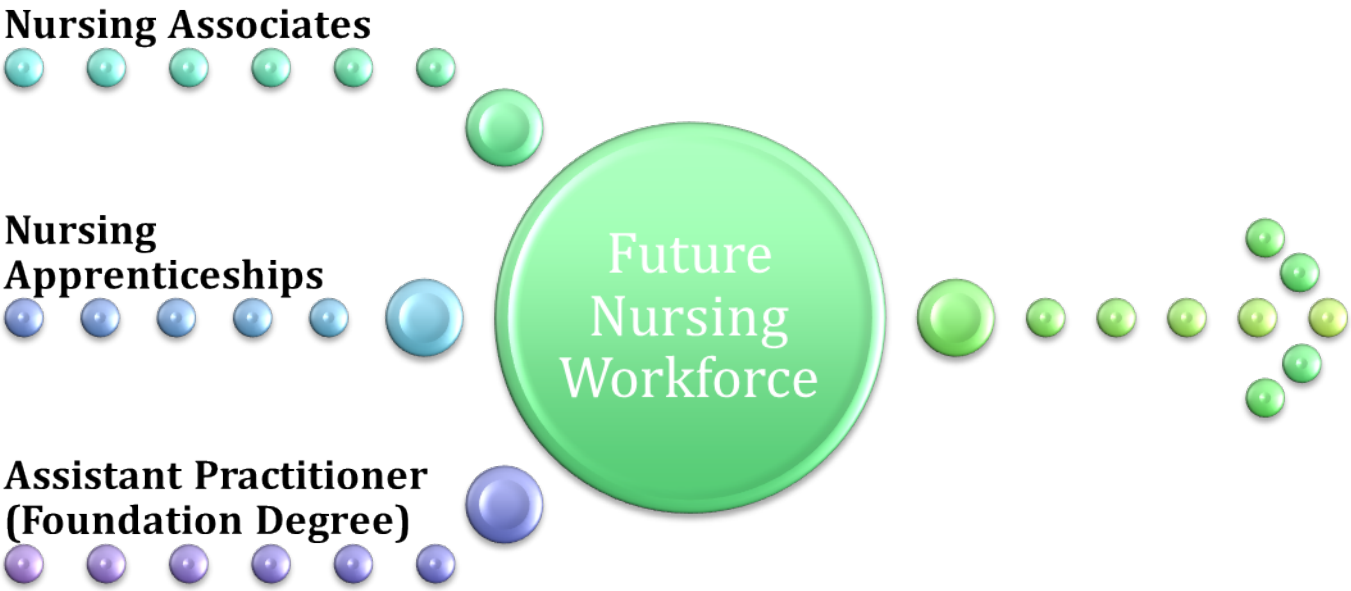
The NHS Five Year Forward View (DH, 2014) sets out a collective view of how the health service needs to change over the next five years, and emphasises delivery of high quality patient care with staff working in extended roles across a variety of settings. The Derbyshire STP will explore utilisation of advanced practitioners to support the medical workforce challenges. This will include Advanced Clinical Practitioners, Non-Medical Approved and Non-Medical prescribers.

Derbyshire has committed to increasing the number of, drawing this workforce from all healthcare professionals, i.e. Occupational Therapists, Paramedics, Nursing, Psychology and Pharmacists



4. New Roles: 'Growing Our Own' Nursing

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



There is a need for Psychiatry to explore a pathway for utilisation of Physician associates & Medical Assistants. The physical health expertise which this workforce will bring will have a positive impact on mental health service users. Derbyshire STP will benefit from supporting a pilot this workforce.

5. IAPT

The education providers in the East Midlands are currently operating at maximum capacity, with no spare capacity to run another PWP or HIT programmes before March 2018. Although we need to increase this workforce across Derbyshire, there are challenges around the reduced caseloads and the requirement for high level supervisions for high intensity trainees. Derbyshire leads will need support from HEE to move this forward, as we continue to attempt to balance service delivery and increase this workforce.

6. Recruitment and Retention

Multi-pronged approaches are being used across the county to recruit and retain a sustainable mental health workforce. Clinical recruitment and retention forms part of regular discussion points across the county at various stakeholder forums; with local HEIs working on recruiting large numbers of pre-registration mental health nursing students to increase future supply.

These initiatives mirror the National Mental Health Workforce Plan and Strategy, which requires wide-ranging stakeholders across Derbyshire for successful implementation.

- Rolling Mental Health Nurse Recruitment Programme
- Return to Practice - according to HEE almost a third of all qualified mental health nurses on the NMC register do not currently work substantively in the NHS. In response to the Derbyshire mental health nursing shortages campaign and "Growing Nursing Numbers" initiative, HEE have committed to supporting Derbyshire to attract mental health nurses back into practice and work is now underway to deliver more nurses back into the workplace.
- International Recruitment - plans are underway to explore international recruitment of mental health nurses, although this is not new to Derbyshire STP, it is new to mental health. This initiative will need a lot of investment in order to ensure recruits are adequately supported to meet all the standards required to deliver safe practice
- International initiatives are active for the psychiatry medical workforce in the long-term, however these will not yield instant results. Hence, there is an urgent need to continue to tackle recruitment and retention from numerous angles.

7. Continuing Professional Development (CPD)

The shrinking Learning Beyond Registration Funds (LBR) continue to pose challenges to CPD opportunities and affordability. Due to dependence on depleting LBR funds, other funding streams need to be sourced at organisational level and across organisational boundaries; with a view to investing in our existing workforce, improving staff engagement, strengthening retention and attracting new employees. Moreover, funding allocations across the STP also need to reflect parity of esteem. Flexibility and engagement with educational stakeholders are necessary to achieve a robust review of LBR-funded mental health CPD that addresses both service and staff development needs.

To strengthen the integration of physical and mental health and improve care delivery for the Derbyshire patient and other service users, organisations across the STP need to proactively demonstrate system level leadership and behaviours and utilise local skills/expertise to support CPD across the Derbyshire footprint.

NEXT STEPS

The following summarises the steps we need to take in order to develop the workforce plan between December 2017 and March 2018:

- Fully understand the numbers – we need to verify the waterfall diagram and be sure we understand the trajectories
- Use the 'SWIPE' methodology which is being used across the Derbyshire STP to understand the resources required and the numbers within each category i.e. Foundation, Core, Enhanced and Advanced

- Work with other organisations such as Adult Care and the Voluntary Sector to understand the contribution their workforce make
- Fully understand the risks associated with the workforce – recruitment, retention, training etc.
- Understand the investment requirements and the potential funding available. This may generate further risks which will require further work.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 31 January 2018

Integrated Performance Report Month 9

Purpose of Report

This paper provides Trust Board with an integrated overview of performance as at the end of December 2017. 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.

The issues identified in previous reports continue to be worked on through the plans that are referenced both in the Executive Summary and wider report.

Board members will note that there has been an addition to the report with data quality 'Kitemarks' added to a number of indicators. This is in line with best practice for performance reporting. Further detail on how the Kitemark is constructed is provided at the end of the report. This is a further evolvement in our reporting and will continue to be developed over time. The purpose is to provide assurance on the quality of the data being used to report Trust wide performance.

1. Single Oversight Framework

The Trust is compliant against all Single Oversight Framework operational standards.

In surplus terms, the Trust remains ahead of plan year to date by £1.6m due to non-recurrent income benefits in the earlier part of the financial year.

The forecast has changed this month and we have increased our forecast surplus to over achieve the control total by £636k. This in turn then increases our STF income by £636k.

Our forecast has improved due to the significant reduction in the out of area cost pressure. This cost had previously been offsetting the benefit of the one-off overage income we received in July. Therefore the yearend surplus position will increase to £4.036m which is an overachievement of the Control Total of £1.3m (£636k additional surplus plus £636k additional STF (Sustainability Transformation Funding) 'bonus' income).

Within the NHSI financial metrics four out of five are relatively strong, but the agency metric continues to be challenging, both in terms of the ceiling and the medical staff cost reduction target.

The numbers reported in the attached finance report are consistent with the numbers reported in the monthly finance return sent to NHS Improvement on 23 January 2018.

2. Areas of concern and / or under-performance

Slide 1 of the integrated performance report provides an overview of where the Trust is performing above and below the required standards that have been agreed by Board, with further detail provided in the body of the report.

3. Performance Triangulation

Inpatient Services

Pressures remain in the inpatient areas as previously reported to Board. The italic narrative below provides a brief update on some of the actions that were referenced in previous Integrated Performance reports.

1. Red2Green programme which focuses on most efficient use of the resource available to reduce length of stay, therefore impacting positively on bed occupancy and the need for placing patients out of area. Trust Management Team has oversight of this programme.

   Since the implementation of Red2Green there has been a considerable reduction in the number of Adult Acute Out of Area placements. During December there were zero Adult Acute patients placed Out of Area. In the early part of January 1 patient was placed Out of Area due to bed capacity over the holiday period. Patients that require a Psychiatric Intensive Care Unit bed (PICU) continue to be placed Out of Area as this service is commissioned in Derbyshire

2. Inpatient staffing and recruitment plan focusing on recruitment and retention strategies, for example recruitment fairs, overseas employment, return from retirement schemes, advance recruitment of students from universities, rotation schemes, development of internal bank.

   Whilst some improvements have been made in a number of service areas less progress has been made in recruiting staff to the Radbourne Unit. Hartington Unit is improving but still remains an issue. This continues to be a concern and is risk managed on a day-to-day basis, compounded by short term sickness issues over the winter period. This is further detailed in the ward staffing tables included in the report. Requests for agency staff have been approved to help provide further stability for each ward. The Trust wide recruitment plan continues to be implemented and assured by the People and Culture Committee; however, Board members should note that this remains a high risk.

Community Services

Pressures remain in Community Services as previously reported to Board. The italic narrative below provides a brief update on some of the actions that were referenced in the previous Integrated Performance report.

1. A review of Neighbourhood model is being undertaken focusing upon the clinical model and how more capacity could be created from limited resources. Trust Management Team will have oversight of this work. *Assurance has been provided to the Quality Committee regarding the progress being made on the Neighbourhood Review. It is progressing in line with agreed timeframes, with a particular focus in January and February of*

wider engagement with all Community Mental Health teams to ensure that the future agreed service model is developed in conjunction with our staff.

2. Supervision and appraisal action plans are in place and monitored and are showing some improvement.

   These were reviewed for Neighbourhood and Childrens divisions at Performance review meeting on 22 January where improvements were noted in line with the agreed trajectory.

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

Actions to Mitigate/Minimise Identified Risks

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

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

Recommendations

The Board of Directors is requested to consider the content of the paper and consider:

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

Report presented by:

Mark Powell
Chief Operating Officer

Claire Wright
Director of Finance

Amanda Rawlings
Director of People and Organisational Effectiveness

Carolyn Green
Director of Nursing and Patient Experience

Report prepared by:

Peter Charlton
General Manager, Information Management

Rachel Leyland
Deputy Director of Finance

Liam Carrier
Workforce Systems & Information Manager

Rachel Kempster
Risk and Assurance Manager

Peter Henson
Performance Manager

Financial Perspective

Highlights
- Surplus ahead of plan year to date
- Reduction in Out of Area cost pressures
- Forecast over achievement of control total
- Cash better than plan
- Delivery of Cost Improvement Programme

Challenges
- Containment of agency expenditure within ceiling set by NHSI
- Maintaining reduction in Out of Area costs
- High level of non-recurrent CIP

Operational Perspective

Highlights
- Two new Indicators have been introduced this month, Data Quality Maturity Index and Out of Area Placements.

Challenges
- Clustering continues to be a challenge
- Cancellations and DNAs in outpatients
- The process of monitoring discharge emails sent in 2 working days is under review
- The target for outpatient letters sent within 10 working days has been breached.
  - 7 patients have had their discharge delayed this month.

People Perspective

Highlights
- Compulsory training compliance remains high and is above 85%.
- Turnover remains low.

Challenges
- Monthly and annual sickness absence rates remain high, however the annual sickness absence rate continues to reduce.
- Budgeted Fte vacancies remain high.
- Appraisal compliance rates remain low, but are increasing.

Quality Perspective

Highlights:
- Graphs have been updated to include Q3 data, enabling trends to now emerge
- There is a slight downward quarterly trend in the number of episodes of patients held in seclusion
- There is also a slight downward quarterly trend in the no of incidents of patient to patient physical assault
- No of patients absconding is falling
- No of patients with a safety plan is continuing to steadily increase
- Compliance with VTE assessments is increasing significantly
- % of patients with a recorded capacity assessment remains high

Challenges:
- Patient to staff physical assault incidents is increasing
- Clinical and management supervision targets remain a challenge
- No of outstanding actions following serious incident investigations is increasing

FINANCIAL OVERVIEW –December 2017

Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Governance	Finance Score	**Finance Score**	YTD	1	1	G	→	At the end of December the Finance Score is an overall '1' as per the plan. Forecast is a score of '2' which is slightly worse than the plan of '1'. This is mainly driven by the agency metric which is forecast at a '3' for the end of the financial year.
			Forecast	1	2	Y	→	
		Capital Service Cover	YTD	2	2	Y	→	
			Forecast	2	2	Y	→	
		Liquidity	YTD	1	1	G	→	
			Forecast	1	1	G	→	
		Income and Expenditure Margin	YTD	1	1	G	→	
			Forecast	1	1	G	→	
		Income and Expenditure variance to plan	YTD	1	1	G	→	
			Forecast	1	1	Y	↑	
		Agency variance to ceiling	YTD	1	2	Y	→	
			Forecast	1	3	A	→	
	Single Oversight Framework	NHS I Segment	YTD		2	n/a	n/a	

				Plan	Actual	Variance	Trend	
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	143	189	G	↓	At the end of December the surplus is ahead of plan by £1.6m. This is mainly due to non-recurrent income being received earlier in the year. Our forecast has improved due to the significant reduction in the out of area cost pressure. This cost had previously been offsetting the benefit of the one-off overage income we received in July. The forecast is to over achieve the control total at the end of the financial year (see exception reporting section). The normalised forecast takes out the non-recurrent income and expenditure. Without the non-recurrent income mentioned above we would have a small gap to the control total.
			YTD	2,347	3,946	G	↑	
			Forecast	2,765	4,036	G	↑	
		Control Total position ex STF £'000	In-Month	64	109	G	↓	
			YTD	1,831	3,430	G	↑	
			Forecast	1,971	2,606	G	↑	
		Normalised Income and Expenditure position £'000	In-Month	64	132	G	↓	
			YTD	1,831	2,723	G	↑	
			Forecast	1,971	1,959	R	↑	

Liquidity	Cash	Cash £m	YTD	13.205	17.054	G	↓	Cash is ahead of plan year to date due to non-recurrent income and additional STF income from 2016/17. Cash is forecast to be ahead of plan by £4.5m which is due to the current cash balance plus forecast cash receipts from future asset disposals. Capital expenditure is behind plan year to date but is forecast to achieve full spend.
			Forecast	12.193	16.681	G	↑	
	Net Current Assets	Net Current Assets £m	YTD	8.468	9.116	G	↘	
			Forecast	8.345	7.797	R	↑	
	Capex	Capital expenditure £m	YTD	2.298	1.693	R	↑	
			Forecast	3.338	3.338	G	→	

Efficiency	CIP	CIP achievement £m	In-Month	0.321	0.233	R	↓	CIP is ahead of plan YTD and the forecast assumes an overachievement of £1.2m by the end of the financial year. A significant amount of CIP is non-recurrent in nature.
			YTD	2.887	3.676	G	↓	
			Forecast	3.850	5.003	G	↑	
			Recurrent	3.850	1.654	R	↘	

Key:

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

Plan In-month or Year end Trust plan

Achieving plan
Not achieving plan

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

OPERATIONAL OVERVIEW – DECEMBER 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up (M)	Month	95.00%	100.00%	G	→			All NHS metrics are compliant. Two new Indicators have been introduced this month, Data Quality Maturity Index and Out of Area Placements. Both indictors have not yet have targets set by NHSi. For each metric we have indicated if it is monitored by NHS Quarterly (Q) or Monthly (M).
			Quarter	95.00%	100.00%	G	↑			
		Data Quality Maturity Index (DQMI) - MHSDS Data Score (Q)	Month	95.00%	96.79%	G	→			
			Quarter	95.00%	96.79%	G	→			
		IAPT RTT within 18 weeks (Q)	Month	95.00%	99.82%	G	→			
			Quarter	95.00%	99.95%	G	→			
		IAPT RTT within 6 weeks (Q)	Month	75.00%	92.63%	G	→			
			Quarter	75.00%	92.40%	G	→			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Month	50.00%	75.00%	G	↓			
			Quarter	50.00%	88.89%	G	↓			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Month	50.00%	50.00%	G	↓			
			Quarter	50.00%	73.91%	G	↓			
		Patients Open to Trust In Employment (M)	Month	N/A	9.78%		→			
			Quarter	N/A	9.31%		→			
		Patients Open to Trust In Settled Accommodation (M)	Month	N/A	60.18%		→			
			Quarter	N/A	57.76%		↓			
		Under 16 Admissions To Adult Inpatient Facilities (M)	Month	0	0	G	→			
			Quarter	0	0	G	→			
		IAPT People Completing Treatment Who Move To Recovery (Q)	Month	50.00%	51.12%	G	↓			
			Quarter	50.00%	52.91%	G	→			
		Physical Health - Cardio-Metabolic - Inpatient (Q)	Month	N/A						
			Quarter	N/A						
		Physical Health - Cardio-Metabolic - EI (Q)	Month	N/A						
			Quarter	N/A						
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)	Month	N/A						
			Quarter	N/A						
		Out-of-Area Placements (M)	Month	N/A	218		↑			
			Quarter	N/A	744		↓			

Key:

Period

Month Current Month

Quarter Current Quarter

Achieving target

Not achieving target

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

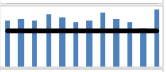
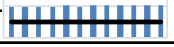
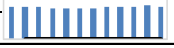
OPERATIONAL OVERVIEW – DECEMBER 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	95.57%	G	→			A paper was presented to the Finance and Performance Committee in January 2018.
			Quarter	90.00%	95.57%	G	→			
		CPA Employment Status	Month	90.00%	97.25%	G	→			
			Quarter	90.00%	97.25%	G	→			
		Patients Clustered not Breaching Today	Month	80.00%	75.14%	R	↓			
			Quarter	80.00%	76.01%	R	→			
		Patients Clustered regardless of review dates	Month	96.00%	93.92%	R	→			
			Quarter	96.00%	93.99%	R	→			
		7 Day Follow-up - all inpatients	Month	95.00%	95.88%	G	↓			
			Quarter	95.00%	96.73%	G	↑			
		Ethnicity coding	Month	90.00%	90.93%	G	→			
			Quarter	90.00%	90.93%	G	↓			
		NHS Number	Month	99.00%	100.00%	G	→			
			Quarter	99.00%	100.00%	G	→			
		CPA Review in last 12 Months (on CPA > 12 Months)	Month	95.00%	95.88%	G	→			
			Quarter	95.00%	95.88%	G	↓			
		Clostridium Difficile Incidents	Month	7	0	G	→			
			Quarter	7	1	G	↑			
		18 Week RTT Greater Than 52 weeks	Month	0	0	G	→			
			Quarter	0	0	G	→			

OPERATIONAL OVERVIEW – DECEMBER 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ	Key Points
Performance Dashboard	Schedule 6	Consultant Outpatient Trust Cancellations	Month	5.00%	7.44%	R	↑			The most common reason was "consultant absent from work". Work is ongoing to address vacancies. A pilot was being undertaken in Derby City of telephoning patients to remind them of upcoming outpatient appointments. Sign-off of letters has been impacted by an unplanned absense and some extended leave.
			Quarter	5.00%	6.41%	R	↓			
		Consultant Outpatient DNAs	Month	15.00%	16.70%	R	↑			
			Quarter	15.00%	15.33%	R	→			
		Under 18 admissions to Adult inpatients	Month	0	0	G	→			
			Quarter	0	1	R	→			
		Outpatient letters sent in 10 working days	Month	90.00%	89.74%	R	↑			
			Quarter	90.00%	88.14%	R	↓			
		Outpatient letters sent in 15 working days	Month	95.00%	95.89%	G	↑			
			Quarter	95.00%	94.63%	R	→			
		Inpatient 28 day readmissions	Month	10.00%	7.27%	G	↑			
			Quarter	10.00%	7.80%	G	↓			
		MRSA - Blood stream infection	Month	0	0	G	→			
			Quarter	0	0	G	→			
		Mixed Sex accommodation breaches	Month	0	0	G	→			
			Quarter	0	0	G	→			
		Discharge Emails sent in 2 working days	Month							Process under review
			Quarter							
		Delayed Transfers of Care	Month	0.80%	2.92%	R	→			7 Patients were delayed
			Quarter	0.80%	2.43%	R	↑			
		18 Week RTT Less Than 18 Weeks - Incomplete	Month	92.00%	92.24%	G	→			
			Quarter	92.00%	93.46%	G	↓			

OPERATIONAL OVERVIEW – DECEMBER 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ	Key Points
Performance Dashboard	Fixed Submitted Returns	18 weeks RTT greater than 52 weeks	Month	0	0	G	→			Compliant with Fixed Targets
			Quarter	0	0	G	→			
		18 Week RTT incomplete	Month	92.00%	98.38%	G	↑			
			Quarter	92.00%	95.27%	G	→			
		Mixed Sex accommodation breaches	Month	0	0	G	→			
			Quarter	0	0	G	→			
		Completion of IAPT Data Outcomes	Month	90.00%	96.58%	G	→			
			Quarter	90.00%	96.57%	G	→			
		Ethnicity coding	Month	90.00%	91.95%	G	→			
			Quarter	90.00%	92.17%	G	→			
		NHS Number	Month	99.00%	100.00%	G	→			
			Quarter	99.00%	100.00%	G	→			
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	99.58%	G	→			Compliant with Targets.
			Quarter	98.00%	100.00%	G	→			
		% 6-8 Week Breastfeeding coverage	Month	98.00%	98.89%	G	↓			
			Quarter	98.00%	99.39%	G	→			
	IAPT	Recovery Rates	Month	50.00%	51.21%	G	↓			Compliant with Targets.
			Quarter	50.00%	52.99%	G	→			
		Reliable Improvement Rates	Month	65.00%	66.19%	G	→			
			Quarter	65.00%	67.17%	G	→			
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	N/A	103.7%		↓			Detailed ward level information shows specific variances
			Quarter	N/A	104.6%		→			

WORKFORCE OVERVIEW – December 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Dec-17**	10%	**9.90%**	↗	G	↓	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 11.99% (as at October 2017 latest available data). The monthly sickness absence rate is 0.15% higher than the previous month, however compared to the same period last year (December 2016) it is 0.08% lower. The annual sickness absence rate continues to reduce running at 5.28% (as at November 2017 latest available data). The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.19% (as at September 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 28.89% of all sickness absence, followed by surgery at 12.19% and cold / cough / flu at 10.74%. The Funded Fte vacancy rate has increased slightly by 0.20% to 5.94%. The number of employees who have received an appraisal within the last 12 months has increased by 2.13% to 76.78%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £695k. Compulsory training compliance has increased by 0.79% to 86.41%.
			Nov-17		9.85%		G		
		Sickness Absence (monthly)	**Dec-17**	5.04%	**6.47%**	↗	R	↑	
			Nov-17		6.32%		R		
		Sickness Absence (annual)	**Nov-17**	5.04%	**5.28%**	↘	R	↓	
			Oct-17		5.29%		R		
		Vacancies (including funded fte flexibility / cover)	**Dec-17**		**5.94%**	↗		↓	
			Nov-17		5.74%				
		Appraisals (**all staff** - number of employees who have received an appraisal in the previous 12 months)	**Dec-17**	90%	**76.78%**	↗	R	↑	
			Nov-17		74.65%		R		
		Appraisals (**medical staff only** - number of employees who have received an appraisal in the previous 12 months)	**Dec-17**	90%	**77.36%**	↗	R	↓	
			Nov-17		71.15%		R		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Dec-17**	£0	**£0.695m**	↘	R	↓	
			Nov-17		£0.706m		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Dec-17**	0%	**29.83%**	↘	R	↓	
			Nov-17		33.96%		R		
		Compulsory Training (staff in-date)	**Dec-17**	90%	**86.41%**	↗	A	↓	
			Nov-17		85.62%		A		

Key:

Period Current month and previous month

Plan Trust target

↗ Variance to previous month

Achieving target/within target parameters

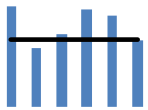
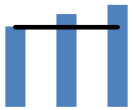
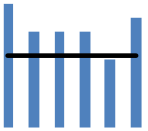
Approaching target/approaching target parameters

Not achieving target/outside target parameters

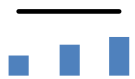
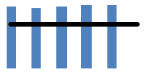
Trend based on previous 4 months

Turnover parameters (8% to 12%)

QUALITY OVERVIEW – DECEMBER 2017

Safe	No of incidents of moderate to catastrophic actual harm	Month	29	29			Plan: average last fin yr 2016/17 (month). The quarterly increasing trend is attributable to incidents that are not reportable to the CCG
		Quarter	88	112			Plan: average last fin yr (Qtr) 2016/17. Actual: 2017/18 Q3 data
	No of deaths of patients who have died within 12 months of their last contact with DHcFT	No of deaths of	104	78			Note, data as at 03/01/2018, but Dec 17 data likely to rise
		Quarter	312	339			Plan: average last fin yr (Qtr).Actual: 2017/18 Q3 data
	No of serious incidents reported to the CCG	Month	5	8			Plan - average last fin yr (month). Reducing trend inflenced by peakreporting in May 17. Relative stability in reportable incidents since
		Quarter	16	20			Plan: average last fin yr (Qtr). Actual: 2017/18 Q3 data
	No of episodes of patients held in seclusion	Month	10	9			Note: 3 patients had 3 or more separate episodes of seclusion in December.
		Quarter	30	37			Plan: average last fin yr (Qtr). Actual: 2017/18 Q3 data
	No of incidents involving patients held in seclusion	Month	16	19			
		Quarter	47	59			Plan: average last fin yr (Qtr). Actual: 2017/18 Q3 data
	No of incidents involving physical restraint	Month	48	49			
		Quarter	143	139			Plan: average last fin yr (Qtr). Actual: 2017/18 Q3 data
	No of incidents involving prone restraint	Month	10	18			Month plan based on average from 1/7/16 when prone restraint collected on Datix as defined field
		Quarter	29	33			Qtr plan based on average for Q2/Q3/Q4. Actual 2017/18 Q3 data
	No of incidents of physical assault - patient on patient	Month	12	14			
		Quarter	37	39			Actual: 2017/18 Q3 data
	No of incidents of physical assault - patient on staff	Month	19	38			
		Quarter	56	89			Actual: 2017/18 Q3 data

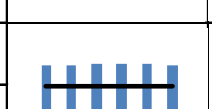
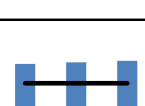
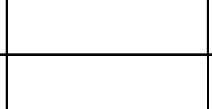
QUALITY OVERVIEW – DECEMBER 2017

Safe	No of falls on in-patient wards	Month	32	31			
		Quarter	96	99			Actual: 2017/18 Q3 data
	No of incidents of absconsion	Month	33	19			
		Quarter	99	68			Actual: 2017/18 Q3 data
	No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	74.20%			
		Quarter	100%	73.09%			Actual: 2017/18 Q3 data
	Of above, no of patients with a Safety Plan	Month	90%	53.64%			Safety Plan replaced FACE from 1/4/2017
		Quarter	90%	53.94%			Actual: 2017/18 Q3 data
	% of staff compliant with combined Level 3 Safeguarding Children and Think Family training	Month	85%	NA			Compliance figure now only relates to Safeguarding Children Level 3
		Quarter	85%	NA			Qtr comparison not available
	% of staff compliant with Level 3 Safeguarding Children training	Month	85%	75.37%			New indicator from Nov 17
		Quarter	85%	NA			Qtr comparison not available
	% of staff compliant with Clinical Safety Planning eLearning	Month	95%	92.65%			Decrease is small from 94.99% in April 2017
		Quarter	95%	NA			Qtr comparison not available
	% of CTRs (Care & Treatment Reviews) completed	Month	100%	Not available			The metric and data are currently under review and clarification
		Quarter	NA	NA			
	% of compliance with inpatients VTE assessment	Month	95%	93.88%			
		Quarter	95%	NA			
	HCR20 assessment completed (Low Secure)	Month	100%	0			
		Quarter	100%	NA			

QUALITY OVERVIEW – DECEMBER 2017

Caring	No of complaints opened for investigation	Month	12	10			
		Quarter	37	40			Actual: 2017/18 Q3 data
	No of concerns received	Month	35	24			
		Quarter	104	107			
	No of compliments received	Month	100	119			
		Quarter	300	305			
	No of investigations by the Parliamentary Ombudsman	2016/17	NA	6			Data is provided cumulatively from 1st April each year
		2017/18	NA	1			Data is provided cumulatively from 1st April each year
	% of complaints upheld (full or in part) by the Parliamentary Ombudsman	2016/17	NA	1			5 no further action
		2017/18	NA	0			1 ongoing
	% of responded to (orange) complaint investigations completed within 40 working days, opened after 01/04/2017	Year	100%	22%			129 (orange) complaints as at 04/01/2018. 66 not responded within 40 working days. 44 ongoing
	% of responded to (red) complaints investigations completed within 60 working days, opened after 01/04/2017	Year	100%	50%			5 (red) complaints as at 04/01/2018. 1 not responded within 60 working days. 3 ongoing
	No of incidents requiring Duty of Candour	Month	1	0			These figures will fluctuate based on the outcome of investigations.
		Quarter	2	3			Actual: 2017/18 Q3 data

QUALITY OVERVIEW – DECEMBER 2017

Effective	% of in-patients with a recorded capacity assessment	Month	100%	95.04%			
		Quarter	100%	95.37%			
	% of patients who have had their care plan reviewed and have been on CPA > 12months	Month	90%	95.88%			
		Quarter	90%	96.32%			
	No of seclusion forms not received by MHA Office	Month	0	0			Process now automated. Cross referenced with seclusion incidents reported on Datix. All data matches for Dec 2017
		Quarter	0	0			Actual: 2017/18 Q3 data
	% of CTO rights forms received by MHA Office	Month	100%	85%			
		Quarter	NA	NA			
	% of in patient older adults rights forms received by MHA Office	Month	100%	64%			
		Quarter	NA	NA			
Responsive	% of staff uptake of Flu Jabs	2017/18	45%	43.97%			Figure as at 31/12/2017
		2016/17	45%	38.40%			Relates to 2016 campaign. Final data as shown in 16/17 Quality Account
	% of policies in date	Month	95%	91.38%			Further focus on workforce policies required
		Quarter	NA	NA			

QUALITY OVERVIEW – DECEMBER 2017

Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	100%	61.81%			
		Quarter	100%	NA			
	% of staff who have received Management Supervision, within defined timescales	Month	100%	71.50%			
		Quarter	100%	NA			
	No of outstanding actions following serious incident investigations	Month	5	64			Total overdue actions as at 05/01/2018
		Quarter	0	NA			
	No of outstanding actions following complaint investigations	Month	5	38			Total overdue actions as at 05/01/2018
		Quarter	NA	NA			
	No of outstanding actions following CQC comprehensive review report (2016)	Month	0	14			Figure as at 04/01/2018

Financial Section

Exceptions month 9

- **Over achievement of the control total**

  NHS Improvement have requested that Trusts consider whether they can improve their financial forecasts and look to over achieve their control totals wherever possible. A full review of potential options was undertaken. These have been discussed and agreed with the Chair, Chief Executive, Director of Finance and Chairs of Audit and Risk Committee and the Finance and Performance Committee. It has also been discussed with NHSI in tele-conference on 10th January 2018.
  With an over achievement of the control total comes an incentive payment of Sustainability and Transformational Fund (STF) income on at least a £1 for £1 basis.

  Our forecast has improved due to the significant reduction in the out of area cost pressure. This cost had previously been offsetting the benefit of the one-off overage income we received in July.
  Therefore we have been able to increase our forecast surplus to over achieve the control total by £636k this in turn then increases our STF income by £636k. Therefore the yearend surplus position will increase to £4.036m which is an overachievement of the Control Total of £1.3m (£636k additional surplus plus £636k additional STF 'bonus' income).

- **Capital Expenditure continues to be behind plan**

  Underspent by £605k YTD, which is a reduction on last month's YTD variance. The forecast remains to spend to plan by the end of the financial year. The capital schemes have been reprioritised in year for schemes that are due to complete in the last few months of the financial year. Therefore the current balance of £1.64m (49% of the plan) will be spent over the last three months of the financial year. The capital plan and forecast are monitored on a monthly basis by the Capital Action Team.

- **CIP performance – Non-Recurrent delivery**

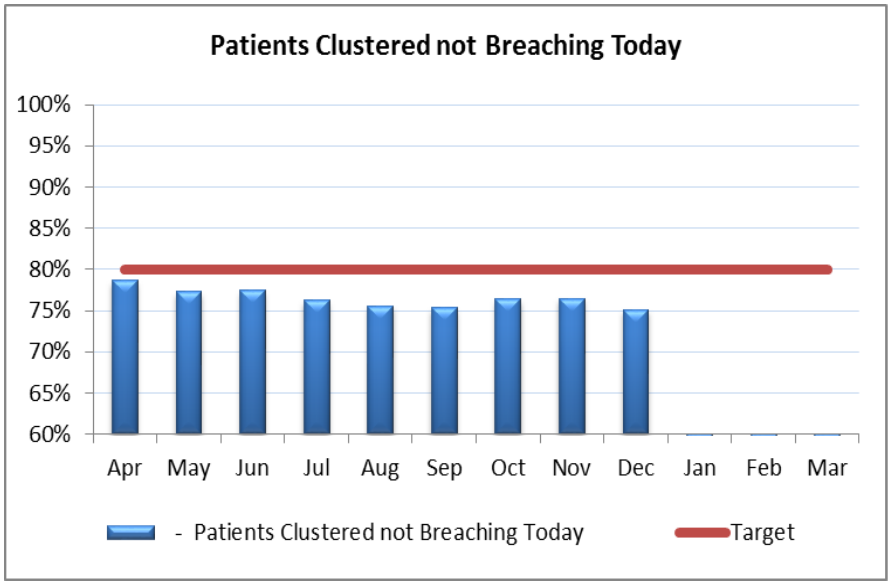
  The total CIP forecast to be delivered is £5.0m which is an overachievement of £1.2m against the target of £3.8m. Of the forecast £5.0m, £3.3m is non-recurrent in nature. The non-recurrent nature of this year's delivery poses a significant risk to next year's financial performance.

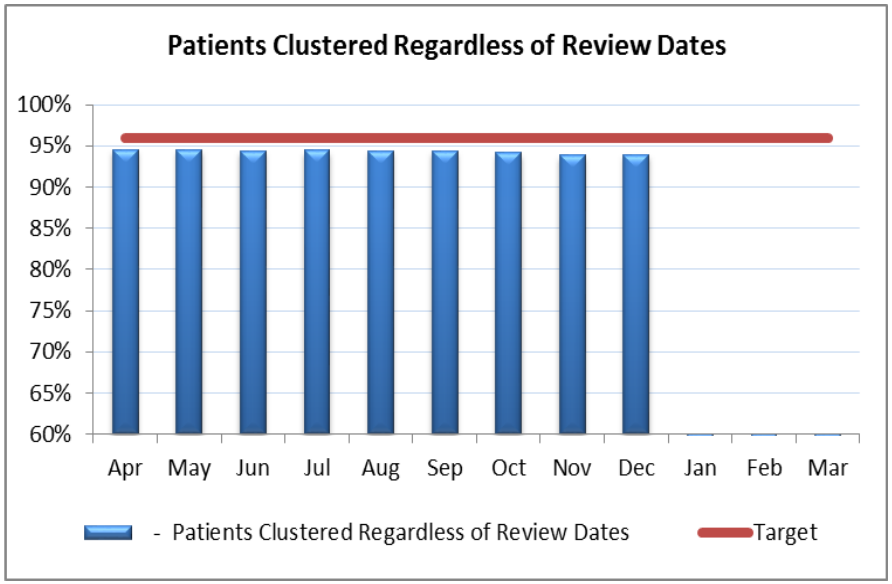
- **Agency expenditure**

  YTD is above the ceiling by £506k (20%) which is generating a '2' on the agency metric. The agency expenditure is forecast to exceed the ceiling by £1.1m (36%) which is an improvement on last month's forecast. This is generating a '3' on the agency metric within the Finance Score.

Operational Section

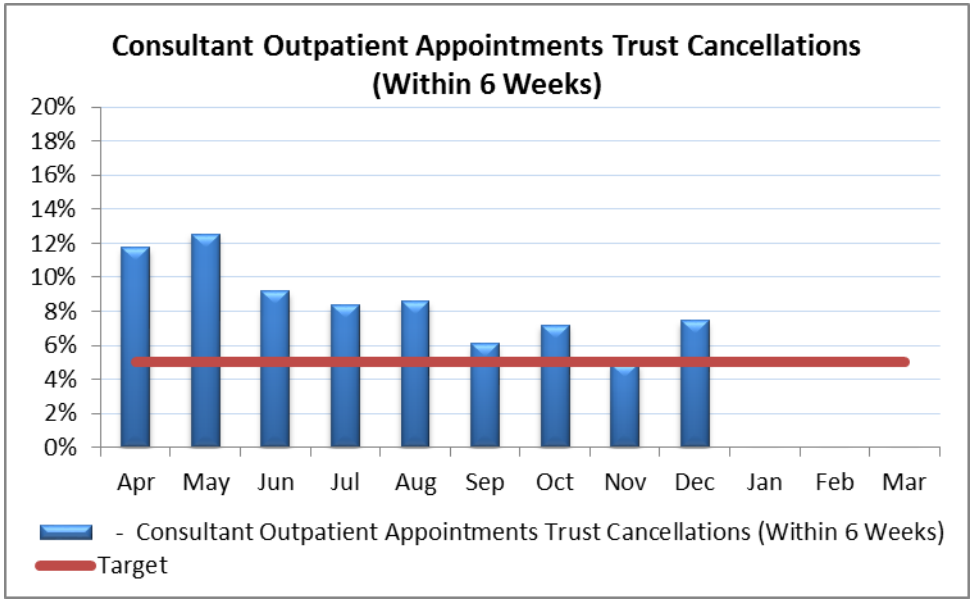
Patients Clustered not Breaching Today and Patients Clustered regardless of review dates





A PbR Care Clustering report was presented to the Finance and Performance Committee in January 2018. This set out the current Trust position regarding PbR performance and proposed a number of actions on how performance could be improved alongside the best use of cluster data to support service reviews.

Consultant outpatient appointments Trust cancellations (within 6 weeks)



Reason	n	%
Clinician Absent From Work	144	58%
No Consultant	32	13%
Moved - Trust Rescheduled	19	8%
Clinic Booked In Error	19	8%
Moved - Location Issue	8	3%
Clinician On Annual Leave	7	3%
Moved - Clinic Cancelled	6	2%
Moved - Staff Issue	5	2%
Paris System Issue	5	2%
Clinician Must Attend Meeting	2	1%
Estates Issue	1	0%
Grand Total	**248**	**100%**

248 appointments were cancelled in December. The main reasons for cancellation were clinician absence from work and there being no consultant. Work is ongoing to address vacancies. A total of 105 days were lost through sickness absence as follows:

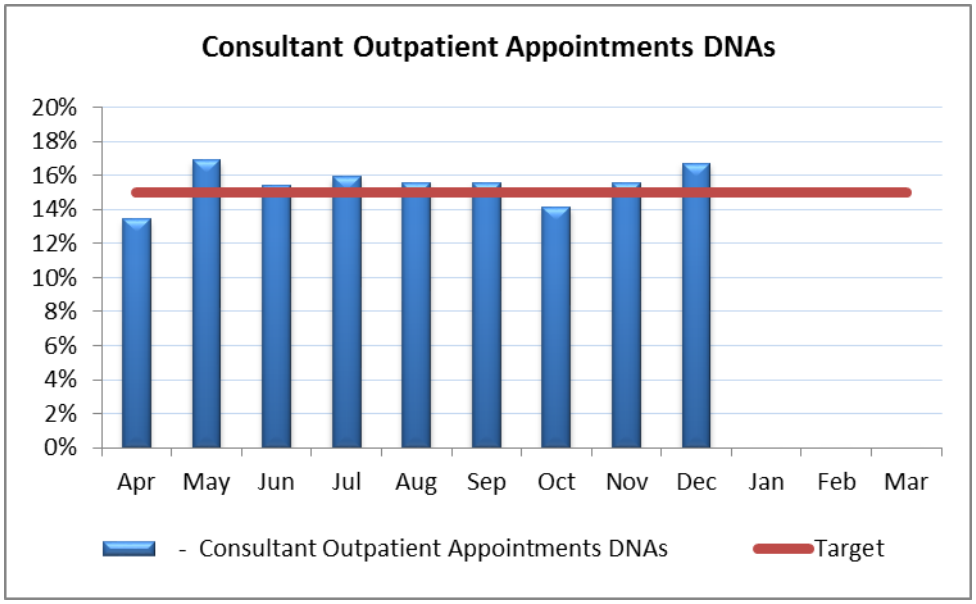
Consultant	Absence reason	Days absent in month
Consultant1	Other musculoskeletal problems	2
Consultant2	Anxiety/ stress/ depression/ other psychiatric illnesses	22
Consultant3	Anxiety/ stress/ depression/ other psychiatric illnesses	31
Consultant4	Cold, Cough, Flu - Influenza	1
Consultant5	Cold, Cough, Flu - Influenza	3
Consultant6	Asthma	2
Consultant7	Asthma	1
Consultant8	Chest & respiratory problems	10
Consultant9	Chest & respiratory problems	5
Consultant10	Chest & respiratory problems	3
Consultant11	Other know n causes - not elsew here classified	25

If it was not for this unavoidable absence, performance would have been well below the 5% threshold for cancellations.

Absence is being managed through the Trust's sickness protocols.

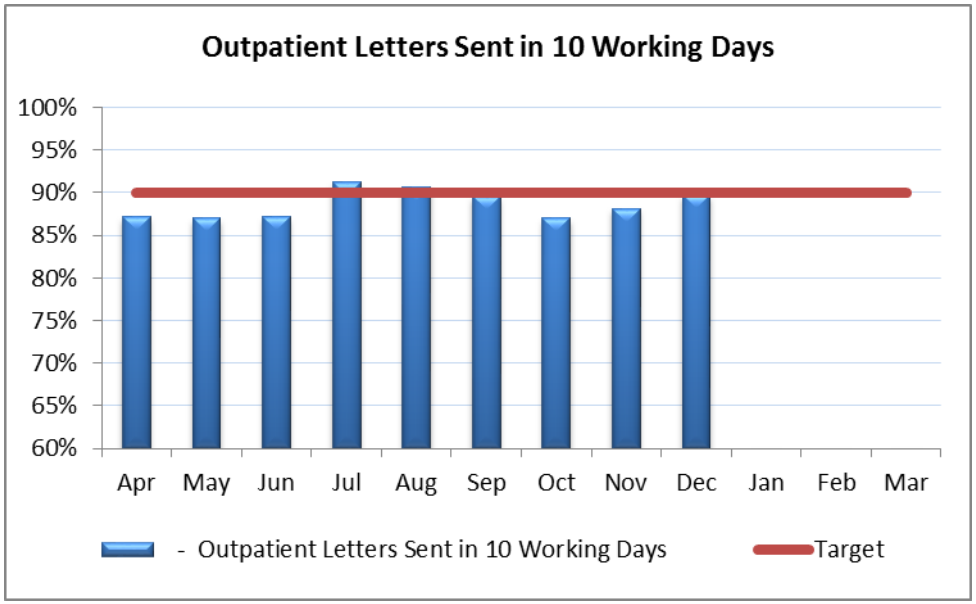
Changes are being made to the way we record and report on cancellations to enable accurate monitoring of the impact on patient experience. The changes will come into effect from 1st April 2018.

Consultant Outpatient DNAs



A pilot was being undertaken in Derby City of telephoning patients to remind them of upcoming outpatient appointments. Unfortunately the pilot had to be put on hold owing to sickness, however it will recommence from 8/1/2018 for a period of 2 months. The impact of the pilot will be evaluated and if proven to be effective this practice will be rolled out across all outpatients.

Outpatient letters sent in 10 working days



Some delay arose out of Doctors not being available to sign off letters owing to unplanned absence.

In addition, a large number of letters were uploaded by a locum immediately prior to a period of extended leave, without being signed off.

Discharge Emails sent in 2 working days

A new approach is being implemented in January 2018. The target is a fully operational process by the start of the next financial year.

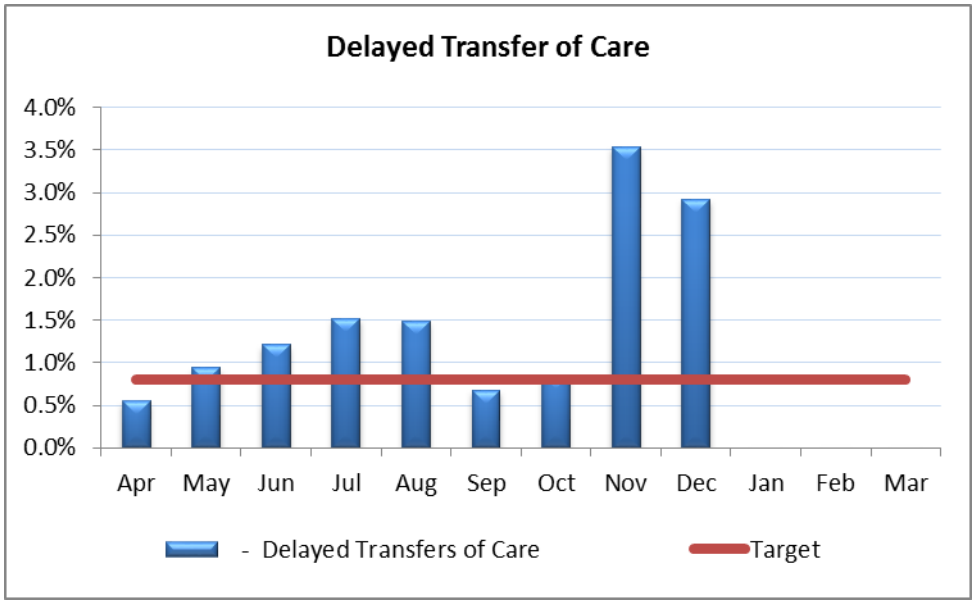
How the process will work;

Inpatient staff will record the discharge in the usual way as the patient leaves the ward so there is a clear date/time recorded. Once the “flimsy” has been attached within Paris the system will automatically generate an email to the GP practice with this document attached to it. The email is sent via the secure NHS.NET network.

Once this feature is implemented and staff are scanning the flimsies into Paris will finalise the KPI reporting and develop the required exception reports.

The KPI will compare the date/time of discharge with the date/time of the email to enable the Trust to report on the level of compliance in advising GPs of a patient discharge. At this stage there will be no change to the way in which the full discharge details will be forwarded to the GP practice.

Delayed Transfers of Care



7 discharges were delayed in December, for the following reasons:

Reason	n
J2 - awaiting supported accommodation	3
C1 - awaiting further non-acute NHS care	2
K2 – awaiting emergency accommodation from Local Authority	1
D1 - awaiting residential home placement or availability	1
Grand Total	**7**

WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
AUDREY HOUSE RESIDENTIAL REHABILITATION	82.58%	167.0%	74.1%	66.1%	0.0%	Yes	This represents an accurate picture of the staffing at Audrey House. We currently have two registered staff posts which we are interviewing for in late January 2018. Also one RN off long term sick and one returning from career break on the 1st February 2018.
CHILD BEARING INPATIENT	94.09%	61.5%	75.3%	93.5%	112.9%	Yes	Registered nurse fill rate tolerances has been broken in December due to 0.6 WTE vacancy and career break backfill. For unregistered staff backfill has been needed to cover long term sickness absence and clinical activity with increased observations.
CTC RESIDENTIAL REHABILITATION	67.32%	132.4%	95.6%	132.3%	143.5%	Yes	We had one staff who returned from long term sickness on 4 weeks phased return . We have two staff on long term sickness . Two Nursing assistants have been off sick since Christmas day . There are some shifts where our staff are asked to move to support other wards . We have two patients on level 2 observations and 1 on level 1 observations where we were not able to cover the shifts.
KEDLESTON LOW SECURE UNIT	40.00%	91.8%	68.1%	87.1%	79.0%	Yes	Our numbers are like this due to one ward being temporary closed for refurbishment, so the staffing numbers are reduced that we currently work on.
KINGSWAY CUBLEY COURT - FEMALE	71.33%	118.2%	106.3%	69.4%	144.1%	Yes	We had increased sickness during December especially Registered Nurses. We are actively recruiting into Nursing Assistant vacancies – one new starter yesterday.
KINGSWAY CUBLEY COURT - MALE	82.26%	90.8%	112.7%	85.5%	179.6%	Yes	Cubley Court Male aim to ensure 2 qualified staff are rota'd to work every night, throughout December on occasions where this as not been possible we have had to back fill with unqualified staff to ensure safe staffing. There as been some sickness through December and annual leave to cover. Staff are always called upon to support other wards when they have reduced qualified cover this includes supporting the Radbourne unit.
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	102.51%	86.6%	106.7%	100.0%	146.8%	Yes	There has been a significant amount of sickness within the registered nursing group in this period. This has also coincided with some annual leave at the earlier part of the roster period.

WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
HARTINGTON UNIT - MORTON WARD ADULT	85.08%	98.7%	144.7%	66.1%	203.2%	Yes	We currently have some Band 5 vacancies, these have been recruited into and are awaiting new starters to come to the ward during the early part of the year. One of the registered nurse posts has now been filled with a ward based OT, they have started work but are currently supernumery during their induction. One of the Band 5 nurses is also acting up into the vacant Band 6 position which, coupled with the existing vacancies, obviously has an impact on having x2 qualified nurses on night duty. We also have one of our full time Band 5 nurses on long term sick leave. We have had high activity on the ward of late and this has led to an increase in staffing numbers on each shift. Some of the new starters are under preceptorship and presently cannot work on shifts as the nurse in charge.
HARTINGTON UNIT - PLEASLEY WARD ADULT	84.84%	83.4%	106.4%	37.1%	200.0%	Yes	Pleasley ward currently has Registered Nurse vacancies, and has had some short term staff sickness, which means that the safer staffing requirements for Registered Nurses unfortunately hasn't be met. The uncovered Registered Nurse shifts have been filled by Care Staff to ensure 5,5,3 staffing requirements have been met where possible.
HARTINGTON UNIT - TANSLEY WARD ADULT	93.01%	72.0%	129.7%	51.6%	222.6%	Yes	Through December there were a number of issues leading to the figures in the returns for Tansley Ward. There are currently 4.6 Band 5 vacancies and in addition 2 vacancies filled but the staff members have not yet commenced in post. The Band 5 funded compliment has decreased by 1 x Band 5 to allow for the recruitment of an OT however the person recruited into the post is not due to commence until July so this remains an unfilled post. In addition to the vacancies above 1 x wte Band 6 nurse was on a long term sickness absence however she has now commenced a phased return to work and will hopefully be back to normal duties by February. A further 0.6 wte Band 5 nurse on long term sickness absence pending surgery and as yet has no estimated return date. HR are fully involved with both absences. We still have a wte Band 5 on special leave. All of the above deficits are being backfilled by Bank HCA given the lack of bank registered staff accounting for the increase in HCA duties, wehave also had some very challenging night shifts for which we have increased staffing when required and where possible.

WARD STAFFING

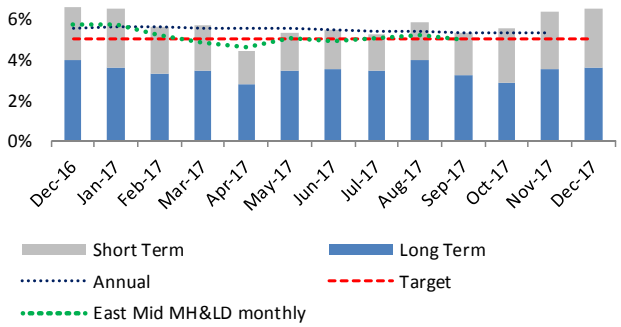
Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
ENHANCED CARE WARD	87.74%	75.7%	125.1%	48.4%	212.9%	Yes	
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	103.06%	96.6%	126.6%	71.0%	274.2%	Yes	All inpatient wards at the Radbourne unit remain affected by low recruitment into Registered Nursing vacancies. The current staffing establishment for Ward 33 is unable to meet the full demands for RN cover on each shift. In order to maintain safety and stability within the clinical areas, we have over recruited into HCA posts, hence the higher than required fill rates for unregistered staff. The Trust and individual ward areas continue to proactively recruit into RN vacancies and staffing/ skill mix are reviewed on an ongoing basis at ward level, operational level and Trust level. In addition we are making all attempts to book regular bank/ agency staff who are familiar to our areas in order to provide a level of consistency. The Trust are currently looking to provide additional support into the unit, in order to allow senior and regular staff to work within clinical numbers on the wards where necessary.
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	87.10%	74.6%	111.7%	61.3%	232.3%	Yes	There continues to be high numbers of RN vacancies which are then filled by unqualified staff , when appropriate. This is especially impactful on night shifts.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	96.29%	74.0%	135.3%	64.5%	132.3%	Yes	This is due to current RN vacancies which are being filled with NA's.
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	96.61%	83.1%	134.5%	50.0%	267.7%	Yes	There was a high level of sickness among staff members, leading to an increase in unqualified bank staff during the day. The night shift required an increase in unqualified bank staff due to an increase in observation levels.

Workforce Section

WORKFORCE DASHBOARD

Sickness Absence

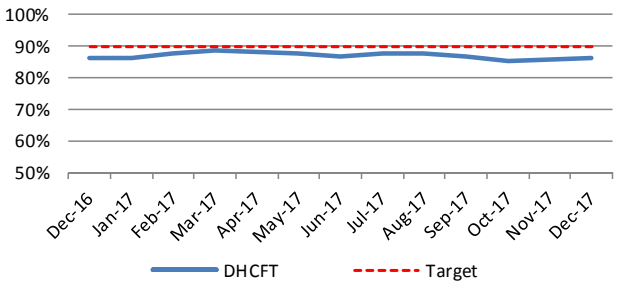
	Oct-17	Nov-17	Dec-17
(Monthly)	5.51%	6.32%	**6.47%**
(Annual)	5.29%	5.28%	**tbc**
Target	*5.04%*		



The monthly sickness absence rate is 0.15% higher than the previous month, however compared to the same period last year (December 2016) it is 0.08% lower. The Trust annual sickness absence rate continues to reduce and is running at 5.28% (as at November 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 28.89% of all sickness absence, followed by surgery at 12.19% and cold / cough / flu at 10.74%. Compared to the previous month short term sickness absence has increased by 0.13% and long term sickness absence has increased by 0.02%.

Compulsory Training

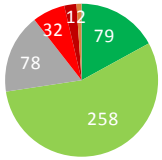
	Oct-17	Nov-17	Dec-17
(Staff in-date)	85.58%	85.62%	**86.41%**
Target	*90%*		

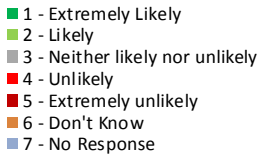


Compulsory training compliance continues to remain high running at 86.41%, an increase of 0.79% compared to the previous month. Compared to the same period last year compliance rates are 0.20% higher.

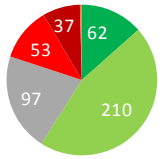
Staff FFT Q2 2017/18 (465 responses, 20.5% response rate) & Staff Survey 2016

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





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

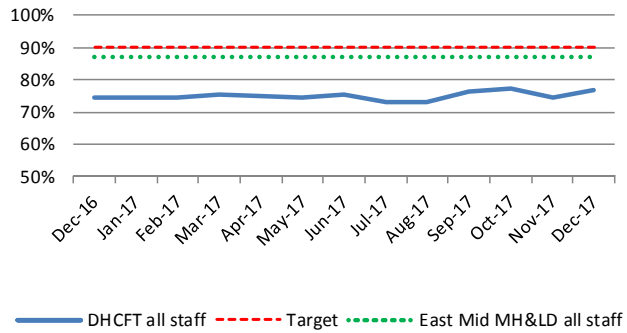


	2016	National average 2016	2015	National average 2015
Overall staff engagement:	**3.69**	3.84	3.73	3.81

Appraisals (All staff)

Oct-17	Nov-17	Dec-17
77.02%	74.65%	**76.78%**

Target 90%

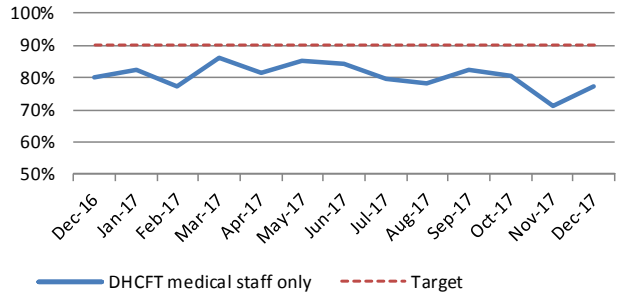


The number of employees who have received an appraisal within the last 12 months has increased by 2.13% during December 2017 to 76.78%. Compared to the same period last year, compliance rates are 2.50% higher. According to the 2016 staff survey results, the national average for Mental Health & Learning Disability Trusts is 88.79%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 85.40%.

Appraisals (Medical staff only)

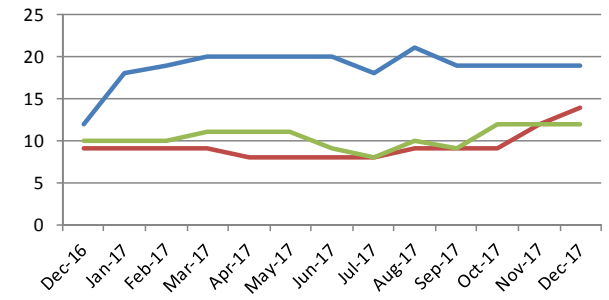
Oct-17	Nov-17	Dec-17
80.37%	71.15%	**77.36%**

Target 90%



The number of Medical staff who have received an appraisal within the last 12 months has increased by 6.21% to 77.36%. Compared to the same period last year, compliance rates are 2.83% lower. Junior Doctors on rotational training are excluded from the figures.

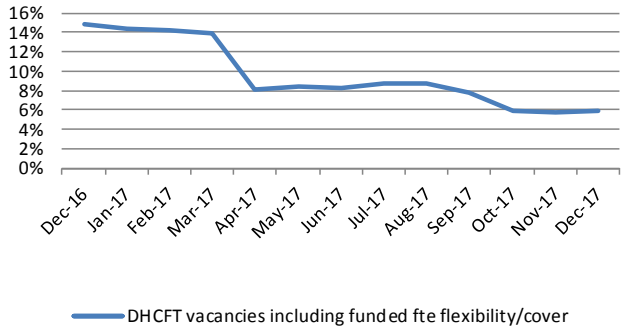
Disciplinaries/Dignity at Work/Grievances as at 31/12/2017



There are 19 Disciplinary cases, 1 new case has been lodged and 1 case has been resolved. There are 14 Dignity at Work cases, 2 new cases have been lodged. There are 12 Grievance cases lodged at the formal stage, 1 new case has been lodged and 1 case has been resolved.

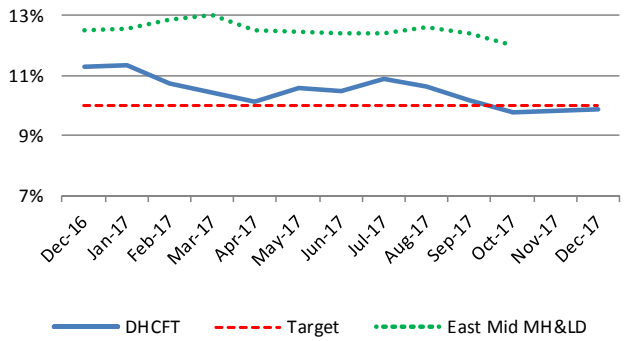
WORKFORCE DASHBOARD

Vacancy	Oct-17	Nov-17	Dec-17
(Funded full time equivalent) Including funded fte flexibility/cover	5.96%	5.74%	**5.94%** ↗



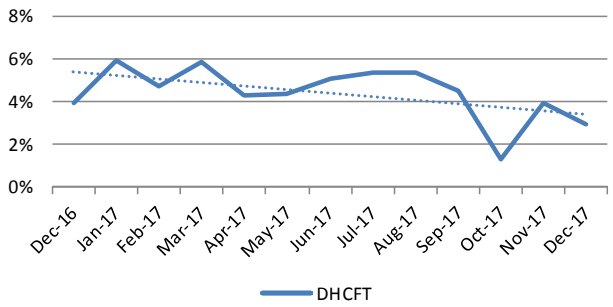
The Trust vacancy rate includes funded Fte surplus for flexibility including sickness and annual leave cover. Funded vacancy rates have increased slightly to 5.94% in December 2017. 2017/18 budget changes included a large reduction in Fte from 2016/17 investment not materialising and Cost Improvement Programmes. During the period January 2017 to December 2017, 241 employees have left the Trust and 345 employees have joined the Trust.

Turnover	Oct-17	Nov-17	Dec-17
(Annual)	9.76%	9.85%	**9.90%** ● ↗
			Target 10%



Annual turnover remains within Trust target parameters at 9.90% and remains below the average for East Midlands Mental Health & Learning Disability Trusts (11.99%). The average number of employees leaving over the last 12 months has decreased from 19.58 to 19.25. During December 2017 13 employees left the Trust which included 1 retirement.

Agency Usage	Oct-17	Nov-17	Dec-17
(Spend)	1.29%	3.90%	**2.93%** ↘



Total agency spend in December was 2.93% (3.35% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 0.58%, Medical 2.14% and other agency usage 0.21%. Agency Qualified Nursing spend against total Qualified Nursing spend in December was 1.8%. Agency Medical spend against total Medical spend in December was 12.8%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £695k.

Data Quality Kitemark

Background

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

Approach

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

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
Sponsor (Assessment of Executive Director)	Does the responsible Director for the indicator believe the data used for this indicator to be a true reflection of actual performance?	Not yet assessed	The Executive Director can give significant assurance about the quality of the data.	The Executive Director cannot give assurance about the quality of the data.
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.

Data Quality Indicator	Definition	Not yet assessed	Sufficient	Insufficient
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.
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 Trust 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 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 Board of Directors – 31 January 2018

Quality Position Statement

Purpose of Report

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

Executive Summary

This position statement sets out:

1. **Safety** – NHS Improvement and the National Quality Board have requested all NHS Trusts to publish a review of mortality by 31 December 2017. The Trust's report and summary of required actions have been completed on time. The remaining action for a detailed report in the 2018 published Quality account remains on trajectory. The Executive Lead is John Sykes.

2. **Responsiveness** - Decision making and mental capacity draft guidelines have been published by NICE in December 2017 with a closing date for consultation in February 2018 with an expected publication date of May 2018. Our clinical skills tutor and leads for Mental Capacity Act have been provided with this work to enable to be on the front foot for any changes in practice standards surrounding decision making and mental capacity. The Executive Lead is John Sykes.

3. **Effectiveness** - In December, the Safeguarding Committee reviewed our 'Looked after Children Annual report' (LAC). This data reviewed our care and treatment of children who are looked after children in Derby city and some individuals who are the responsibility of Derby city currently in foster or supported care outside of our county boundary. The report details information on performance and a concerning trend in further increases in children on a child protection plan and increases in 'Looked after Children'. The Executive Lead is Carolyn Green.

4. **Well led** – Working on quality improvements - working with international partners on Safewards. A research trial for nursing practice that has a randomised controlled trial demonstrating reduction in containment and reductions in violence and improvements in staff morale. This is a briefing on a recent international visit which reinforces in-patient nursing staff commitment to this well regarded nursing intervention. The Executive Lead is Carolyn Green.

5. **Well led** - The ability to review your service from the opinion of your Commissioners, Watchdogs and Regulators is a key outcome of a well led organisation. We maintain our routine surveillance monitoring level by the Quality Surveillance Group and Regulators. The report outlines direct feedback on our responsiveness to our Watchdog. The Executive Lead is Carolyn Green.

6. **Well led** – Our Care Quality Commission (CQC) Action Plan Performance to assure the public of our progress and commitment and that we now are off trajectory for our

timeline for completion in January 2018. The evidence produced and performance in key operational and clinical areas of practice has not been to the required level and has not been achieved and has been further extended to the end of January and to April 2018 for some areas to ensure improved performance and re-audit to ensure adequacy and completeness. The Executive Lead is Carolyn Green.

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

Strategic considerations

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

(Board) Assurances

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

Consultation

This paper has not been previously presented, but does reference information available to the Quality Leadership Teams and Quality Governance Structures.

Governance or Legal issues

- Evidence of our compliance with the Health and Social Care Act 2008 (Regulation activities) Regulations 2014 Part 3 and CQC (Registration) Regulations 2009 (Part 4).
- Children and Families Act 2014.
- The Care Act 2014.
- There are legal issues under the Regulatory Reform (Fire) Safety Order 2005, the Health & Safety at Work etc. Act 1974 and the Health & Social Care Act 2010 contained within this Report.

- Care Quality Commission Regulations this report provides assurance to:-
  - Outcome 4 (Regulation 9) Care and welfare of people who use services
  - Outcome 10 (Regulation 15) Safety and suitability of premises
  - Outcome 11 (Regulation 16) Safety, availability and suitability of equipment
  - Outcome 12 Regulation 210) Requirements relating to workers
  - Outcome 14 (Regulation 23) Supporting staff
  - Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
  - Children's Act (1989)
  - Adoption and Children Act (2002)
  - Children and Young Peoples Act (2008)
  - Children and Families Act (2014)

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

Any impact or potential impact on equality is considered as a key part of all our quality work. Some of the examples are improving the equalities position for individuals and their families are fully in line with our duties and responsibly and due regard.

Individuals with mental health and learning disabilities are often adversely affected by economic disadvantage, due to the significant impact on life due to the period of illness.

Children from a specific cultural background have been noted in the report as being at higher levels of abuse, this is a concerning matter, which will be monitored.

Recommendations

The Board of Directors is requested to:

1) Receive this quality position statement.
2) Gain assurance, be advised on safety.
3) Review its content and seek clarity or challenge on any aspect of the report.

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

Report prepared by: **Carolyn Green**
Executive Director of Nursing & Patient Experience

Quality Position Statement

1. Safety – Our work toward meeting The National Requirements as outlined by the National Quality Board

The requirements were to publish our 'Learning from Deaths' policy, to publish our learning from deaths mortality report and include in our 2018-2019 Quality Account and review of our annual data.

We can confirm compliance with our policy in September.

We can confirm compliance with our mortality report published on 31 December 2017 and the report is available in full on the Trust website and at the end of this report.

http://www.derbyshirehealthcareft.nhs.uk/about-us/publications

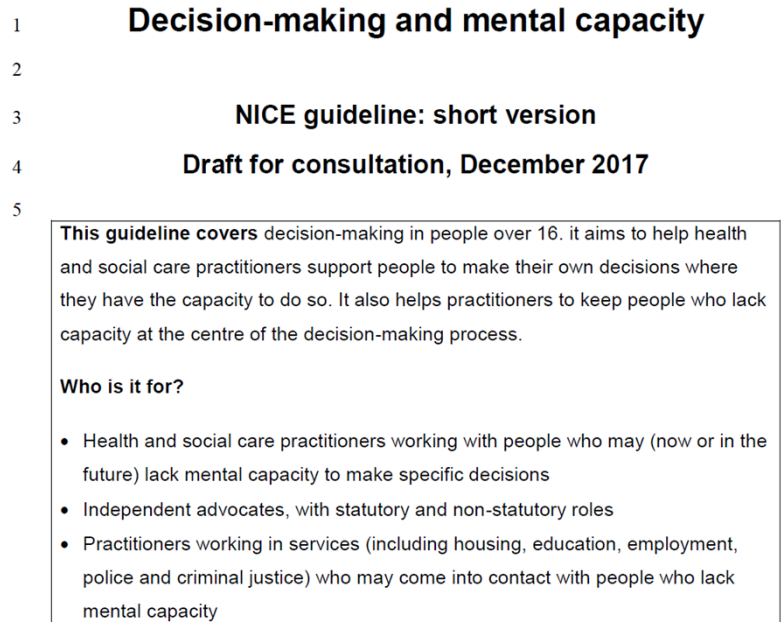
Actions: We will publish in our annual accounts in the Quality account the required data as specified by the national guidance and we have already included learning from mortality in our quality dashboard.

The Executive Lead for this work is Dr John Sykes and this will be monitored in the Quality Committee.

2. Responsiveness

Decision making and mental capacity draft guidelines have been published by NICE in December 2017 with a closing date for consultation in February with an expected publication date of May 2017. Our Clinical Skills Tutor and Leads for Mental Capacity Act have been provided with this work to enable to be on the front foot for any changes in practice standards surrounding decision making and mental capacity.

In development [GID-NG10009] expected publication date: 16 May 2018



Decision-making and mental capacity

NICE guideline: short version

Draft for consultation, December 2017

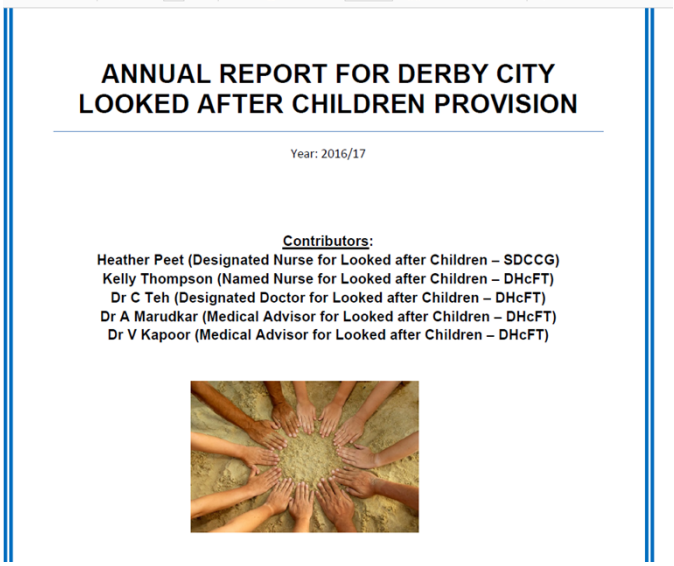
This guideline covers decision-making in people over 16. it aims to help health and social care practitioners support people to make their own decisions where they have the capacity to do so. It also helps practitioners to keep people who lack capacity at the centre of the decision-making process.

Who is it for?

- Health and social care practitioners working with people who may (now or in the future) lack mental capacity to make specific decisions
- Independent advocates, with statutory and non-statutory roles
- Practitioners working in services (including housing, education, employment, police and criminal justice) who may come into contact with people who lack mental capacity

Action: Clinical Leads – Clinical Skills Tutor, Lee Smith and Dr Edward Komocki as Mental Capacity Act Lead, have been asked to comment and review this NICE guideline and provide operational and tactical guidance on immediate actions and any changes to strategy or clinical direction to the Mental Health Act Committee operational group and on publication undertake a mapping and provide assurance to the Mental Health Act Committee on compliance.

3. **Effectiveness - In December, our Safeguarding Committee reviewed our 'Looked After Children' Annual report. This data reviewed our care and treatment of children who are looked after children in Derby city and some individuals who are the responsibility of Derby city currently in foster or supported care outside of our county boundary.**



ANNUAL REPORT FOR DERBY CITY
LOOKED AFTER CHILDREN PROVISION

Year: 2016/17

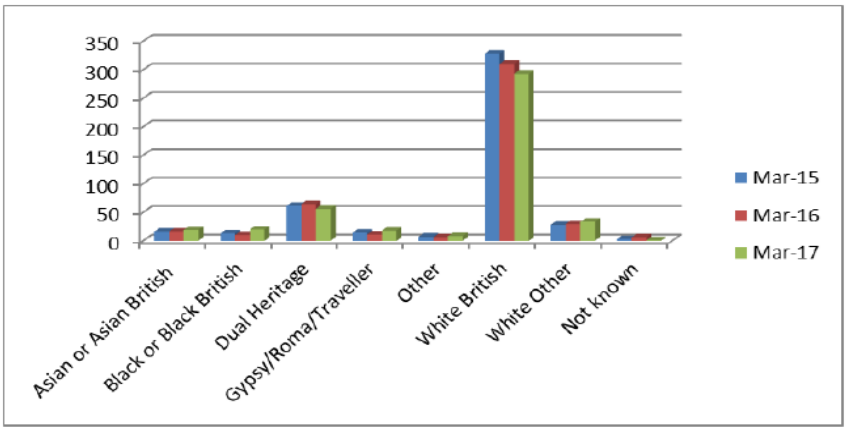
Contributors:
Heather Peet (Designated Nurse for Looked after Children – SDCCG)
Kelly Thompson (Named Nurse for Looked after Children – DHcFT)
Dr C Teh (Designated Doctor for Looked after Children – DHcFT)
Dr A Marudkar (Medical Advisor for Looked after Children – DHcFT)
Dr V Kapoor (Medical Advisor for Looked after Children – DHcFT)

The ‘Looked After Children’ report provided significant assurance on the care and provision of children in our care. It has, however, noted changes in the number of children coming to the attention of services with support needs and increases in children from Gypsy / Romany / Traveller and White other ethnic groups. This may be a trend or a reflection of the changes in Derby City’s ethnic population changes.

Ref: Data made available from Derby City Local Authority Informatics Department

Profile of looked after children in Derby City

3.4 Ethnicity comparisons over the last three years:



Ref: Data made available from Derby City Local Authority Informatics Department

On analysing the data, it is clear that there is an increase of looked after children from the Gypsy/Roma/Traveller and White Other ethnic group; this reflects the Derby City picture of a recent influx of new emerging communities. There have been significant cultural differences found in the new emerging communities, in relation to childcare, parenting, disciple and safety aspects. This has resulted in an increase of cases being referred to Children’s Social Care and involvement at all levels of intervention; in some cases children/young people taken into care. The number of white British children coming into care has decreased over the past three years; again this may be reflection of the population changes within Derby City.

This internal assurance report is shared with Commissioners. In the discussion of the report, some key facts were discussed that may impact upon our strategic decision making and operational performance in 2018/2019.

In addition, there have been significant changes in the number of children on the Child Protection Plan. This is a substantially changing pattern and has had a statistically significant impact on our community and the children service that we provide.

We are now experiencing presented levels of children on the Child Protection Plan with record levels of safeguarding issues in Derby. Thresholds have been checked and are appropriate. This will impact upon pressure in our children’s service and pressure particularly on Health Visitors and School Nurses. Additional discussions with our Lead Public Health Commissioner and in contracting discussion talk about some mitigating solutions.

Today we now have over 500 children on a plan in Derby, see this slide, so that is over 200 - 250+ more cases than 12 months ago. This is a further increase on the data published in December and in previous Board briefings.

The slide below is a Derby City Safeguarding Board publication of the significant changes in children who are subject to Child protection plans. This now results in Derby city being an outlier against other areas. Informal discussions with other areas nationally are also reporting some changes, but not to the degree of our city. Their levels of physical abuse have grown and this also correlates with increasing levels of adult violence in the city.

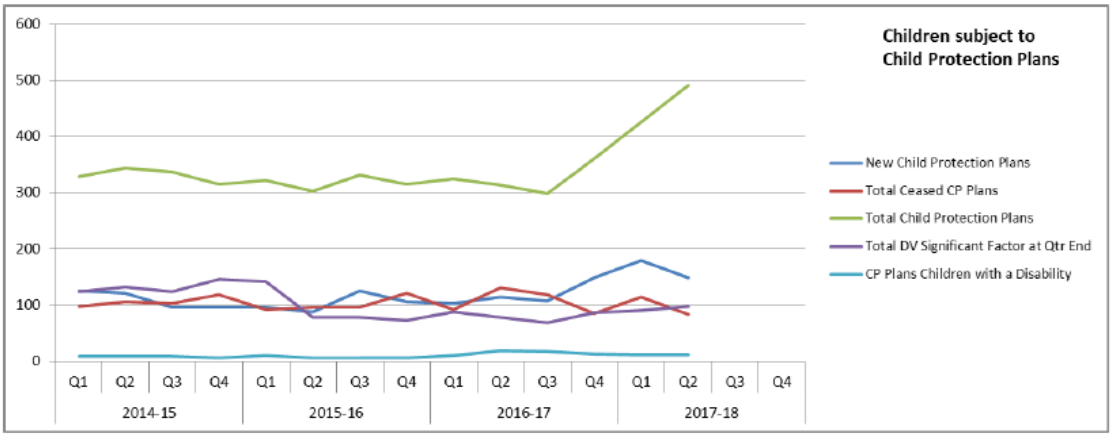
3 Children subject of Child Protection Plans

An additional report is included to illustrate the assurance sought in respect of the increasing numbers of Children subject of Child Protection Plans.

There is a range of work being undertaken to understand the significant rise in CPP's over the last 12 months.

What we know so far:

- Increase in CPP's for 5-15 yrs.
- Ethnicity-increase in CPP's for CYP from other ethnic origins (Gypsy/Roma/Traveller-saw the largest increase (1.2% in 2016 and 6.4% in 2017).
- Increase in single children and larger sibling groups have impacted on increase
- CYP subject to plans for physical abuse has grown



2

Actions: The ability of our children's team to work under sustained pressure is not viable in the medium term. Discussions with Commissioners on solutions, de-prioritisation of other service outcomes has commenced, to ensure the needs of the child are paramount and staffs are supported to manage their workload. This operational issue with strategic impact on staff morale will be reviewed at the Children's COAT (Clinical Operational Assurance Team) and Trust Management Team, with overarching monitoring from the Executive Lead and assurance reports to the Safeguarding Committee.

4. Well Led

Briefing regarding the visit from North Zeeland Mental Health Services Safe wards visit 28 November 2017.

A group of 18 Managers, Clinicians and Medics from the Northern Zeeland Mental health Services in Denmark visited the Hartington unit on 28 November 2017 to discuss and explore the use of the Safewards methodology across the unit. Safewards is a model explaining variation in conflict and containment that uses ten easy interventions to pre-empt and reduce conflict in clinical settings.

The team approached the staff at the Hartington unit following on from a previous visit by colleagues from the Southern Region of Denmark.

Clinical practice in Denmark has higher levels of restraint and use of mechanical methods and they were interested in the Safe wards methodology to try and change this practice.

The team used their time in the UK to visit the Taith Newydd Low Secure Unit at Glan Rhyd Hospital in Wales and then came on to Chesterfield.

The team at Chesterfield was led by Vicki Miller, one of the Lead Nurses on the unit. She co-ordinated a programme that looked at the baseline theories of Safe wards, had visits to the wards and discussion with patients (all patients had been asked if they wanted to meet the group and if they were happy with them participating in the activities), attending mutual help meetings and mindfulness groups and a question and answer session.

The Danish team was also given some of the debrief balls that assist with debriefing sessions held after restraint / seclusion incidents.

The balls have questions printed on the surface that prompt and support the conversation and exploration of the incident. Staff are encouraged to use these to enable discussion and to move away from superficial issues to those that might have a deeper impact on their wellbeing and clinical practice.

Vicki also created a cake in the shape of a mermaid's tail that referenced the fairy tale by the Danish author Hans Christian Anderson called 'The Little Mermaid.'

The team from Denmark were very complementary about what they had seen and were keen to look at how they could implement the Safe wards methodology. Vicki Miller and Dave Harrison (Practice Development & Compliance Lead for Restrictive Practice/Positive and Proactive Tutor) will be remaining in contact with them to offer support and advice.

Well Led - The ability to review your service from the opinion of your commissioners and regulators is a key outcome of a well led organisation

This is an extract of a letter noting previous concerns relating to our performance in serious incidents and the progress of implementing our comprehensive CQC action plans. The outcome is that the Trust remains on routine monitoring by our regional Quality Surveillance group.

Dear Ifti

Re: Nottinghamshire & Derbyshire Quality Surveillance Group (QSG)

QSG is a forum which systematically brings together the different parts of the system to share information. Partners will share a view of risks to quality across NHS commissioned services through sharing intelligence. QSG provides opportunities to coordinate actions to drive improvement, respecting statutory responsibilities of and ongoing operational liaison between organisations.

The purpose of this letter is to inform you of the discussions at the Nottinghamshire & Derbyshire QSG on 22 November 2017 in relation to Derbyshire Healthcare NHS Foundation Trust. Please find below a summary of the areas considered:

- **Serious Incidents:** QSG were briefed that improvements have been seen around the reduction in the number of overdue Serious Incident Investigations. It was noted that there has been an increase in resources within the patient safety team therefore improving responsiveness.
- **CQC:** QSG were informed that the CQC action plan is being managed through established QAG process. No concerns highlighted.

As per national QSG guidance a surveillance rating system is in place which monitors ongoing, new and closed concerns. After due consideration and based on the discussion during the meeting, the QSG agreed that Derbyshire Healthcare NHS Foundation Trust should remain on Routine Surveillance.

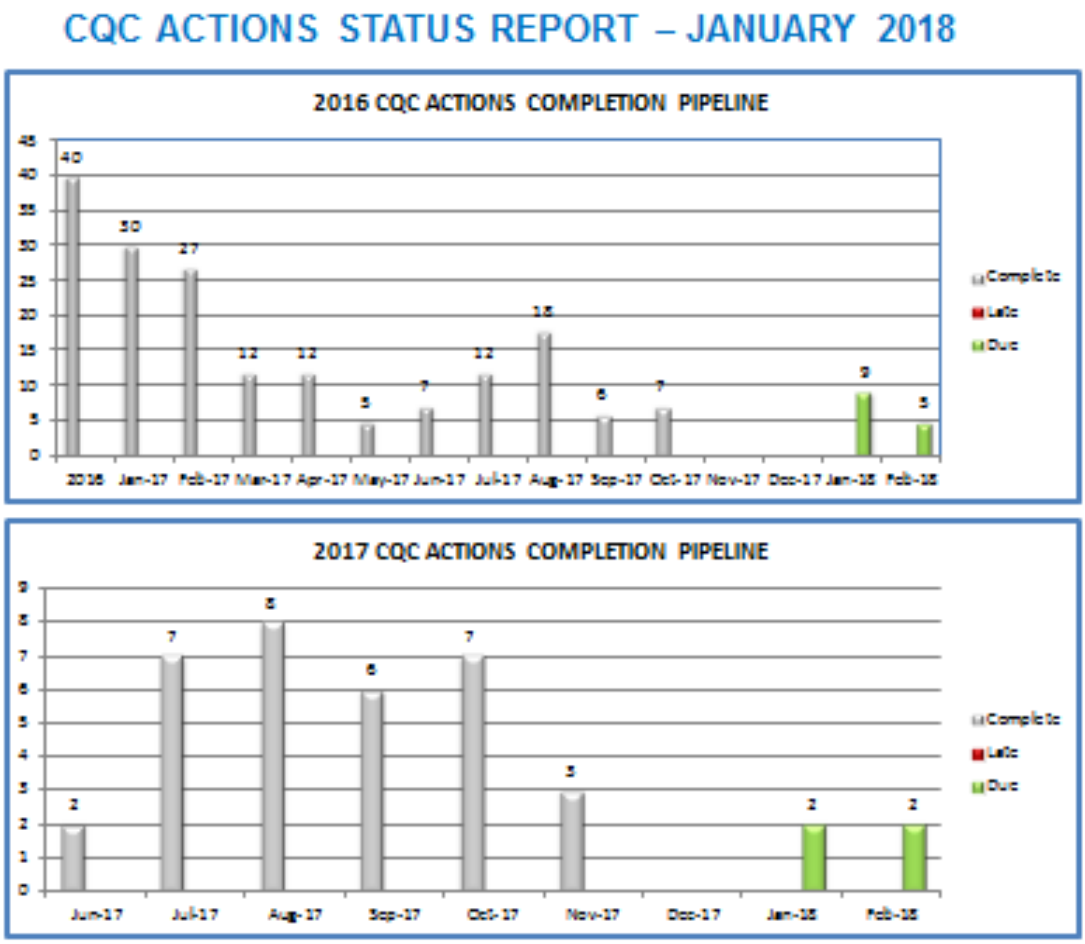
In addition to our Regulators, we asked for feedback from Derbyshire Healthwatch provided in December (2017)

Derbyshire Healthcare NHS Foundation Trust regularly receives feedback from patients and carers from Healthwatch Derbyshire, and from the Mental Health Together Engagement Service. Responses to comments are without exception thorough, and consider actions taken by and necessary next steps for Trust, along with any other more systematic learning that can be applied. Experiences requiring more urgent attention are always picked up by the team without delay.

Responses to Healthwatch reports are also thorough, with full consideration given to the range of recommendations made. Reasonable steps taken to address recommendations as far as possible, with updates provided to Healthwatch regarding progress made. Evidence of the above can/will be supplied as requested.

Actions: We will continually seek feedback from partners on our organisational performance and learning and when we are informed in areas we can improve we will make headway on improving our performance as identified in this summary

5. Care Quality Commission Comprehensive – Completing Our Action Plan



PROGRESS UPDATE
This month's review took place with the Deputy Director of Nursing & Quality Governance and the Leads on all outstanding actions. Final requirements were identified to complete all of the outstanding actions, and to improve sustained compliance with the CQC recommendations. Target dates have been extended on the majority of actions to allow for additional work to be completed and additional evidence to then be uploaded to the CQC Portal.

RISKS AND CONCERNS
There are 14 actions still outstanding from the 2016 CQC visits, which is a concern. However, the requirements for completion have been specified, amended target dates have been agreed, and full support is being given to the action leads to meet those requirements.

GOING FORWARD
The CQC and Governance Coordinator will review that status of outstanding actions again on 01.02.18 and provide an update to the Quality Committee.

There will also be a final review meeting mid-February with the Deputy Director of Nursing & Quality Governance and the Leads on all outstanding actions to assess the progress of the last of the outstanding actions and to provide mutual support in meeting the completion date on them.

Report prepared by: Kelly Sims, CQC & Governance Coordinator

The performance this month has been disappointing. We continue to have 14 remaining actions on the 2016 comprehensive plan and 4 remaining action on the 2107 plan. Leaders have not been able to make the requisite improvements and provide additional evidence in both appraisal, supervision and in some training areas.

There has not been enough sustained improvement in copies of care plans being evidence in the clinical record. There remains further evidence required in community mental health settings in the full and quality standards of assessment mental capacity act and care planning.

The residual areas, although improved are inconsistent and sustained improvement is required before completion of care pathway level compliance is confirmed.

Action

1. We continue to make progress on our CQC action and improvement plan and we will continue to ensure that these recommendations and final actions are fully delivered. We look forward to meeting all of our essential standards and providing maintenance of our compliance levels to refocus our attentions to continuous quality improvement, innovations and solution focused approach to our staff and community.

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Quality Committee - 14 December 2017

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 specified information on deaths quarterly. This should be through a paper and Board item to a public board meeting in each quarter to set out the Trusts policy and approach (by end of Q2) and publication of the data and learning points by Quarter 3 .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, how many of these deaths were judged more likely than not to have been due to problems in care. This report outlines the information required to be reported by the end of Quarter 3.

2. Current position and progress

- Learning from Deaths Procedure approved through Public board papers
- Application for NHS digital continues and the Trust is currently awaiting an outcome.
- Two staff , Professional Lead for Patient Safety and Experience and Investigation Facilitator have attended the national training on Structured Judgement Reviews (SJR) by the Royal College of Physicians
- The Mortality Review Group continue to trial two methods to case review records , these are PRISM and Structured Judgement Review

3. Data Summary

Total number of deaths recorded since 1 April 2017								Total
April	May	June	July	August	September	October	November	
148	145	151	141	142	128	93	82	1030

Correct as at 30.11.2017

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

Since April 2017 the Trust has received 1030 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 6 months contact, this took effect from 20 October 2017. A decrease can therefore be seen in the number of deaths recorded for the months of October and November.

4. Review of Deaths

Untoward Incident and Investigation policy and procedure

From 1 April to 30 November 2017, 129 deaths reported through the Trust incident reporting system (Datix).Of these 48 have been reviewed and closed through the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*.

An Initial Service Management Review (ISMR) was completed for all 11 inpatient deaths; these were discussed at the Serious Incident Group where 6 deaths were then commissioned for further investigation, one of which was an expected death.

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are 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. (This criteria only relates to patients open to services within the last 6 months)
- Domestic homicide - perpetrator or victim (This criteria relates to patients open to services within the last 6 months)
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatients 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 DoLs (Deprivation of Liberty Safeguards) 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/ombudsman, or staff have raised a significant concern about the quality of care provision
- Death of a child (and will likely 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

The Mortality Review Group has currently case reviewed four deaths using the PRISM method. This was undertaken by a multi-disciplinary team and it was established that no deaths were due to problems in care. The Mortality Group are currently reviewing the following red flags:

- Patient on end of life pathway, subject to palliative care
- Anti-psychotic medication
- Referral made, but patient not seen prior to death
- Death of patient on Clozapine

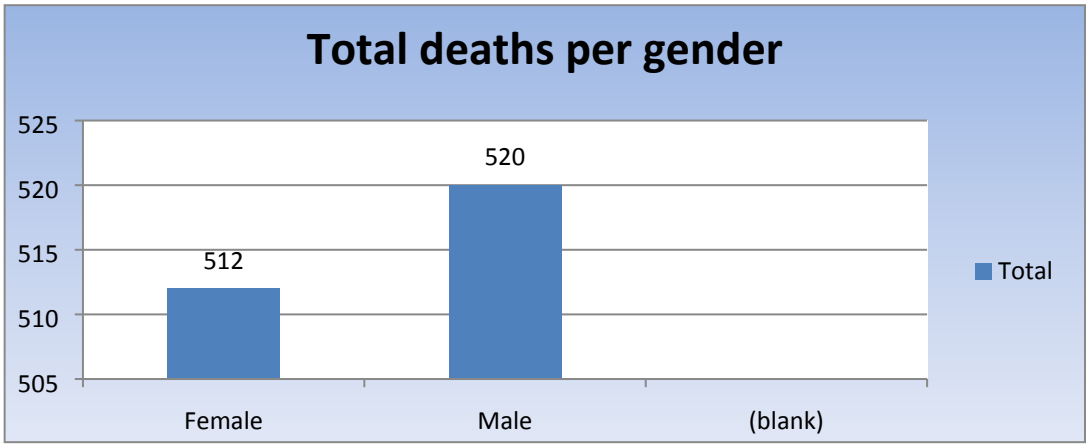
Initial analysis of death notification information shows the most prevalent causes of death are:

- Alzheimers Dementia
- Old Age
- Pneumonia

6. Analysis of Data

6.1 Deaths by gender

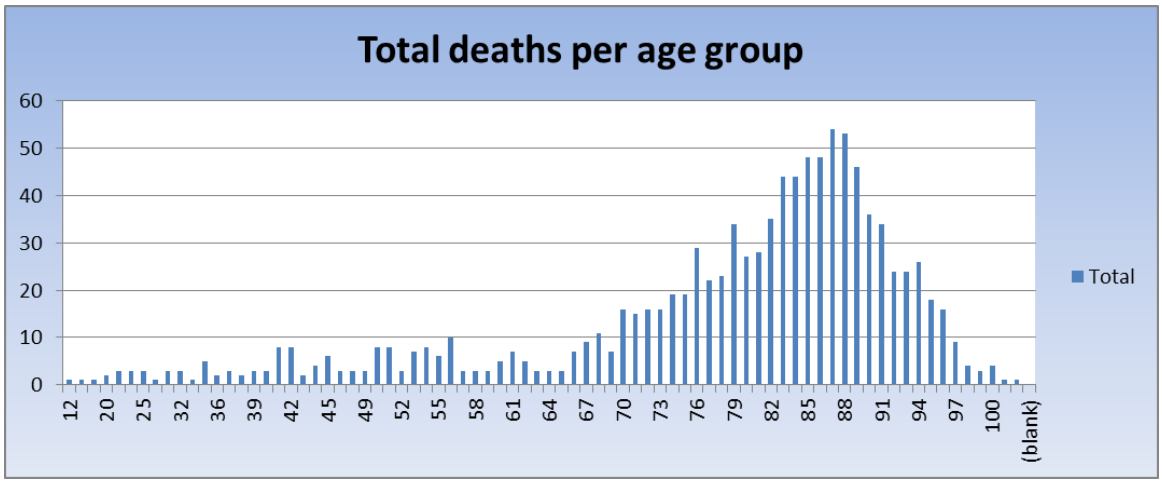
The data below shows the total number of deaths by gender. There is very little variation between male and female deaths, 520 male deaths were reported compared to 512 female



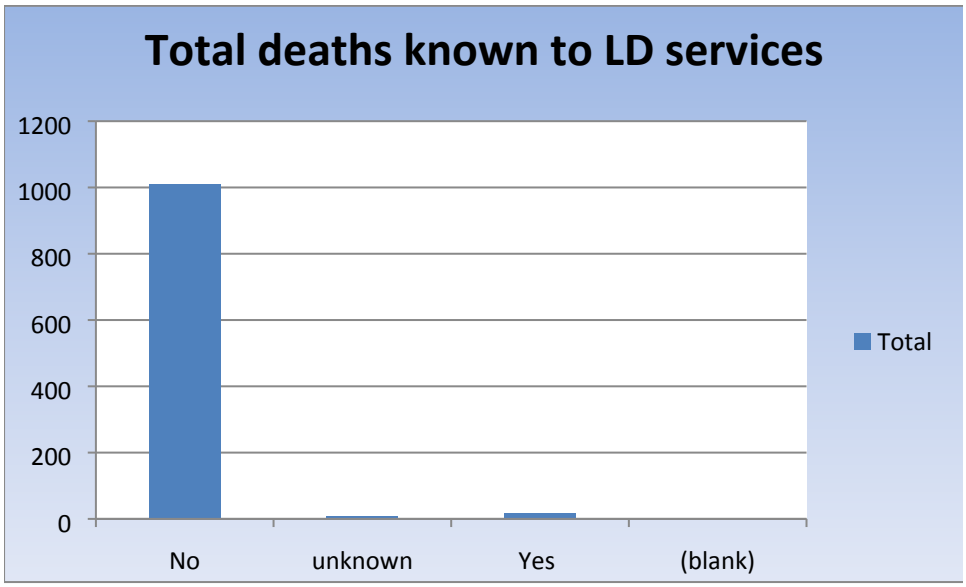
6.2 Death by age group

The youngest age was 12 and the oldest age was 104 years. Most deaths occur within the 80-90 age group.

Three child deaths are currently been investigated by the Child Death Overview Panel (CDOP).



6.3 Learning Disability Deaths

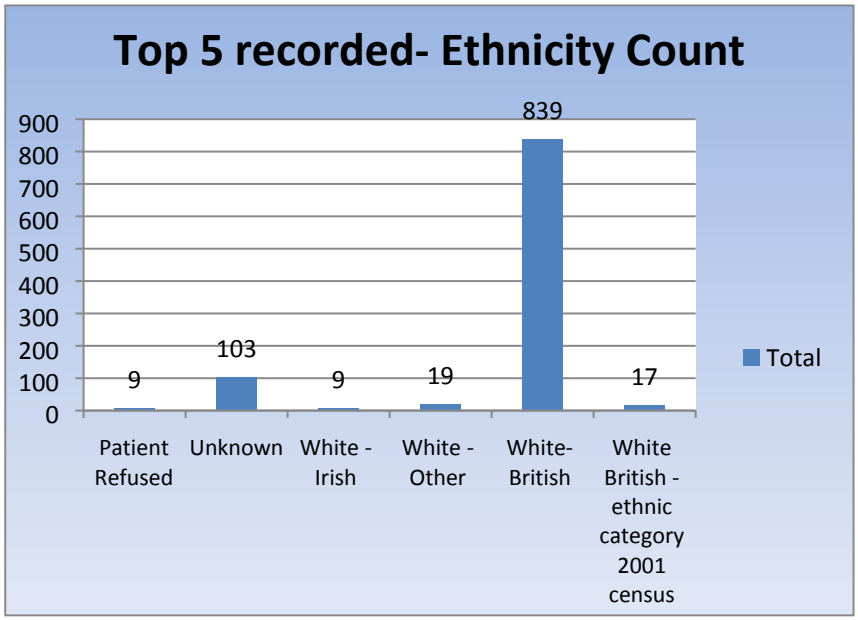


Known to LD	Count of deaths
No	1007
yes	16
Unknown	**6**
Total	**1030**

18 deaths have been sent to LeDER for review as per procedure. The Learning Disabilities Mortality Review (LeDeR) Programme is delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in June 2015 for an initial three-year period.

A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The Programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. The LeDeR Programme will also collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements

6.3 Death by Ethnicity



Ethnicity	Count of deaths
Patient Refused	9
Unknown	103
White - Irish	9
White - Other	19
White - British	839
White British - ethnic category 2001 census	17
Grand Total	**996**

White British is the highest recorded ethnic group, 9 patients refused to give their ethnic origin and ethnicity of 103 were unknown.

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. This is not an exhaustive list

1. Liaison with alcohol services should be made prior to decisions being made on whether to assess or not.
2. Scanning of patient records on to the Trust electronic patient record (PARIS) for patients under the care of the HUB
3. There appears to be an overreliance on assurance based on a patients presentation at a particular time as opposed to risk assessment based on an understanding of a patient's life story, family and social circumstance

4. Improvement of physical healthcare and associated risk assessments and care-plans, fluid and nutrition monitoring.
5. The Process for managing Front Door Presentations to Psychiatric Units needs to be reviewed and clarified.
6. Review the process for discharge when concerns have been raised by the patient or family.
7. Reinforcement of use of the safety box to medical staff
8. An offer of psychiatric advice around complex medication issues should form part of the discharge information sent to primary care for patient who have Severe Mental illness
9. Staff learning events using case studies highlighting the importance of updating risk assessments, robust care planning in relation to suicide/self-harm and the Think Family principles and involving universal services when children are present.
10. Any clinical discussion with 3rd party sector including Primary Care during an in-patient admission or post-discharge from services should be documented in the patient's electronic patient records system.
11. As per recommendation within the DHCFT Substance Misuse Operational Policy Guidelines, service users who have a history of and/or significant ongoing mental health issues should be discussed in Multi-Disciplinary Meeting allocated to be under the care of the Consultant Psychiatrist.
12. Clear and comprehensive documentation of all clinical contact with patient.
13. Clinical/caseload supervision to include risk data audit
14. Closer collaboration and joint working with the General Practitioner
15. Collateral information should be sought from families wherever possible to add to the clinical assessment and understanding of the presentation.
16. Review of Adult safeguarding training to ensure consideration of families with multiple and complex needs with chronic issues, including limited engagement with key family members and the impact of individual's behaviour on others within the family.
17. Community Psychiatric Nurses and the Consultant to be briefed about the need for taking in to account the prescribed medications as part of suicide prevention strategy and also to link with primary care to enable regular review of medications like Morphine and pain killers.
18. Development of a Safeguarding Protocol which would include details regarding how to access safeguarding advice and support which would complement information already available via the Safeguarding Connect web page.
19. Development of clinical standards for 2 day and 7 day follow ups with expectations of practice in the Trust Discharge and Transition policy
20. Review of NICE guidance on Acute Kidney Injury (2013) if not already undertaken to assess implications for service. Consideration of development of teaching packages / information (not polices) for the clinical ward staff to access on adequate fluid intake and signs of dehydration

8. Update on action plan

Action	Handler	Timescale
'Learning from Deaths' process to be written, agreed and implemented as a process within the Trust	• Lead for Patient Safety	30 September 2017
Await confirmation from NHS Digital on success of application	• Lead for Patient Safety	31 December 2017
Pilot two methods of reviewing case records within the mortality process – Prism and Structured Judgement Review – in progress	• Mortality Review Group	31 December 2017
Attendance of selected members of the Mortality Group to attend national training on a method to undertake reviews (Structured Judgement Review) and cascade this training to the review group – training dates November and December 2017 Update 2 staff have attended the training	• Investigation Facilitators • Interim Assistant Director of Clinical Professional Practice • Medical Director • Lead for Patient Safety	31 December 2017
Complete areas for improvement actions for family and carer involvement during investigations.	• Lead for Patient Safety • Family Liaison Facilitator	31 December 2017

Board Committee Summary Report to Trust Board
Audit & Risk Committee 14 December 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Welcome/ Apologies	Apologies received from Julia Tabreham	-	--	-	-
Draft Minutes Committee meeting 3 October 2017	Agreed as accurate record.	-	-	-	-
Action Matrix and Matters Arising:	**AUD 2017/076:** Members agreed not appropriate to complete clinical audit survey. **Matters arising:** CW raised the issue of a third theft in the Medical Annex. Report to be presented to next meeting on this issue.	Agreed that not appropriate Action to be removed (H Josephs)	- Operational actions have been taken to address risks. Risks relating to the incident are being explored through internal investigation	S Harrison (SH) to raise with John Sykes that NEDs did not feel completion of the survey was appropriate.	-
Policy update	Noted	SH gave assurance on the process in place to prompt authors in good time to review and update policies	-	-	-
Deep Dive BAF Risk 4a Financial Plan	Claire Wright (CW) updated on risks, controls and assurance relating to management of this risk.	Assurance controls were outlined and improvements noted. The Committee scrutiny at Finance & Performance and	Risk to maintaining agency spend below 50% ceiling Risk relating to ongoing lack of clarity in CQUIN	It was agreed to maintain the current risk rating of Extreme (5x5) pending clarification of current position relating to	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	Ongoing uncertainties relating to the CQUIN reserve were outlined.	triangulation with People & Culture Committee was highlighted. Improvement in liquidity was welcomed. Internal assurance was noted from meetings in place to hold to account. The Deloitte well-led review had also endorsed Trust work in accountability for performance management.	guidance as yet unresolved	external financial risks.	
Report on Conflicts of Interest and Declarations of Interest	SH outlined the progress to date in publication and rollout of the Conflict of Interest policy following issue of national guidance in June 2017. Proactive work has been undertaken to encourage compliance although uptake/response is low. KPMG confirmed that this is a common position across the NHS.	Although the development of a clear framework was noted, limited assurance was received on the practical application of the policy. **Action:** SH to liaise with KPMG on good practice to implement and administer declarations of interest Future report to be presented to Committee in July to incorporate update on end of year publication of registers **Action:** SH	Lack of staff awareness and potential breaches of the policy	SH to draft letter from ARC to identified decision making staff to request that returns are made promptly	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Review of Raising Concerns and Whistleblowing Arrangements	SH updated on progress with work and processes underpinning 'Freedom to Speak up' activity within the Trust.	The Committee welcomed the recent appointment of the Trust's Freedom to Speak up Guardian (FSUG) and noted the range of work planned for the role. This will include much proactive activity and wide promotion of the role to staff, including hard to reach groups. Significant assurance was received on the plans and processes in place although limited assurance was received relating to evidence of number of concerns raised to date. It was noted that the FSGU will report regularly to the People and Culture Committee and link with Engagement activities to ensure qualitative analysis and triangulation of concerns raised.	Staff not aware of raising concerns channels may lead to patient/public safety issues being missed	-	Freedom to Speak up report to People and Culture Committee (proposed quarterly report)
Annual reporting timetable 2017/18	Details of the timetable to coordinate production of the annual accounts,	Significant assurance was received of the plans in place to produce	Project management of elements will not achieve completion to	-	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	annual report and quality account were outlined.	the elements of the annual report and accounts to ensure Committee oversight and completion to deadline. May A&R Committee date to be finalised and circulated to those required to attend **Action** : ST	compliance requirements and deadline		
Revised Committee Terms of Reference	SH outlined the revised terms of reference that had been updated to reflect the decision agreed at the October meeting that the Committee should oversee Information Governance compliance.	Quarterly reporting on IG issues to the Committee was agreed. This will be added to the forward plan. **Action** : SH	-	Revised terms of reference agreed.	-
Summary report of Board Committee Chairs meeting	The summary of the Board Committee chairs meeting was noted. Discussions included membership of committees, well-led framework themes and focus on encouraging concise and focussed reporting to Committees.	Significant assurance was received that the group discussed key areas of good governance to ensure consistent and robust best practice across Board Committees.	-	It was confirmed that the Board Committee chairs group should continue to meet quarterly.	-
Intellectual Property Policy (IPP) and Procedures – for	SH presented the revised IPP policy and procedures. This had been updated to reflect	Significant assurance was received that this policy was fit for	That IP opportunities may be missed by the Trust	The policy was approved.	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
approval	good practice in line with the agreed policy review cycle.	purpose. It was agreed that reference to contacting the Legal Services Manager for staff who may see an IPP opportunity should be added to the policy before issue **Action** : SH The policy will be issued to all staff through the policy bulletin			
SFI Waiver Report	SH presented the waiver report detailing all waivers approved from 1 April 2017 to 30 September 2017.	Significant assurance was received relating to the waiver approval process. Analysis of waivers approved was welcomed to give further assurance and information to Committee members.	-	Current analysis and reporting six monthly to the Committee to continue	-
Internal Audit Progress Report	Progress with internal audits was outlined. Q2 benchmarking across the NHS was reviewed.	The Trust's strong position on cash balance as highlighted by the benchmarking was noted. Additional expenditure on counter fraud investigations was noted and a reconciliation across the KMPG contract was requested	- Non-compliance with the IG 95% training target will mean breach of NHS	Amendments to the internal audit plan based on reduced risk were agreed.	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
		Action: KMPG Significant assurance was received on the IG Toolkit internal audit.	contract requirement		
Audit Progress Report and Sector Update Year ending 31 March 2018	Mark Stocks presented the progress report. The timeframe for audit work and planned liaison with the Finance team were outlined. Criteria for the Value For Money work to be undertaken were explained.	Sector updates to be circulated to wider Board members for information. Significant assurance was received on the plans in place to carry out external audit work			
Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework	Discussion on agenda items was reviewed to assess any impact on BAF risks not directly referenced.	No additional issues impacting on the BAF were raised.	-	-	-
2017/18 Forward Plan and dates/frequency of meetings for 2019/18	It was noted that dates for 2018/19 are to be finalised as soon as possible to align with reporting requirements.	-	-		-
Meeting effectiveness	-	It was agreed that the meeting had been effective and all thanked Barry Mellor for his role as Committee chair over the past year.	-	-	-

Board Committee Summary Report to Trust Board
Quality Committee - meeting 14 December 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Welcome, apologies and declarations of interest	Agreed	Not applicable			
Minutes of previous meeting 9 November 2017	Reviewed Agreed	Not applicable			
Matters Arising	None noted	Not applicable			
Actions Matrix	Reviewed and updates on actions Up-date on Physical health care issues	Not applicable			
Policy Status Matrix	All policies are in-date. NICE guideline in review	Not applicable			
Attendance Log	Confirmation of improved attendance	Confirmed			
BAF risks for the Quality	Reviewed	Limited assurance	Lack of movement on key risks.	Review summary sheet	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Committee					
Quality Dashboard	Reviewed of complaints, has continued to improve.	Significant assurance on process Limited assurance on outcome, due to in completed action plan.	Lack of movement on key risks.	Mark Powell to bring back performance issues and trajectory.	
Carers feedback	Carer's feedback on a wait for neighbourhood team. Patient and family experience – on a waiting list- estimate.	Received feedback	Improvement work- quality improvement. What to expect and waiting list? And a letter. Operational report- design and outcome Return report on outcome and plan to return to February.	Quality improvement work- on this issue	
NICE guideline report	Review, risks of NICE guidelines, to improve the current governance of NICE and assessments of NICE.	Reviewed and agreed Limited assurance.	Reduced capacity and effectiveness to full review and issue. Priorities and improvement plan. Policy reviewed and ratified.	3 month review is all progressing well. Full report in 6 months.	
Patient and carer report	Request for feedback on structure Scrutiny and overview of	Received feedback Significant assurance –	Reflective on the services.	Feedback to the QAG on the service.	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	care issues. Challenge on feedback	on process Signicant assurance on outcome	Impact of services. Feedback- benchmark/ trend and themes.		
EDS2	An up-date of the review of EDS2. Feedback on equality impact analysis on children services. Overall- predominantly green rating.	Full assurance on the process. Significant assurance and action plan	Improvement work on access, information and BSL improvement work Scheduled and discussed at COATs You said and we did on the feedback, continuous Improvement on the actions Childrens review through to TMT.	Dashboard agreed Action and improvements agreed. Upload for March 2018. Review and audit of Accessible information standards. Request too S Harrison.	
Serious Incidents monthly report	Investigation capacity and impact on investigations have improved. Overdue actions and mitigations issues are in progress.	Limited assurance due to capacity and overdue actions to be mitigated	Pressure and overdue, SIRI reports and actions. Progress but not fully mitigated. Trajectory for improvement for February	Target and trajectory to be monitored. Escalation report if not hitting trajectory. Development of a dual diagnosis strategy April 2018.	
Learning from deaths	Review of NQB guidance. 129 deaths and 48 reviewed and closed. And the rest of	Significant assurance on process Significant assurance on	Review to 6 months of deaths, using the PRISM tool. Risks to structured	Capacity issues of 30 minutes Unavoidable and avoidable death	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	reviewed through the mortality group, the remaining group are in process.	outcome.	review, no current mental health version. Improvement work on NHS digital project will improve mortality Improve action on page 11 and additional information.	reporting.	
Improvement work to serious incident governance structure.	Change to SIG structure – advised. Discussed theory and model changes Model agreed, wider expanse.	Agreed and confirmed	Risks and operational actions Review by executive on any risks and concerns / improvements	Agreed. Review by executives on any concerns.	
Suicide and self-harm safety plan.	Review of the safety plan, longitudinal view and inter team review. Zero tolerance of suicide is not the recommended model of practice for our staff.	Verbal update Written up-date January and up-date	Clinical – false assurance. Individual planning on engagement with colleagues on what and how we implement the safety plan. Development of improvement on the work.	Staff engagement on the model and improvements that can be made. Road shows on staff engagement on safety planning.	
Quality assurance	Clinical risk escalation Public board and	Agreed and confirmed, on significant assurance	Substantial risks		CEO discussion and action

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
group.	escalation of timeline, with an action of a joint communication, CEO and chair.	on process Assurance- formal escalation by executives. No response to date from commissioners on outcome			Escalation to Board and purpose/ action.
Neighbourhood review – scope and delivery timeframes	Discussion re the neighbourhood delivery Future service model to 31st march and June sharing model. Management scrutiny and neighbourhood engagement and pre step.	Improvement picture and flexibility	Significant risks to delivery. If mitigating actions not delivered	Ensure strategic overview, assessment of equalities and quality impact assessment. Timescales and reviews	
EPRR	Full assurance Signed off and oversight	Agreed	Achieved.	Review 6 monthly review and one annual report	
Risk Assurance & Escalation Report	Quality assurance report on MAPPA and chronology and failure to progress, an outcome for commissioners	Agreed		MAPPA Depot medications and risk register	
Meeting effectiveness	Operational and assurance. The feedback, patient	Learning and reflection on the impact of the waiting time.	Considering our improvement of challenge re achieving		

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	impact story. Versus the impact and the issues Well chaired. Presenting papers (in and out) More challenging on actions and pace. Issues on action and process.		outcomes. Focusing on outcome. Timeliness and outcome and trajectory.		

Board Committee Summary Report to Trust Board
Quality Committee - meeting held 11 January 2018

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Minutes and Actions matrix	Declarations Agreed and ratified One minor amendment made to Minutes	Good assurance on model See Minutes for full actions	Risks with some overdue actions that need further information updated Up-date on risks and issues surrounding carers and service receivers meetings		
Matters arising Actions Matrix	Matters arising- Audit feedback on observation Hate crime and racism – staff response				
Attendance Log	Agreed				
Policy matrix	Agreed and assurance plan for forward planning				
Summary of BAF risks for the Quality Committee	Update on escalation of risks associated with non-commissioned community forensic service. Up-date briefing on risks and the IPP	Progress on an integrated model Limited assurance	Significant unmitigated risks continues. Risk mitigation plan, re risk stratification		

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	population. Trust bid for NHS England- submission due.				
Quality Dashboard: **- Internal analysis on interventions by ethnicity** **- Community waiting times (progress made over last 12 months)**	Improved performance CQC action plan Quality of response of complaints- addressed the complaint, not defensive. Responsiveness is improving	Significant assurance on model and monitoring Limited assurance specifically the CQC actions.	CQC actions some residual issues CEO review	Change to the health service ombudsman	
Carer and Service Representative Feedback (verbal)	No feedback in attendance – verbal feedback		Challenge from leads of the impact of contract changes on our carers		
Risk assurance and escalation quarterly report	Review of risk and model and future analysis.	Review and significant assurance of risks Reflection on all risks are reflected across into the BAF	Enhanced escalation report to the risks and to the BAF Continued risks on decommission issues.	Revision Revisit BAF risk 1a if decommissioning does occur Deep dive on eating disorders Action to match Risk assurance to Well-led.	
Physical Healthcare Strategy	Strategy very well received Addition of pathway too	Strategy ratified and measures	Challenge on leadership and how we implement this, form a	High level statement and position statement from John- foresight and future position	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	per area – with trajectory and measures Positive feedback to the strategy author on this model. Full brief out on physical strategy, approved with communications plan on briefing to all staff on Billy.		Trust wide leadership How do we gain traction and roll out - chair of QC feedback, on why it's valuable.	statement on strategy	
Positive & Safe six monthly report	Detailed and analysis and plans on the Quality priority Evidence of improvement in practice. Significant analysis	Significant assurance, approved.	Deep dive – 12 month data sweep Service analysis, EDS and reverse commissioning and grading. Discussions mitigations - post meeting note	Accepted follow-up in 6 months.	
Review of quality visits programme - BME inclusivity	The quality visit programme was reviewed and agreed and focus on continuous quality improvement and supplement with Performance compliance visit	Agreed and approved. Significant assurance on Season 8 Significant assurance on review and analysis	Risks and agreed and plans Exploring diffusion as a quality priority- what have you applied and learnt from another team. DEED award and social media developments	Directly link the Continuous quality priorities and themed to link too quality priorities.	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
			Practical elements to communications and brief out.		
Review of Quality Strategy and priorities	The process and development of the improvement. Positive and areas to improve.	Assurance on the process of development.	Development and engaging staff in development and decisions	Quality improvement strategy timescale, confirm by next month - when Quality priorities on the forward plan for March	
Development of Neighbourhood Review (verbal)	Scope and component parts of the review. Survey and plan for neighbourhood review.	Limited assurance on model	Development and engaging staff in development and decisions Current risks and pressures on staffing due to capacity and demand.	Neighbourhood written paper in March 2018	
Improving Care and CPA process and planning Policy	Presentation of model of a new draft designed model of care. In response to historical incidents and 2017 incidents and quality standards Remove informal carers and improve the language	Emerging clinical model	Clinical model in development Time limited and intervention. Potential risks	Trajectory for completion May 2018.	
Research Governance Framework Policy and	Policy ratified				

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Procedure					
Any other business	None				
Items for escalation to Board or other Committees	No additional items				
Consideration of any items affecting the BAF	Changes to decommission of provision add explicitly to BAF 1a. Complete physical strategy mitigated gap in assurance Emerging mitigation of community forensic team				
Forward Plan and draft agenda for February meeting	Additional item on neighbourhoods				
Meeting effectiveness (members only)	More effective outcome due to smaller group Improved quality of papers				

Board Committee Summary Report to Trust Board
Audit & Risk Committee 16 January 2018

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Welcome/Apologies	Noted. Agreed that Rachel Kempster (RK) and Rachel Leyland (RL) would attend to present their respective items	-	-	-	-
Draft Minutes Audit & Risk Committee meeting held 14 December 2017	Agreed as accurate record.	-	-	-	-
Action Matrix and Matters Arising	Status of actions were reviewed and completed actions agreed.	It was requested that in future additional detail is provided for completed actions – **Action:** Sam Harrison (SH) **(AUD2017/113)** Claire Wright (CW) updated that the Medical Annex theft was under investigation and progress would be overseen by ELT	-	Action status agreed as outlined on matrix	-
Policy Matrix	The timeframe for review of policies was outlined.	It was proposed that the policies for review should be spread across April and May meetings **Action**: SH	-	-	-
Review Board Assurance Framework	SH and RK outlined the issue 4 changes on the	Significant assurance was received relating to	As identified on BAF	Agreed to be submitted to January Trust Board	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
- Issue 4	BAF including reduction in 1d and 3e. Finance risk 4a had also been agreed to be reduced to moderate (2x5 - target risk rating) by the Finance and Performance Committee as the CQUIN issue had been resolved in the Trust's favour and achieving a higher surplus than the control total. An additional risk relating to EPR had been proposed by ELT on 15.1.18 and would be added to next BAF issue. Updates to the BAF were noted in blue type.	the process for review and management of the BAF and engagement by Board Committees. The Deep Dive programme is progressing as planned. Non Commissioning of services to be considered for 2018/19 BAF risk at Board Development session **Action**: SH Positive feedback on the BAF and its management was noted in the Deloitte Phase 3 Well Led report which gave the Committee external assurance.	itself	subject to referencing additional risk (EPR) and risk movement on 4a as outlined.	
Deep Dive BAF Risk 3a Attract and Retain Clinical Staff	Amanda Rawlings (AR) was welcomed to meeting. This risk relates to the ability to attract and retain staff and is a key focus of People and Culture Committee. The role of the Audit and Risk Committee in oversight of BAF extreme risks and the deep dive process was	Activity on recruitment was noted. Progress on medical appointments was outlined – including international recruitment pipeline. 84% of the five year workforce plan has been delivered. Key controls and gaps in controls were outlined. Assurance on key actions were outlined.	Recruitment and retention to ensure capability and capacity of workforce to deliver services Lag to impact of some of the initiatives	Actions taken were noted. It was agreed to review risk as part of 2018/19 BAF development.	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	reiterated.	There is early progress on staff engagement and feedback with initial results from 2017 staff survey and staff forum in place. It was reaffirmed that there is significant and regular Board discussion on this issue. Limited assurance on output achieved - significant assurance on range of appropriate actions underway.			
Implementation of Internal and External Audit Recommendations Progress Report	RK outlined the report highlighting completed actions and updates. SH updated on behalf of John Sykes relating to the outstanding job planning action.	Assurance received on actions completed and updates given. Assurance was given that consultant job plans were complete but not centrally maintained. A business case to use software to coordinate and oversee job planning is proposed and will be presented to ELT. An update will be brought to March A&R Committee **Action:** SH to liaise with IM and JS to progress Report to be updated to include IG toolkit recommendation Action:	Ongoing delay in implementation of centralised oversight of job planning will not achieve potential organisational benefits	-	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
		RK			
Information Governance Report and General Data Protections (GDPR) Update	SH presented the quarter 3 report on IG including progress towards meeting the IG toolkit. This included an update on training figures, role of the IG Committee and policy review progress. SH also updated on progress towards readiness for implementation of the GDPR regulations which come into force in May 2018.	Significant assurance was received on the report and progress made towards IG toolkit compliance. Significant assurance was also noted by the Committee from the recent internal audit by KPMG on the IG Toolkit who had also observed good preparation for GDPR implementation. IG breaches reported were queried and SH is to seek further detail relating to the increase in those involving emailing personal information. **Action**: SH Additional information on % trends is requested for the Q4 report. **Action**: SH Significant assurance was received on preparation for GDPR compliance. Risks relating to the reduced timeframes for subject access compliance was noted and is covered in	Risk of non-compliance with IG Toolkit (as NHS contract requirement) and non-compliance with GDPR (EU legislation) from May 2018.	-	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
		operational risk registers.			
Deloitte Well-Led Phase 3 – verbal update	SH updated that the report by Deloitte on the Phase 3 well led framework review had been received by the Trust	Significant assurance had been received from the amber-green rating given for all reviewed well led areas. The Executive Summary and recommendations are to be presented to the Trust Board on 31 January where oversight role for progressing recommendations will be confirmed.	-	-	-
Accounting Policies for 2017/18 Annual Accounts	RL outlined the updated policies relating to the 2017/18 annual accounts. The list of changes were outlined.	Significant assurance was received that these policies were in line with the Governance Accounting Manual and that they will be audited as part of the accounts audit process.	-	Reviewed and agreed.	-
Internal Audit Progress Report	Update was given on progress with the internal audit programme. The fraud action review is awaiting finalisation. The Data Quality report, Payroll and Purchase ledger reports are in process of agreement and finalisation.	SH confirmed that ELT had approved the Mental Capacity Act internal audit scope. Julia Tabreham welcomed that it focussed on CQC assurance and action plans. It was agreed that the KPMG contingency balance would be used	-	-	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	KPMG confirmed that they would conduct the HFMA Audit Committee effectiveness survey during February 2018.	to rebalance resource across the internal audit and counter fraud plan, leaving a balance of 3 days. KPMG gave assurance that reducing audit days would not affect the Head of Internal audit end of year opinion. KPMG suggested that counter fraud referrals were as result of increased awareness and confirmed that controls were in place for informed decision by management to proceed with investigations.			
External Audit Plan	Joan Barnett presented the update on the external audit plan for the year ending 31 March 2018. Value for money work is to include longer term financial sustainability and STP. Also CIP based on a non-recurrent basis. The revised ISAs were noted to have impact on the content of the audit	The Committee welcomed that the current adverse opinion on governance is not included in the planned review as a significant risk. Grant Thornton are assured that the Trust continues to focus on governance. The timeline for work with the Trust was noted. Fees covering the Value for Money work and Quality Account were	Significant risks as highlighted in the external audit plan were noted to be generic to all organisations and not specific concerns about this Trust.	-	-

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	opinion.	agreed. The review of payroll expenditure will build upon work undertaken by internal audit.			
Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework	Discussions from the meeting were considered in the context of all BAF risks	Risks relating to information governance/GDPR implementation and considered at the BAF development session to be held in February **Action:** SH	-	-	-
2017/18 Forward Plan & dates/ frequency of 2018/19 meetings	Meeting dates were noted.	All dates for 2018/19 have been confirmed.			
Meeting effectiveness	-	Members considered the papers, debate and length of meeting to be effective in conducting the Committee's business. Appropriate holding Executive Directors to account.	-	-	--
CONFIDENTIAL SESSION was held following the meeting					

Board Committee Summary Report to Trust Board
People & Culture Committee – 19 January 2018

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Minutes of People & Culture Committee held 16 November 2017	Minutes approved	N/A	N/A	N/A	N/A
Actions Matrix and Matters Arising	Mindful Health and Wellbeing Strategy Year-end effectiveness to be presented at the March meeting	Will be presented at the March meeting	N/A	N/A	N/A
Policy Matrix	Progress noted	All policies are up to date and a planner is in place	N/A	N/A	N/A
Staff Story	Staff story of a member of staff who left the trust but decided to return	Story was noted	N/A	N/A	N/A
BAF Risks	BAF risks 3a, 3b, 3d and 3b were discussed. 3a was a deep dive at the Audit Committee	The work programme was noted with partial assurance on the current outcome	Workforce supply remains as one the highest risk the trust as at present	N/A	N/A
Deep Dive BAF Risk 3d Inclusivity **Draft Workforce Race Equality Standard (WRES) action plan**	Progress was noted	Actions were noted	Positive assurance on the progress was agreed	N/A	N/A
GIAP Embeddedness	HR3, HR4, PC4 – structure for the HR team	Progress was noted and that the structure was agreed ready for implementation		Audit reports required for assurance on process adherence across the trust	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	WOD2 & WOD7 WOD8 CQC2	Progress was noted, with agreement internal audit of the process adherence is required Committee took assurance that the building blocks have been put into place but it will take time to see the outcome in improved staff engagement Progress was noted but full assurance could not be provided to the ongoing recruitment challenges			
Freedom to Speak Up Guardian Survey 2017	The committee received a report on the progress that has been made in DHCT regarding raising concerns following the 'Freedom to Speak up' 2015	The committee took assurance from the report and noted the newly appointed Freedom to Speak up Guardian	N/A	N/A	N/A
Strategic Workforce Report	The committee received an oversight of the NHS draft Workforce Strategy – Facing the Facts, Shaping the Future, the Nursing Associate role, the development of the HR/Workforce function and the in-house bank provision	The overview was received and noted	N/A	N/A	N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
People Plan Close Off Report	The committee was provided with a detailed close off report for the 2017 People Plan noting the progress that had been made the actions that were continuing into 2018	Progress was noted	Workforce supply and staff engagement were noted as ongoing challenges as reflected in the BAF		
Workforce Plan	The committee was briefed on the developing year 2 implementation plan for the workforce plan	The committee noted that the workforce plan is being developed in tandem with the business plan	N/A	N/A	N/A
Workforce Performance Report	Monthly performance report was presented	There was a discussion about the net increase of 100 staff in 12 months, further analysis to be undertaken	N/A	N/A	N/A
CQUIN Update	Flu campaign update was provided	Full CQUIN update to come to next PCC	N/A	N/A	N/A
Staff Survey – what do we know so far?	Initial oversight of the staff survey results were considered	Committee took assurance that the staff survey results are showing that staff engagement is moving in the right direction	N/A	N/A	Board to receive the full report in February 2018
Workforce Supply Update	Status report on recruitment was presented	Committee noted the activity but was not able to take assurance due to the ongoing recruitment challenges	In line with BAF risk 3A	N/A	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Training Compliance	An overview of the current mandatory training requirements and the review that has been undertaken	Committee noted the process that the trust has undertaken to stream line mandatory training	Ongoing challenge to meet % requirements	N/A	N/A
Forward Plan - Year-End Effectiveness reporting for discussion	To come to the March 2018 meeting	N/A	N/A	N/A	N/A
Items escalated to the Board or other Committees	N/A	N/A	N/A	N/A	N/A
Identified risks arising from the meeting for inclusion or updating in the BAF	N/A	N/A	N/A	N/A	N/A
Meeting effectiveness	Noted that the meeting structure and membership will change from April 2018				

Derbyshire Healthcare
NHS Foundation Trust

Kedleston Unit- Jan 2018 Where are we now?

Rebecca Mace, Service Manager

Kedleston Unit Philosophy

“At the Kedleston Unit, we will work together to keep you and those around you safe.

We will work with you and those people important to you to promote health, well-being and recovery as well as inspire hope for the future”

Making a positive difference

Kedleston Unit Away Day

- **3 March 2017 – attended by 27 staff members and NHSE Case Manager**
- Training elements – MCA, person centred approaches
- Staff engagement in bespoke training package
- Staff involvement in development of Unit Philosophy
- Staff engaging in discussions around moving the Unit forward
- Understanding role of NHS England and how the Service is commissioned
- **Invigorated staff and improvement in morale!!**

Progress in 2017

- Implementation of the Recovery College
- Men's Health Wellbeing Group - first pilot successful
- Improved environment for patients
- Sustained improvements with regards to CQC/NHSE
- Positive Quality Visits - Trust and Forensic College Quality Network
- New Operational Policy (currently in draft at present)
- Improvements in performance and staff supervision – ensuring processes are in place
- HCR20 Risk Assessments - all in date; systems in place to ensure continued compliance

Making a positive difference

Ongoing work/ future focus

- Skill mix – attempting to explore recruitment of social worker. Clinical Lead advertised at present
- Developing distinct ward philosophies and clinical outcomes to improve patient delivery and care
- Building on team development – 3 staff have returned after leaving
- Diversifying Recovery College Prospectus – angling for health session in January. Restrictive practice course being developed
- New psychologist commencing spring 2018 – will be able to provide structure and support for Registered Nurses to be more psychologically informed

Aims for 2018

- Continue stability with Team – recruitment and retention of staff, valuing staff by ensuring adequate training and support
- Consistency regarding care planning and treatment
- Embedding new Operational Policy and Procedures (currently in draft form)
- Develop the Senior Leadership Team to ensure team cohesion
- Improving our work / engagement with carers - developing a alternate monthly Carers' Forum

Achievements

- Kedleston – a teaching hub for all disciplines
- Work being showcased at Forensic Conference 2018
- DHCFT Quality Award for Innovation and Improvement
- Regraded to ‘‘Requires Improvement’’ from ‘‘Inadequate’’ from CQC
- Gained confidence from NHSE Commissioners

Any questions?

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – Wednesday 31January 2018

Board Assurance Framework (BAF) 2017/18 - Fourth issue

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the fourth issue of the BAF for 2017/18

Executive Summary

There remain eleven risks identified on the BAF for 2017/18. The risk rating for three of the risks have been reduced since the BAF was last considered by the Board:

- 1d. *Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident.* Reduced from a likelihood of 4 (likely) to 3 (possible) due to full compliance achieved with the EPRR Standards. The risk rating overall remains moderate
- 3e. *Potential turnover of board members*. Reduced from a likelihood of 3 (possible) to 2 (unlikely) and a consequence of 4 (major) to 2 (minor) due to a number of substantive Board appointments. This reduces the risk rating overall from moderate to low.
- 4a. *Failure to deliver financial plans.* Reduced from a likelihood of 4 (likely) to 2 (unlikely) due to confirmation received from commissioners that they will pay the 0.5% CQUIN risk reserve in full. This reduces the risk rating overall from extreme to moderate.

Risks 1d, 3e and 4a are now identified as 'tolerated risks' on the BAF, together with risk 3d *There is a risk that the Trust does not operate inclusively and may be unable to deliver equity of outcomes for staff and service receivers* which was identified as tolerated in the previous issue.

These changes result in three risks remaining identified as extreme, four as high, three as moderate and one as low risk

Following the recommendation from the Board in Nov 2017, risk 2a *Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system* has been expanded to address sovereignty/STP issues.

Discussion by the Executive Leadership Team in January 2018 has identified a new risk for inclusion on the BAF in relation to the risk associated with the operational implementation of the electronic patient record. This will be developed by the Chief Operating Officer and included in the final issue of the BAF for 2017/18

Discussion at the Audit and Risk Committee in Jan 2018 highlighted a risk for inclusion in the 2018/19 BAF in relation to the non-commissioning of services. This will be further discussed at the Board Development session on 14th Feb 2018. The risk arising in relation to information governance compliance (in particular compliance with the new GDPR) were also discussed and will be further considered as part of the cycle of review for the final issue of the BAF for 2017/18

Risk ratings at each quarter continue to be shown, together with risks which have been removed from the BAF in year. This is updated each quarter to show the movement of risk ratings during the year.

An updated programme for undertaking 'Deep Dives' for all risks on the BAF is detailed. This programme is on track to have been completed by the end of March 2018 to plan.

The BAF risks for the responsible committee are now being presented at the start of each Board Committee agenda in order to drive the committee agenda. Reflection of changes to the BAF, following discussion of agenda items, remains as a standing item.

Following approval of revised Trust vision and values at Board in Nov 2017, the Trust Strategy will be refreshed with this new approach and will be incorporated into future iterations of the BAF going forward into 2018/19

KPMG are undertaking an audit of the BAF and risk register during Jan 2018, building on the 2017 audit findings and actions. A Board Development session is planned for 14 February 2018 to begin to develop the BAF risks for 2018/19.

Minor changes have been made to the format of the BAF, reducing the overall number of pages from 37 (Issue 3) to 31. In addition hyperlinks have been added to aid navigation

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 significant assurance 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

Consultation

Individual Executive Directors – during November/December 2017
Executive Leadership Team - 11 December 2017
Audit and Risk Committee - 16 January 2018

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

There are no adverse effects on people with protected characteristics (REGARDS).	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 – not applicable

Recommendations

The Board of Directors is requested to agree and approve this fourth issue of the BAF for 2017/18 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.

Report presented by: **Claire Wright**
Director of Finance

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

Rachel Kempster
Risk and Assurance Manager

Board Assurance Framework 2017/18 - Fourth issue

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 fourth formal presentation of the Board Assurance Framework to the Board of Directors for 2017/18. Changes to the BAF since Issue 3 to the Board, are highlighted in blue text in the detailed word document attached

1) Overview and movement of risks

A summary of all risks currently identified in the 2017/18 BAF is shown below, together with any movement of these risks to date

BAF ID	Risk title	Director Lead	Risk rating Q1	Risk rating Q2	Risk rating Q3 (current)	Movement Q3
1a	Failure to achieve clinical quality safety standards required by our regulators	Executive Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	⟷
1b	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients	Executive Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	⟷
1c	Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)	HIGH (3x4)	HIGH (3x4)	⟷
1d	Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident	Chief Operating Officer	MOD (3x3)	MOD (4x3)	MOD (3x3)	↓
2a*	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME (4x5)	EXTREME (4x5)	EXTREME (4x5)	⟷
3a	Ability to attract and retain high quality clinical staff across all professions	Interim Director of People and Organisational Effectiveness	EXTREME (4x5)	EXTREME (4x5)	EXTREME (4x5)	⟷

BAF ID	Risk title	Director Lead	Risk rating Q1	Risk rating Q2	Risk rating Q3 (current)	Movement Q3
3b	There is a risk to staff engagement and wellbeing by the Trust not having supportive and engaging leaders	Interim Director of People and Organisational Effectiveness	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	↔
3d	There is a risk that the Trust does not operate inclusively and may be unable to deliver equity of outcomes for staff and service users	Interim Director of People and Organisational Effectiveness	MOD (4x2)	MOD (4x2)	MOD (4x2)	↔
3e	Board turnover	Director of Corporate Affairs and Trust Secretary	NEW	MOD (3x4)	LOW (2x2)	↓
4a	Failure to deliver financial plans	Executive Director of Finance	EXTREME (4x5)	EXTREME (4x5)	MOD (2x5)	↓
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	EXTREME (4x5)	EXTREME (4x5)	EXTREME (4x5)	↔

Risks removed from the BAF during 2017/18, are summarised below:

BAF ID	Risk title	Date removed from BAF	Rationale
2b	Insufficient engagement with staff side and governors in relation to proposed merger with DCHS	July 2017	Due to decision of 6 June 2017 to withdraw from the merger with DCHS.
4c	That the process leading to acquisition of DHCFT by DCHS may have a detrimental impact on the Trust's ability to manage day to day performance due to increased capacity demands on senior leaders and directors	July 2017	Due to decision of 6 June 2017 to withdraw from the merger with DCHS.
3c	There is a risk that the Trust will continue to be subject to NHSI enforcement action and CQC requirement/warning notices	July 2017	Target risk rating achieved and within limits of the agreed risk appetite, so risk removed.

2) Deep Dives

Deep Dives remain fully embedded in the BAF process and enable review and challenge of the controls and assurances associated with each risk.

The Audit and Risk Committee undertakes those for risks with a current rating of extreme and risks for which it is the 'responsible committee'. Other Deep Dives are undertaken by the responsible committee for the risk. The plan for Deep Dives for 2017/18 is shown below, in line with the Q3 17/18 position for the current risks on the BAF.

Risk ID	Subject of risk	Director Lead	Committee
1a	Clinical quality safety standards	Carolyn Green	*Audit and Risk Committee: Jul 2017. Completed
1b	Clinical quality effectiveness standards	Carolyn Green	Quality Committee: Nov 2017. Completed
1c	Compliance with MHA/MCA	Dr John Sykes	Mental Health Act Committee: Oct 2017. Completed
1d	Business continuity	Mark Powell	Quality Committee: Oct 2017. Completed
2a	System change	Lynn Wilmott-Shepherd	Audit and Risk Committee: Oct 2017. Completed
3a	Attract and retain clinical staff	Amanda Rawlings	Audit and Risk Committee: Jan 2018. Completed
3b	Staff engagement and wellbeing	Amanda Rawlings	People and Culture Committee: Nov 2017 Completed
3d	Inclusivity	Amanda Rawlings	People and Culture Committee: Jan 2018.Completed
3e	Board turnover	Samantha Harrison	Remuneration and Appointments Committee Dec 2017. Completed
4a	Financial plan	Claire Wright	Audit and Risk Committee: Dec 2017. Completed
4b	Internal transformation	Lynn Wilmott-Shepherd	Audit and Risk Committee Mar 2018

*Note the Deep Dive for this risk was planned prior to the proposal that only risks currently graded as extreme be required to present their Deep Dive to the Audit and Risk Committee

Summary of Board Assurance Framework Risks 2017/18 - Issue 4. 3

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)
Strategic Outcome 1. We will deliver quality in everything we do providing safe, effective and person centred care			
1a	Failure to achieve clinical quality safety standards required by our regulators	Executive Director of Nursing and Patient Experience	HIGH (4x4)
1b	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients	Executive Director of Nursing and Patient Experience	HIGH (4x4)
1c	Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)
1d	Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident	Chief Operating Officer	MODERATE (3x3)
Strategic Outcome 2: We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time			
2a	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME (4x5)
Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff			
3a	Ability to attract and retain high quality clinical staff across all professions	Interim Director of People and Organisational Effectiveness	EXTREME (4x5)
3b	There is a risk to staff engagement and wellbeing by the trust not having supportive and engaging leaders	Interim Director of People and Organisational Effectiveness	HIGH (4x4)
3d	There is a risk that the Trust does not operate inclusively and may be unable to deliver equity of outcomes for staff and service receivers	Interim Director of People and Organisational Effectiveness	MODERATE (4x2)
3e	Potential turnover of board members	Director of Corporate Affairs and Trust Secretary	LOW (2x2)
Strategic Outcome 4. We will transform services to achieve long-term financial sustainability			
4a	Failure to deliver financial plans	Executive Director of Finance	MODERATE (2x5)
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	EXTREME (4x5)

Strategic Outcome 1. We will deliver quality in everything we do providing safe, effective and person centred care

Principal risk:

Risk: **Failure to achieve clinical quality safety standards required by our regulators**

Impact: May lead to harm to service receivers, their family members, staff, or the public

Root causes:

a) Financial settlement in contracts chronically underfunded
b) Workforce supply
c) Substantial increase in clinical demand
d) Increasing service receivers and family expectations of service
e) Changing demographics of population
f) Stability of clinical leadership at all levels
g) Interconnectivity with Risk 1c (MCA/MHA) and Risk 3a (retention of staff)
h) Compliance with CQC standards

BAF ref: **1a**	**Director Lead**: Carolyn Green, Executive Director of Nursing and Patient Experience	**Responsible Committee**: Quality Committee	Datix ID: 21103

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

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, health and safety audits and fire 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
Directive – Quality Framework (Strategy) outlining how quality is managed within the Trust
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 - Clinical analysis and triangulation from across governance reports leading to actions to rectify clinical practice concerns through Patient Experience Reports to be followed by QUEST model reporting	- National enquiry into suicide and homicide identifies rates lower than national average, although increase in homicide incidents evident for 2017. - NHLSA Scorecard demonstrating low levels of claims - Safety Thermometer identifies positive position against national benchmark - Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards - CQC comprehensive review identified 4 services rated as 'good' for safety - KPMG 2016/17 BAF and Risk Register Review - Schedule 4/6 analysis and scrutiny by commissioners - Results of Section 11 Safeguarding Children Inspection, July 2017

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Ability to recruit and retain adequate numbers of staff to ensure safe practice	Implement workforce plan [ACTION OWNER DPOE]	31/01/2018	Successful recruitment campaign, nurse vacancy rate now 6%. Further expansion of recruitment strategies underway for OT, social workers and RGN's in core areas.	Medium 
	Develop and implement training plan to increase number of staff trained to deliver psychological therapy in the community. [ACTION OWNER DPOE/DON]	31/03/2018	Training plans awaiting external or trust wide funding	
	Test model of non-medical Responsible Clinicians (RC) role in community setting to mitigate vacancies in psychiatry. [ACTION OWNER DON]	31/03/2018	Job description agreed, awaiting evaluation. Limited take up from services as pilot, meeting with COO and team to explore feasibility	
Commissioner commitment to invest in mental health and children's services. Role of primary care models underdeveloped in Derbyshire.	Commissioner lobbying and provision of evidence to support need to increase funding or to provide an alternative strategic plan [ACTION OWNER DON]	31/03/2018	Pilot developments recommended to commissioners in line with PLACE to explore options to create flow from mental health and support to primary care. Meetings with HEEM to explore monetary support undertaken in Nov/Dec 2017	High
Lack of effective forensic clinical service pathway following prison release. In addition new policy to release IPP prisoners (indeterminate imprisonment for public protection) increases risks.	Interagency solutions being sought, including proposal for commissioner solutions including benchmarking and mitigation plans [ACTION OWNER MD]	31/03/2018	Principal funding agreed for community forensic service. To be operational from March 2018. STP development plan signed off by Provider Assurance Group. MAPPA co-ordinator in process of establishing who Derby and Derbyshire IPP people are and reviewing each in terms of priorities.	Medium 
Non commissioned services for Derbyshire based PICU beds and a secure and effective forensic pathway, and	Improvement plan with commissioners in place [ACTION OWNER DON]	31/03/2018	PICU provision remains an improved situation with no known concerns or incidents re access. CAMHS Tier 3.5, partial commissioning in design and development	Medium

CAMHS Tier 4 beds				
Stable clinical workforce in neighbourhood, children's services, crisis services, psychology and forensic services and model	Clinical and operational leadership to develop an improvement plan [ACTION OWNER DPOE/DON]	31/01/2018	Neighbourhood improvement plan completed. To be reviewed by Quality Committee Jan 2018	High
Staff competence and knowledge in suicide prevention	Suicide reduction strategy in place and roll out of patient safety planning to be completed [ACTION OWNER DON]	31/03/2018	Safety planning completion monitored through Quality Dashboard. Survey underway to staff and patients re attitude to suicide. National benchmarking has identified low incidence of ligature against population	Low
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 DON]	31/01/2018	Implementation stalled whilst full mapping across all teams completed	Medium ⬆
Compliance with medicines management code, including storage compliance	Improvement plan in place to deliver [ACTION OWNER DON]	31/01/2018	Compliance with fridge temperatures for storage of medicines remains, being monitored and escalated through Drugs and Therapeutics Committee.	Medium
Fully integrated Quality Leadership Teams and escalation to Quality Committee	Assistant Director for Quality Governance to provide coaching and support to QLT's/COATs. Undertake team performance reviews	31/01/2018	Six month review identifies significant improvement across all QLT's/COATs although not all fully embedded. Trajectory to full integration by Jan 2018	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
CQC comprehensive review identified 6 services as 'requires improvement' for safety	Fully implement CQC actions plan, with subsequent plan to raise all services identified as requires improvement to a rating of good [ACTION OWNER DON]	31/03/2018	Significant improvement reported. Warning notice lifted. Remaining actions monitored monthly and reported to the Quality Committee. 21 actions to complete. Trajectory to completion by end Jan 2018.	Medium
Effective plan to ensure ability to achieve quality priorities, CQUIN and Non CQUIN targets	Implement CQUIN action plan. Identify ring fenced resources to ensure implementation of required targets.[ACTION OWNER DOF/ DON]	31/01/2018	Contract negotiations underway to prioritise neighbourhoods and paediatric structural deficits	High
Participate in national 'Sign Up to Safety' campaign to meet contractual requirements	Implement CQUIN improvement plan including 'Sign up to Safety'. Each integrated quality leadership team to complete one quality improvement project of their design [ACTION OWNER DON]	31/03/2018	First draft improvement plan for 'Sign Up to Safety' submitted to commissioners July 2017. Update provided to Quality Committee Nov 2017. On target	Low
Increase in number of mental health related homicides (3 incidents over 3 month period during 2017), and inpatient deaths (2 over recent 3 month period)	Learning reviews by DHCFT. Elevating commissioning risk for forensic pathway with commissioners [ACTION OWNER DON]	31/01/2018	External investigators assigned for all homicide investigations. Peer review commissioned with Medical Director for Lincolnshire trust and external consultant nurse, commenced. Local benchmarking undertaken by NHSE. Elevated risk but Trust not outlier in region. Awaiting national homicide benchmarking results	High
Gap in governance and system processes to meet revised essential CQC standards	Develop automated process to meet requirements of revised CQC PIR	31/01/2018	PIR in process. Portal 3 launched and being updated monthly. CQC 'you said: we did' presentation completed. CQC preparation groups	Medium

to meet 110 changes of PIR			commenced.	
Physical health care compliance against CQC essential standards and national CQUIN	Development and delivery of a physical health care strategy [ACTION OWNER MD]	31/03/2018	Physical health care strategy due to be developed by end of Jan 2017	Medium
Safeguarding processes are effective to prevent sexual assault of our patients	Explore breath of potential issue and learning from adult sexual assault referrals to safeguarding [ACTION OWNER DON]	28/02/2018	Report to Safeguarding Committee Oct 2017 to include benchmarking and further action to identify is there are potential patterns or clusters. Audit work underway to explore patterns of abuse Trauma and support conference planned for Oct 2017 to support staff competency re victim support strategies.	Medium

Related operational high/extreme risks:

Divisional Risk Assessment (Clinical)	21002		Commissioning Risk	Withdrawal of police support for inter-facility transport of patients
Trust wide Risk Assessment (Clinical)	21106	Children's Therapies & Complex Needs	Commissioning Risk	Sexual Abuse Referrals
Trust wide Risk Assessment (Clinical)	21068	Pharmacy	Clinical - Medication/ Pharmaceutical	Medicines Management - providing effective care for patients
Trust wide Risk Assessment (Clinical)	21101	Workforce, Organisational Development & Culture	Strategic risk - Other	Insufficient safeguarding children's training resources.
Team Risk Assessment	21171	Children's Therapies & Complex Needs	Environmental risk - Other	Medicines fridge in a room too hot/cold

Strategic Outcome 1. We will deliver quality in everything we do providing safe, effective and person centred care

Principal risk:

Risk: **Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients**

Impact: May lead to our service receivers not receiving effective treatment leading to delays in recovery and longer episodes of treatment

Root causes:

a) Lack of investment in clinical workforce
b) Gaps in clinical evidence
c) Complex cases
d) Capacity to deliver effective care across all services
e) Lack of embedded outcome measures – clinically defined and patient defined
f) Staff capacity in patient centred care planning

BAF ref: **1b**	**Director Lead**: Carolyn Green, Executive Director of Nursing and Patient Experience	**Responsible Committee**: Quality Committee	Datix ID: 21107

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

Key controls:

Preventative – Quality governance structures and processes in to manage quality related issues; engagement with clinical audit and research programmes
Detective – Quality visit programme; HoNoS clustering; CAMHS IAPT measures; use of FSR to identify gaps in effectiveness through compliance checks
Directive – Quality Framework (Strategy) outlining how quality is managed within the trust, Agreed clinical policies and standards, available to all staff via Connect.
Corrective – Board committee structures and processes ensuring escalation of quality issues;

Assurances on Controls (internal):	Positive assurances on Controls (external):
Clinical Audit Programme and action plans where gaps identified	- National Community Patient Survey results (2017 results identify Trust as third highest in country) - National Inpatient survey (above average results for 2016, awaiting 2017 results) - CQC comprehensive inspection identified 8 services as 'good' and 2 as 'outstanding' for caring and 3 services 'good' for effectiveness - Mental Health Benchmarking Scorecard from NHS England identifies the Trust as 12/58 on effectiveness - HealthWatch ward visits to acute wards with direct and timely feedback

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Clinical buy in to review of NICE guidelines	Clinical buy in to review of NICE guidelines [ACTION OWNER DON]	31/01/2018	Steering group underway. Policy being revised	High
Embeddedness of integrated clinical/leadership teams	Integrated 'plan on a page' to be developed for each clinical pathway [ACTION OWNER DON]	Completed	Performance management plan through Trust Management Team (TMT) from July 2017. Performance management in place	Achieved
	CPD support plan for Chairs of integrated quality meetings [ACTION OWNER DON]	31/01/2018	Evaluation of QLT's in place and completed 6 monthly. . CPD for Chairs to be developed from Oct 2017 onwards, including board report writing skills course and other initiatives	Medium ⇩
Embedded personalised care planning, physical health checks and clinical standards	Implement CQC action plan around care planning [ACTION OWNER DON]	31/01/2018	Recent CQC mental health reports demonstrate improvement in care planning. Clinical skills tutors supporting improvement plans.	Medium
Demands of the Derbyshire population out strips capacity in particular community teams paediatrics, psychological therapies and fast track PREVENT referrals.	Gap analysis and training needs analysis with investment plan to increase psychological therapies in neighbourhoods [ACTION OWNER DON/COO]	31/01/2018	Contract negotiations underway to prioritise neighbourhoods and paediatric structural deficits, led by STP workstreams. Development of non-medical consultant and advanced clinical practitioner posts.	High
Increasing demand on children's services with significant numbers of additional children on child protection register	Revising business processes in children's services to improve efficiency	31/03/2018	Action plan in place, working with Royal Derby Hospital.	Medium
Learning from Serious Case and Homicide Reviews	Review of CPA policy. Review adequacy of family support services through triangle of care implementation plan [ACTION OWNER DON]	31/03/2018	CPA policy phase 2 development day completed. Revised policy to be submitted to Quality Committee Jan 2018. Triangle of care level 2 achieved Dec 2017.	Low ⇩
Effective patient reported outcome measures which actively involves service receivers	Implementation plan for roll out of ReQoL and Patient Activation Measure (PAM) [ACTION OWNER DON]	31/01/2018	Recovery and re-enablement strategy being implemented	Medium
Potential lack of formal patient and public involvement following external tender process	New provider identified, DON meeting to provide support through transition [ACTION OWNER DON]	31/01/2018	DON meeting with new providers. Interventions to support current providers. Negotiated for ward visits to continue in interim	Low ⇩
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
CQC inspection comprehensive review identified 9 services as requiring improvement for effectiveness	Fully implement CQC actions plan, with subsequent plan to raise all services identified as requires improvement to a rating of good [ACTION OWNER DON]	31/03/2018	Significant improvement reported. Warning notice lifted. Remaining actions monitored monthly and reported to the Quality Committee. Progress not at anticipated pace due to staffing pressures	Medium
'Transforming Care' (learning disability	Participate in learning disability services review re	31/03/2018	Workshops with staff underway, along with negotiations with	Medium

services) red rated across Derbyshire County against required strategic plan	effectiveness of service pathways.		Commissioners. Autism strategy reviewed. Continuing to work to implement strategy and meet statutory duty	

Related operational high/extreme risks:

Divisional Risk Assessment (Clinical)	21125	Neighbourhood Services - Admin & Management Team	Clinical - Therapeutic activity	Lack of dedicated resource for personality disorder conditions
Divisional Risk Assessment (Clinical)	21127	Neighbourhood Services - Admin & Management Team	Clinical risk - Other	Lack of Forensic Specialist Community Resource

Strategic Outcome 1. We will deliver quality in everything we do providing safe, effective and person centred care

Principal risk:

Risk: **Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)**

Impact: Resulted in a 'requires improvement' action from the CQC and an impact on person centred care

Root causes:

a) Previous mantra to use MHA (rather than MCA) in psychiatric in-patient settings but now MCA case law and MHA Code of Practice 2015 stipulates use of dynamic interface between MHA/MCA
b) Lack of compliance historically with MHA process partly due to reliance on audits with inherent time lag
c) Frequent turnover of junior doctors presenting training challenges
d) Historically seen as a medical issue, not multi-professional
e) Uncertainty over issues around 'presumption of capacity' for community patients

BAF ref: **1c**	**Director Lead**: John Sykes, Medical Director	**Responsible Committee**: Mental Health Act Committee	Datix ID: 21108

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

Key controls:

Preventative – Comprehensive training plan supported by MCA Training Manual developed by trust clinicians; Increased general awareness of issues (inc. podcasts) amongst clinicians with multidisciplinary team approach; Enhanced junior doctor training; Single place created in PARIS to record MCA assessments

Detective – Rolling compliance checks; Programme of quality improvement audits; Regular feedback on compliance to executive directors via next in line managers; Improved monitoring and reporting processes for seclusion and long term segregation following revision of policy

Directive – MHA and MCA policies and procedures; Lead director accountability and chain of accountability through to consultants senior nurse; Designated MCA medical lead

Corrective – MHA Committee oversight of dynamic application of MHA/MCA

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Reporting of training compliance against plan to MHA Committee - Range of compliance checks and audits agreed in MHA Committee forward plan and clinical audit programme	CQC note improvement with compliance with MCA with gaps remaining to close

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Electronic reminders to undertake assessments	Develop electronic reminders for capacity assessments and Best Interest assessments [ACTION OWNER MD]	Completed	Electronic reminders in place and running. Compliance has improved (as reported to the MHA Committee through the MHA Managers Report Aug 2017)	Achieved
Appointment of Deputy Medical Director to lead on compliance reporting from clinical directors	Appointment of a Deputy Medical Director [ACTION OWNER MD]	Completed	Appointed April 2017. Commenced in post Chairing monthly new medical management meeting to monitor and improve performance, including aspects of compliance with MHA and MCA requirements	Achieved
Consistent application of seclusion and segregation	Embed consistent application in clinical practice led by Chief Nurse [ACTION OWNER DON] Improve training for junior doctors regarding seclusion reviews [ACTION OWNER MD]	Completed Completed	Regular reports to Quality Committee and Mental Health Act Committee demonstrate improved compliance. Last report to MHAC Aug 2017, provided significant assurance. Training now part of Dr Toolkit	Achieved
Delays by local authorities in undertaking DoLS assessments	Continue to monitor and report compliance to the MHA Committee including where escalation to local authorities where illegal detention is a risk [ACTION OWNER MD]	31/03/2018	Monitoring continues to MHA Committee at each meeting; however compliance is dependent on local authority rather than Trust resources. Position is defensible by the Trust.	Low
Monitoring of application of MHA against equality standards	Year-end analysis to be completed and presented to MHA Committee Aug 2017 [ACTION OWNER MD]	Completed	Provided as part of MHA Managers annual report to MHA Committee – Aug 2017. Monitoring to continue an annual basis, as numbers too low for more frequent analysis.	Achieved
Staff competence and checking for compliance with CTO's, Best Interest Assessments and Capacity Assessments	Delivery of CQC action plan in relation to MHA/MCA actions [ACTION OWNER MD]	31/01/2018	Largely completed. Medical Director to confirm final two actions from 2016 review have been completed. These were dependent on PARIS developments	Low ⇩
Gaps in assurances:	**Actions to close gaps in assurances:**	**Review: due**	**Progress on action:**	**Risk to delivery.**
Completion of all actions in relation to 2016/17 Section 132 Rights internal audit	Reporting functionality in PARIS to be developed [ACTION OWNER MD/COO]	Completed	All actions completed. Updated reported went to MHAC June 2017	Achieved
Assurance of junior doctor supervision taking place, which includes focus on MHA/MCA compliance	Improving systems to consistently record supervision [ACTION OWNER MD]	Completed	Supervision reporting supported by medial secretaries from electronic timetables. Trajectory for performance improvement monitored through new medical management meeting .	Achieved
Evidence of compliance with CTO and Section 37/41 reviews undertaken by Responsible Clinicians (RC's) to a sufficient degree to protect patients and the public	Audit of compliance of clinical practice of RC's.[ACTION OWNER MD]	31/03/2018 31/01/2018	Re-audit of CTO quality improvement commencing Dec 2017 Deputy MD undertaking case review as part of peer review of 2 recent mental health homicides. To be completed Dec 2017. S41 register to be developed supported by MHA Manager. Forensic consultant to review as to how S41's are managed.	Medium

				Achieved
Current compliance with MCA training below 50%	Increase compliance with MCA training	31/01/2018	Training package reduced to single module (from 3 separate modules). Combined with face to face training, expectation that compliance trajectory will improve. Aiming to achieve 75% compliance.	Medium ⬇
Inpatient audits evidence positive assurance of adherence to process and quality of capacity assessment and recording. Unknown compliance in community services	Audit in community services	31/01/2018		
Related operational high/extreme risks: None specifically identified				

Strategic Outcome 1. We will deliver quality in everything we do providing safe, effective and person centred care

Principal risk:

Risk: **Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident**

Impact: An inability to deliver services, which may result in harm to service receivers

Root causes:

a) Increasing dependence on IT systems to support the delivery of clinical care and 'back office' functions such as procurement, finance
b) Insufficient mitigation against potential cyber attacks
c) Lack of coherent training plan to ensure that staff know what to do in the event of a major incident
d) Inadequate business continuity planning at service level

BAF ref: **1d**	**Director Lead**: Mark Powell, Chief Operating Officer	**Responsible Committee**: Quality Committee	Datix ID: 21036

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	3	5	MOD	3	3	↓	MOD	3	3			

Key controls:

Preventative – On-call training, table top major incident scenario exercises, fire training and drills, incident/near miss reporting and escalation, risk management processes. Range of defences against cyber-attack including: virus updates and patching of laptops and servers, prevention of use of unencrypted USB devices, email filtering , IT firewall and filters

Detective – IT systems testing, incident response plan testing , IM&T Rigor meeting to test strength of protection, response plans tested during recent cyber-attack and found to be robust

Directive – Emergency Plan, Business Continuity Plan, Lockdown Policy, disconnection of IT devices not regularly connected to the network,

Corrective – Use of extra training, further practice to aid understanding and confidence, GEM employment of security experts to review processes, plan to reduce time (from 90 to 45 days) before disconnection of IT devices not regularly connected to the network

Assurances on Controls (internal):	Positive assurances on Controls (external):
- EPRR Annual Report to Trust Board and periodic reports to Quality Committee and Trust Management Team evidence the overall actual performance against national Core Standards for EPRR, rated against a compliance scale from non-compliant to fully compliant - Includes several sections covering the efficacy of controls include: a) Leadership b) Business Impact Assessments c) Business Continuity Planning	CCG confirm and challenge process against all Core Standards – substantial compliance IT penetration test undertaken by CareCert 31/3/17 – 1/2/17.

d) Incident Response Plan e) Training needs and delivery	

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Learning review following cyber-attack in May 2017 has identified some gaps in control. None have been identified as major.	Action plan developed to include: Laptops and computers infrequently logged onto the network (to enable anti-virus patches to be applied) will be permanently disabled following a risk assessment of the impact Business continuity plans to be developed by departments in the event of an IT major incident (other types of incidents could cause business continuity to be required)	31/01/2018 31/01/2018	Action plan developed following cyber attach. Agreed by Board and overseen by EPRR Steering Group. Progress is reported to the Quality Committee (last report Sept 2107). The 4 actions still outstanding are being followed through by the Trust Management Team Business continuity plans underway in highest risk areas	Low
Not all staff who undertake management on-call duties have received approved training	Ensure there is sufficient training opportunities for both silver and gold command.[ACTION OWNER: COO]	Completed	Training delivered for vast majority of gold, silver and bronze command. Revision to training plan will be agreed for 2018/19	Achieved
As identified in CareCert 'Penetration Trust Report' 02/03/17	Complete actions identified in CareCert report. Action due date to be agreed in line with actions identified. .[ACTION OWNER: COO]	Completed	Actions relating to DHCFT on track. Actions relating to external suppliers escalated and being monitored. Now covered by EPRR on going work	Achieved
Gaps in assurances:	**Actions to close gaps in assurances:**	**Review due:**	**Progress on action:**	**Risk to delivery**
4 Core standards remain amber, resulting in the Trust being graded as substantial compliance and not fully compliant	Deliver actions set out in Core Standards action plan and embed ongoing review process, via EPRR steering group, for all standards. [ACTION OWNER: COO] Progress reported to TMT and QC via EPRR reporting process	Completed	All areas self assessed as green RAG rating. Letter from CCG received stating full compliance by Trust. EPRR annual report and CCG letter considered by the Board Nov 2017	Achieved
Related operational high/extreme risks:				

Trust wide Risk Assessment (Corporate)	21016	IM & T	Operational - Information Security	Introduction of a Virus \ malware via an unpatched server or PC

Strategic Outcome 2: We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time

Principal risk:

Risk: **Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system**

Impact:

1. If not delivered this could lead to deterioration of the Trusts financial position which could result in regulatory action
2. Deterioration of services available to service receivers

Root causes:

a) Financial constraints nationally and locally
b) Lack of confidence by Acute providers in the delivery of local STP outcomes
c) Lack of system wide leadership and 'grip'
d) Lack of engagement with staff groups
e) Lack of engagement with staff from other organisations
f) Changing national directives
g) Regulatory bodies imposing different rules and boundaries
h) Move to system wide working causes tension between loyalty to the system v's sovereign organisation

BAF ref: **2a**	**Director Lead**: Lynn Wilmott-Shepherd, Interim Director of Strategic Development	**Responsible Committee**: Finance and Performance Committee	Datix ID: 21109

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 - Maintenance of strong relationships with commissioners; 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- National agreement of Derbyshire's STP; Reforming of structure for delivery of STP; Fully agreed Mental Health STP
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; Constant check back to sovereign organisation

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 Minutes of CMB

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
System wide governance to oversee the STP not fully embedded	Work with system leaders and other senior stakeholders to embed governance structure [ACTION OWNER CEO]	31/01/2018	Further refinement of STP Governance underway to help decision making process	Extreme
MH System Delivery Board unable to put robust programme structures into place, owing to system changes not yet having taken place	Work with STP central team re co-ordination of release of key project personnel. Full alignment with the CCG QUIP agenda	31/01/2018	On-going issue. However, STP Board are reviewing and organisations have been asked to nominate staff	High
Lack of clarity around collaboration and competition	Continue working with NHSI to gain clarity [ACTION OWNER DSD]	31/01/2018	No up-date received. Generally working towards collaboration where possible Continue working with NHSI to gain clarity	Medium
Issues of communication owing to divergent messages between NHSE and NHSI. This includes Turnaround Directors within CCG's	Communication between differing groups – replay the message [ACTION OWNER DSD]	31/01/2018	New CCG CEO and CFO now in-place, early signs of greater convergence but the NHSI/E differences remain	High
Lack of long term strategic partnerships to deliver quality, sustainable services	Aim to develop partnerships through collaborative working [ACTION OWNER DSD]	31/01/2018	MHSTP workshop on 9th November looked at workforce. Voluntary sector involved and are providing key links to all programme areas as well as overarching work.	Medium
Lack of clinical capacity within DHCFT to fully contribute to system wide programmes of change	To be fully involved in clinic and professional reference groups using key clinical staff and their capacity appropriately [ACTION OWNER DSD]	31/01/2018	Clinicians keen to be involved. If they are unable to attend meetings then discussions are taking place outside of formal meetings	Medium
Lack of engagement with staff internally and staff from other organisations who will be key to success	Development of a robust 'Engagement Plan' overseen by the MH System Delivery Board.[ACTION OWNER CEO/DSD]	31/03/2018	MH STP launch event held 1/8/2017, involving over 100 people from variety of organisations including DHCFT. Further workshop held 9/11/2017 with over 70 attendees. Information distributed to 100+ people. Further workshop planned for 8/3/2018	Low 
Gaps in assurances:	**Actions to close gaps in assurances:**	**Review due:**	**Progress on action:**	**Risk to delivery.**
Feedback from system wide groups	Maintenance of relationships and involvement in relevant groups [ACTION OWNER CO/DSD]	Completed	On-going attendance at system wide meetings by key people	Achieved
The provision of reliable system wide information	Maintenance of relationships and involvement in relevant groups [ACTION OWNER CO/DSD]	31/01/2018	Working with Public Health who are leading the information management area and the development of 'turning the curve' metrics	Medium

Related operational high/extreme risks: None specifically identified

Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff

Principal risk:

Risk: **Ability to attract and retain high quality clinical staff across all professions**

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) Lack of a workforce plan and sufficient funding to accelerate the introduction of alternative workforce models
f) Organisational appetite to try and test alternative workforce models
g) Turnover of key personnel/professions

BAF ref: **3a**	**Director Lead**: Amanda Rawlings, Interim Director of People and Organisational Effectiveness	**Responsible Committee**: People and Culture Committee	Datix ID: 21110

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 – Recruitment campaigns.
Detective – Reflection and action taken following staff survey, Performance Reports, Quarterly Pulse Checks
Directive – Executive led weekly meeting using collaborative approach to reduce recruitment gaps
Corrective – Additional capacity to lead recruitment campaigns. Focused recruitment campaigns i.e. India, and further afield.

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Recruitment tracker reporting to People and Culture Committee and Board - Success reporting to from specific recruitment campaigns - Financial impact tracking on agency spend through Board - Quarterly staff 'pulse checks'. Improvement from staff survey to pulse check evident for Q1 17/18	- HEEM (Health Education East Midlands) quality assurance visit, to test infrastructure and support mechanisms are sufficient for people in training [potential assurance] - Staff survey results and Pulse Checks[potential assurance] - CQC visits identify caring and engaging staff

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Workforce plan to include alternative workforce models	Develop a precise workforce plan to include a bottom up workforce plan with owners of new roles that is costed with a timeline as to what the trust can afford to implement and by when [ACTION OWNER DPOE]	28/02/2018	- Workforce plan was approved at the July Board meeting with investment as required for the next 12 months. This is being refreshed by Feb 2018, to pick up Year 2 plan ready for business planning for 2018/19 - India trip has built pipeline for 13 medics to join the Trust over next 2 years. First person commenced on 12/06/17. Medical vacancies halved over last 3-6 months. - The Strategic Workforce Group monthly tracks progress on implementation. PCC will receive quarterly updates	Low
Appeal of the trust as a place to work	Develop programme of incentives for key national occupational shortages - increasing presence with universities - Increasing opportunities for online marketing and recruitment - increase opportunities for overseas recruitment [ACTION OWNER DPOE] Consideration of incentives scheme where shortage of occupational roles	31/01/2018	- Recruitment and retention group in process of implementing several initiatives aimed at: retention; retire and return; support for people not quite appointable; reduced recruitment process for returners. Retention elements included in the Managing People policy - Staff survey actions in place (see actions for risk 21111) 2017 Staff Survey underway, results will be available early in 2018. Increased participation this year - Jul – Sept 17 pulse check completed. Results cascaded to teams to identify actions. Working with staff engagement groups on actions - First Staff forum took place on 13/11/17. Discussion and actions being taken forward. Further forum planned for Jan 2018	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]	31/01/2018	Allocation of Learning Beyond Registration (LBR) money has now been received. Is significantly lower than previous years. Trust are reviewing where best to support staff and looking for alternative funding streams from HEE STP funds. Implementation plan for Apprenticeship Levy linked to workforce plan.	High
Related operational high/extreme risks:				

Divisional Risk Assessment (Corporate)	867		Clinical - Staffing levels	Commissioned Care Co-ordination Capacity within Neighbourhood Teams
Divisional Risk Assessment (Clinical)	2772	Child and Adolescent Mental Health Services (CAMHS)	Clinical - Staffing levels	Insufficient resources CAMHS workforce
Divisional Risk Assessment (Clinical)	3262	Community Paediatrics	Clinical - Staffing levels	Long waiting lists following reduction in paediatrician staffing levels

Divisional Risk Assessment (Clinical)	3385		Clinical - Staffing levels	Waiting Times for Psychological Assessment and Intervention
Divisional Risk Assessment (Clinical)	3386	Campus - Radbourne Unit	Clinical - Staffing levels	Radbourne Unit - Staffing risk assessment
Team Risk Assessment	3410	Campus - Radbourne Unit	Clinical - Staffing levels	Ward 34 Vacancy levels above 30%_Ward 34
Team Risk Assessment	20993	Children's Therapies & Complex Needs	Clinical - Staffing levels	Staff shortage
Team Risk Assessment	21124	Neighbourhood Services - South	Clinical - Staffing levels	No long term Consultant psychiatrist cover after 28th January 2018

Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff

Principal risk:

Risk: **There is a risk to staff engagement and wellbeing by the trust not having supportive and engaging leaders**

Impact: Negative impact on staff engagement and staff retention
Impact on staff wellbeing
Impact on quality of care
Impact on compliance with internal and external performance requirements

Root causes:

a) Lack of management capacity and capability
b) Clear leadership expectations
c) Lack of leadership and team development
d) Robust recruitment processes ensuring suitability for role
e) Culture of organisation including role modelling by peers and senior managers

BAF ref: 3b	**Director Lead**: Amanda Rawlings, Interim Director of People and Organisational Effectiveness	**Responsible Committee**: People and Culture Committee	Datix ID: 21111

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 – Spotlight on our Leaders events to engage leaders, Membership of East Midlands Leadership Academy offering leadership development menu
Detective – Staff survey results year on year, quarterly pulse check quarterly, people metrics tracked monthly.
Directive – Leadership development training supporting managers to implement policies
Corrective – appraisal and supervision processes

Assurances on Controls (internal):	Positive assurances on Controls (external):
Quarterly Pulse check. Improvement from staff survey to pulse check evident for Q1 17/18	

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of a Leadership Development Plan	Develop and implement a Leadership Development Plan linked to training needs	31/01/2018	12 month plan underway	Low ↓

	requirements			
- Clearly defined staff and leadership expectations linked to values	Implementation plan during 2018 to embed expectations amongst staff and leaders [ACTION OWNER DPOE]	31/03/2018 and into 2018/19	Forms part of Staff Engagement Plan agreed by Board Nov 2018	Medium
- Coaching/mentoring and development/improvement plans for leaders that need support	Build infrastructure and menu of offer for leaders [ACTION OWNER DPOE]	31/01/2018	Agree framework of how to recruit including leadership development guide and coaching and mentoring support	Medium
Lack of organisational wide method of engagement	Implementation of a staff forum	Completed	Staff forum launched Nov 2017.	Achieved
Gaps in assurances:	Actions to close gaps in assurances:	Action/ review due:	Progress on action:	Risk to delivery.
Annual staff survey results	Actions to be focused on: ensuring staff have 'tools to do the job', ensuring staff have a voice, staffing, leadership development [ACTION OWNER DPOE]	31/01/2018	Bi-monthly monitoring by Trust Management Team of local area staff survey plans and progress. Engagement group overseeing overarching action pan and reporting to People and Culture Committee. Awaiting 2017 results. Actions from previous survey ongoing	Medium
Lack of capacity in operational HR department	Delivery of revised model for operational HR to increase the resilience of the HR Team in DHCFT by broadening the number of staff available [Action Owner :DPOE]	31/03/2018	Consultation has commenced on the restructure and joining together of the HR Teams within DCHC and DHCFT. This is scheduled to be implemented by April 2018	Medium
Related operational high/extreme risks: None specifically identified				

Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff

Principal risk:

Risk: **There is a risk that the Trust does not operate inclusively**

Impact: May be unable to deliver equity of outcomes for staff and service receivers and demonstrate compliance with the Equality Act

Root causes:

a) Implementation of Equality Delivery System (EDS2)
   a. Improvement in recording of all protected characteristics of service receivers on clinical systems in order to support equality analysis
   b. Capacity of stakeholders to engage with Trust in order to validate EDS2
   c. Consistent identification of equality related impact in papers presented to Board and Board level committee papers

BAF ref: **3d**	**Director Lead**: Amanda Rawlings, Interim Director of People and Organisational Effectiveness	**Responsible Committee**: People and Culture Committee	Datix ID: 20936

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating MOD	Likelihood 4	Impact 2	Direction ⟷	Rating Low	Likelihood 3	Impact 2	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Reporting of approach and progress reported to Board and the People and Culture Committee

Detective –Urgent non-compliance addressed and reported to the People and Culture Committee

Directive – Full time expertise in post, Launch of a new Equalities Forum,

Assurances on Controls (internal):	Positive assurances on Controls (external):
Self-assessment grading based on equality evidence	Self-assessment grading validated by external stakeholders including HealthWatch (Derby)

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Delivered equality strategic action plan	Reporting on progress to Equalities Forum, Quality Committee, and People and Culture Committee [ACTION OWNER: DPOE]	31/01/2018	- Reporting identifies progress, all objectives on target to achieve amber rating by Q3 17/18. Updates presented at key committees (Quality Committee, People and Culture Committee & Board) June, July Sept 17. - ED& I Strategic Framework overview submitted for approval on PCC 21/9/2017 & BoD 27/9/2017 - EDS2 2018 implementation plan on target, annual grading took place on 23/11/2017 focusing on Children Services and core Corporate KPIs	Low

Evidence of managers supporting staff to work in culturally ways	Delivering equality training. Undertake EDS assessment of services. [ACTION OWNER: DPOE]	31/01/2018	- Equality training commenced through induction and EIRA training. Plan to deliver managing inclusion workshop. Board Development session April 2017. - Workforce EDS2 planned for Feb 2018 - Executive Director champions identified for BME: Acting Chief Executive and LGBTQ Deputy Chief Executive/Director of Finance. Other REGARDS champions being explored. - Equality E-learning compliance 75% (Sept 2017). Monthly Induction now includes 'Why ED & I matters to us' session - Engagement meeting with Carers took place for 6/11/2017.	Low
Improve recording of service receivers protected characteristics on clinical systems	Deputy Director of Operations, Chief Nurse, General Manager IM&T and Assistant Director of Engagement and Inclusion to improve data capture though training, improvement of IT systems and performance management [ACTION OWNER: COO|DON|DPOE]	31/01/2018	Meeting with IT and equality lead took place Oct 2017 to align PARIS fields to national equality. Paper went to TMT 9th Oct, quarterly monitoring to TMT to monitor progress. General Managers training took place 12th Dec. Derbyshire LGBT+ approached to support Sexual Orientation identity, awareness & understanding of sexual identify questions	Medium
Consistent identification of equality related impact in papers presented to Board and Board level committee papers	Evidence of EIRA compliance across selection of Board and Board level committee papers [ACTION OWNER: DPOE]	28/02/2018	Completion audit of EIRA compliance and reporting progress to People and Culture Committee. New template, and training with Board, has resulted in improved standards. Audit to be completed Feb 2018.	Low
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery.
Implementation plan for undertaking EDS2 national performance framework	Plan against EDS2 national performance framework to be developed and implemented [ACTION OWNER: DPOE]	Completed	EDS2 took place on 23/11/2017 EDS2 Service grading focused on Children Services. EDS2 Corporate grading - Better health outcomes and experience Workforce Goals - 3 & 4 planning stages	Achieved
Related operational high/extreme risks: None specifically identified				

Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff

Principal risk:

Risk: **Potential turnover of board members**

Impact: Could adversely affect delivery of the organisational strategy and have a negative impact on wider Trust staff morale

Root causes:

a) Loss of specialist organisational knowledge on Board
b) Loss of Board capacity
c) Disruption of Board stability

BAF ref: 3e	**Director Lead**: Samantha Harrison, Director of Corporate Affairs and Trust Secretary	**Responsible Committee**: Remuneration and Appointments Committee	Datix ID: 21138

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating LOW	Likelihood 2	Impact 2	Direction ⬇	Rating LOW	Likelihood 1	Impact 1	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Substantive roles now in place for Chief Executive and Chair; Succession plan for Board members; Existing NED/Chair of Audit and Risk Committee able to extend appointment until replacement post in place. New NED appointed, to Chair Audit and Risk Committee

Directive – Notice periods for Board Members

Corrective – Recruitment processes in progress,

Assurances on Controls (internal):	Positive assurances on Controls (external):
Fit and proper persons checks Succession plan for Board members under review by Remuneration and Appointments Committee (quarterly review)	Deloitte Well Led review (pending) External competitive recruitment

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Full populated cascade for Board member succession planning	To develop full populated cascade for succession of Board members	Completed	To be considered by the Remuneration and Appointments Committee Sept 2017. Completed. Will be reviewed quarterly by the Committee (and also ELT) as per respective forward plans	Achieved

Communication and engagement plan for trust staff	Communicate with trust staff to raise awareness of forthcoming advertisements and plans to recruit to substantive posts	Completed	Communication sent to staff via Weekly Connect 28/7/17. Chair interviews held 6/9/2017 and recommendations agreed at Council of Governors to appoint new Chair. Staff informed through All staff email 13/9/2017 CEO interviews set for 4/10. Both appointments completed. Staff informed of appointment of CEO on 6 October. Recruitment to COO post 17 November – staff informed 20 November. Staff also informed of NED/Audit and Risk Chair appointment.	Achieved
Substantive recruitment of all board members	Substantively recruit to all board member posts	31/01/2018	Chief Operating Office now substantively recruited to. Interim Director of Strategy post to be appointed to. Post to be considered by Remuneration and Nomination and Committee	Low
Gaps in assurances:	Actions to close gaps in assurances:	Action/ review due:	Progress on action:	Risk to delivery.
Related operational high/extreme risks: None specifically identified				

Strategic Outcome 4. We will transform services to achieve long-term financial sustainability

Principal risk:

Risk: **Failure to deliver 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

BAF ref: **4a**	**Director Lead**: Claire Wright, Executive Director of Finance	**Responsible Committee**: Finance and Performance Committee	Datix ID: 21113

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

Key controls:

Preventative – Budget training, segregation of duties, contract with commissioners to reach mutual agreement on QIPP disinvestment

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

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

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	- Internal Audits– low risk findings on 2016/17 Key Financial Systems - data analysis - External Audits – strong record of high quality statutory reporting (gap: VFM impact) - Grant Thornton shows good benchmarking for key financial metrics (gap: liquidity) - NHSI Use of Resources Metrics – shows good performance (gap: agency metric) - National Fraud Initiative – no areas of concern - Local Counterfraud work – Referrals to KPMG show good counterfraud awareness and reporting in Trust - Deloitte Well Led review – positive affirmation of the effectiveness of the Finance and

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 Service Line Reporting define financial performance for each service line.	Performance Committee - Confirmation received from Commissioners on 02/01/18 that they will pay the 0.5% CQUIN risk reserve in full.

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 weekly meetings.[ACTION OWNER: COO] Implement a collective approach to holding the line on paying cap rates only for medical staff is being explored aim to be introduced [ACTION OWNER: MD] AIM: achieve average £250k per month agency spend (or less)	31/03/2018	Agency controls have led to reduced total agency expenditure and better adherence to capped hourly rates, but ceiling not achieved Trust vision/priorities: Financial sustainability – the leading indicators chosen are agency ceiling and recurrent CIP	Moderate ⇩
Cost control/Cost improvement – large reliance on non-recurrent measures in 17/18 and no firm programme for 18/19	QIPP and CIP incorporated into the mental health STP workstream [ACTION OWNER DSD] Increased CIP meetings and project scrutiny, management action via TMT {ACTION OWNER – COO] AIM: full CIP programme, quality assured. New PMO approach in train for CIP	31/03/2018	CIP and QIPP are part of Mental Health STP Workstream. New Programme Delivery approach planned. Gap remains: no firm plans for 18/19 yet Further action: F&P oversight and scrutiny of continuous improvement/longer term plans for 18/19 and beyond Trust vision/priorities: Financial sustainability – the leading indicators chosen are agency ceiling and recurrent CIP	High
There is Regulator inconsistency in interpretation and implementation of guidance (e.g. planning timeframes and 0.5% CQUIN reserve)	QIPP and CIP incorporated into the mental health STP workstream [ACTION OWNER COO/DSD] AIM: agreed plan showing income reduction is matched by cost reduction	31/03/2018	Regulator inconsistency is being resolved nationally Trust vision/priorities: Financial sustainability – the leading indicators chosen are agency ceiling and recurrent CIP Confirmation received from Commissioners on 02/01/18 that they will pay the 0.5% CQUIN risk reserve in full.	Low ⇩

Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery.
Agency costs exceed NHSI ceiling by >50% and	Weekly agency meetings to reduce costs.	Completed	Control measures have reduced spend level to <50%	Achieved

generate 'use of resources' agency score of 4.	Implementation of recruitment drive and incentives AIM: To have a UoR agency score of 2 or 3 for agency as a minimum)[ACTION OWNER: COO]		with no trigger	
Liquidity is below peer levels in benchmarking terms, but improving year on year	Continued strategic objective to increase cash through retention of disposals and limiting capex programme. AIM: Reach a 'sufficient' cash balance of £18m [ACTION OWNER DOF]	31/03/2018	Much improved due to cash receipts and year on year surpluses – low residual risk Improving quarter on quarter cash balance. Month 4 cash is £16.6m	Low
Adverse VFM opinion from External Auditors for 15/16 and 16/17 accounts due to previous NHSI license breach/ governance/ well led/CQC rating	Complete CQC action plan and governance improvement plan AIM 1: Trust released from NHSI licence conditions and rated as segment 1 or 2. [ACTION OWNER: DCA&TS] AIM 2: Clean VFM opinion for 17/18 accounts [ACTION OWNER: DCA&TS]	Aim 1: 30/09/2017 for licence and segment - complete Aim 2: 31/03/2018 for updated audit opinion	Aim 1: Completed: Rated as segment 2. Full compliance with licence conditions as of 24/05/2017 Audit Opinion updates cannot be delivered until 17/18 audit. Good progress being made.	Low
Related operational high/extreme risks: None specifically identified				

Strategic Outcome 4. We will transform services to achieve long-term financial sustainability

Principal risk:

Risk: **Failure to deliver internal transformational change at pace**

Impact: Could lead to reduced outcomes for service receivers and failure to deliver national 'must do's' i.e. Early intervention in Psychosis, Mental Health Liaison, Crisis and acute care, and physical healthcare interventions.

Root causes:

a) Lack of capacity within Transformational Team
b) Lack of capacity in the Business Development Team to support managers
c) Capacity and capability of managers to deliver change programmes
d) Lack of staff, vacant posts and lack of investment
a) Impact of CIP on quality
b) Lack of schemes which will deliver both quality and financial improvements

BAF ref: **4b**	**Director Lead** Lynn Wilmott-Shepherd, Interim Director of Strategic Development	**Responsible Committee**: Finance and Performance Committee	Datix ID: 21114

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	5	5	EXTREME	4	5	⟷	MODERATE	2	5			

Key controls:

Preventative - Robust project assurance process; Embedding of continuous quality improvement ethos; Regular reporting to F&P showing progress on internal transformation linked to system change; Maintenance of strong links to system wide change including STP, Commissioners and other partners; Full involvement with appropriate system wide groups which translate to internal changes; Maintenance of strong relationships with other providers; service receiver engagement

Detective -5 year Trust wide strategy; Performance management of annual business plans; Scrutiny on the performance of national 'must do's'

Directive - Clear alignment of internal transformational plans to the Derbyshire's STP; Clear alignment to CIP i.e. transform to improve quality and reduce costs

Corrective - Ongoing discussions on transformational change with key managers; Ongoing discussions transformational change with key stakeholders; Engagement and consultation with patients, public and staff as appropriate; development of a continuous quality improvement culture

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Reports to Board regarding any system wide changes or risks which may impact on internal transformation - Develop a culture of continuous quality improvement - Regular feedback to F&P showing progress on internal transformation linked to system change - Updates and feedback at TMT and ELT on progress on internal transformation linked to system change together with 'barriers' to change	- Reporting to NHSI - Updates to CMDG/CMB - Pipeline of CQI projects

- Engagement with Governors in order to update them and gain feedback - Engagement with staff though managers, staff side, focus groups etc.	

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
No clear links to external transformation	Be proactive in STP programme [ACTION OWNER DSD]	31/01/2018	MH Workstream ahead of other areas. Some clear deliverables. Links made to other areas particularly urgent care	Medium
Managers and clinicians not actively involved	Review new accountability framework and TMT as a way of ensuring transformational change is viewed as an imperative [ACTION OWNER DSD]	31/03/2018 and into 2018/19	Managers and lead clinicians agreed for all areas. High level of involvement. Linking Quality Improvement to Continuous Improvement to help develop a culture of improvement. Work underway to fully embed CQI	Medium
'Must do's' are not being met or have slipped when previously being met.	Performance management via TMT, CMDG and CMB [ACTION OWNER DSD]	31/01/2018	Generally on-track - performance reporting being formalised.	Medium
Lack of capacity within business development team to drive forward planning	Appointment of Business Development Manager and graduate trainee	Completed	Graduate trainee in post and new Business Development Manager due to commence Dec 2017	Achieved
Lack of embedded business planning	Integrate work of business development managers within work of operational divisions	31/03/2018 and into 2018/19	Aligned Business Development Managers to two divisions each	Medium
Lack of continuous quality improvement approach/culture	Development of CQI strategy; teams owning the ideas and implementation	31/03/2018 and into 2018/19	Strategy being developed	High
Gaps in assurances:	**Actions to close gaps in assurances:**	**Review due:**	**Progress on action:**	**Risk to delivery.**
Evidence of real change and move towards a CQI culture	Implementation of PDSA cycles and rapid improvement [ACTION OWNER DSD]	31/01/2018	PDSA cycle has been completed for Red to Green. Early signs of changes in behaviour and reduction in lengths of stay. Further PSDA to take place on other projects	Medium
Feedback from project groups	Clear project management structures [ACTION OWNER DSD]	31/01/2018	Projects set-up and Project Vision realigned. Developing Dashboard reports for all Programmes to be reviewed at Mental Health System Delivery Board (MHSDB)	Medium
Related operational high/extreme risks: None specifically identified				

Abbreviations: Action owners

CEO Chief Executive
COO Chief Operating Officer
DON Executive Director of Nursing and Patient Experience
DOF Executive Director of Finance
DCA&TS Director of Corporate Affairs and Trust Secretary
DPOE Interim Director of People and Organisational Effectiveness
DSD Interim Director of Strategic Development
MD Medical Director

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Trust Board - 31 January 2018

Outcome from Deloitte Well-Led Framework Review Phase 3

Purpose of Report

To present the Executive Summary and recommendations of the Deloitte Review of the Trust's Governance Arrangements – Phase 3.

Executive Summary

Deloitte were commissioned to undertake an independent review of the effectiveness of governance arrangements at the Trust in three phases. The findings from the first two phases of this work were outlined in reports received by the Trust in October 2016 (governance and improvement action plan assurance) and April 2017 (governance and HR arrangements). The final report, received by the Trust on 12 January 2018 presents findings of phase 3 of Deloitte's work which includes:

- Revisiting areas highlighted in phases 1 and 2 of the review which had highlighted where further progress was required, namely divisional governance and performance management and progress of implementation of the People Plan

- Reviewing the five areas of the Well-led framework which had not been covered during previous phases of the Deloitte work.

Since the time of the first two phases of work, the Well-led Framework has been updated (June 2017) and therefore we requested that Phase 3 of the review should map across the five outstanding areas to the new framework to ensure that we were reviewing our arrangements and taking forward work arising from recommendations following the new framework requirements.

The areas of focus (new framework) were as follows:

- ***Is there a clear vision and strategy and robust plans to delivery?***
- ***Are there clear and effective processes for managing risks issues and performance?***
- ***Are there robust systems and processes for learning, continuous improvement and innovation?***
- ***Is appropriate information effectively processed challenged and action upon?***

The review involved a desktop review of our self-assessment against the Well-Led areas and supporting information. Interviews were held with each member of the Board and a sample of senior staff. In addition there were two focus groups attended by a total of 30 staff. The Trust Management Team was observed and a series of service visits into clinical and non-clinical areas across the Trust sites were undertaken. In total eight areas were visited. Six external stakeholders participated

in telephone interviews. Following conclusion of these activities an initial feedback meeting was held with the Chair and Chief Executive to share the emerging findings prior to final issue of the report.

Deloitte assessed the areas above and rated each as 'amber–green' which is broadly in line with our own self-assessment. The definition of this score is 'partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe' and that evidence presented shows 'some evidence of good practice, no major omissions and robust action plans to address perceived gaps with proven track record of delivery'. This is the second highest criterion in the NHS Improvement scoring used for assessing the Well-Led Framework and this is a very positive position for the Trust, evidencing a significant achievement of progress and embedding good governance practice over the past two years.

The Executive Summary of the report highlights the key findings of the report including key positive aspects and areas for further improvement. The Trust Board reviewed the report at the Board Development Session held on 17 January and welcomed the report, acknowledging the significant progress made by the Trust and noting that recommendations aligned with work we have recognised require further progress and in many areas, where we have already taken action. There are a total of ten recommendations and following discussion with Board members these have been allocated to Board Committees to take oversight and to receive assurance on progress with the recommendations. Next steps for the Trust will be to assign an Executive Lead and operational committee as appropriate to work up detail to ensure the recommendations are addressed within an agreed timeframe.

The successful completion of the three phases of the Deloitte review work constitutes a full external Well-Led governance review and we will be presenting this external assurance to NHS Improvement at our next Performance Review Meeting on 2 February 2018.

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 review represented the third phase of an external assurance process for the Well-Led Framework.

Consultation

The report was considered at the Board Development Session held on 17 January 2018

Governance or Legal Issues

It is a requirement that Foundation Trusts carry out an external Well-Led Framework review every three years. Completion of this phase 3 of the external review completes the full review and this will be repeated in three years, with annual internal review undertaken.

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 of REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation) and Public Sector Equality Duty & Equality Impact Risk Analysis.

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 – not applicable

Recommendations

The Trust Board is requested to:

1) Receive significant assurance from the Executive Summary of the Phase 3 Deloitte review of governance arrangements
2) Accept the recommendations and note the oversight Board Committees assigned, with assurance on progress to be reported to the Board through their established assurance summary process.

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

Report prepared by: **Sam Harrison**
Director of Corporate Affairs and Trust Secretary

Executive summary

Context and overview

This report sets out the findings from Phase 3 of our work with you which has comprised a review of: vision, strategy and planning; management of risks, issues and performance; learning, continuous improvement and innovation; reporting; and revisiting key areas which required further progress as outlined in our Phase 2 review (see appendix 2) .

We would like to thank Board Members, staff, and external stakeholders for their engagement in this project.

Whilst our scope has not comprised a formal review of the Board and leadership arrangements during this engagement, internal and external stakeholders we spoke with proactively described significant improvements in this area. In particular, the dedication of the CEO was frequently referenced, alongside an appreciation for the increased stability in leadership at Board level brought about by the now-substantive executive team and Chair.

Further key positive aspects we would like to highlight include:

- Work undertaken to define the Trust strategy in a context of significant internal and external change;
- A number of elements of good practice in relation to integrated reporting, alongside a strong use of local dashboards to drive improvements in care; and
- Good progress has been made across the key areas we have followed up from the phase 2 review. In particular, performance management arrangements are much progressed since our initial recommendation.

We have also noted some areas for further improvement:

- Whilst work has been undertaken to develop a coherent strategy, there is now an acknowledged need to refine and update this to reflect changes in the strategic context of the Trust, including to reflect the decision not to proceed with the transaction with Derbyshire Health Services NHS Foundation Trust;
- The quality impact assessment process for efficiency changes needs to be clarified and re-communicated; and
- Processes to support data quality need to be reconfirmed and clarified.

Findings from this independent review have been grouped into four theme areas. A summary of our findings in each of these areas is outlined below.

1. Vision, strategy and planning

- Given the scale of recent internal and external change, the Board has proactively identified the need to refresh the strategy for the Trust. As part of this exercise, it is also intended that this will include a significant increase in the focus on people aspects in recognition of the strategic risk in this area.
- Partly as a result of this change, staff we spoke with were generally unclear on the strategic direction of the organisation and expressed an appetite for clearer communications around this, particularly now that more stable Board-level leadership has been confirmed. Following our onsite activities, work in this area has since commenced, which can be evidenced, for example, through the draft Physical Healthcare Strategy.
- Aspects of business planning within divisions reflect good practice, however plans at this level are of varying quality, and a robust, structured annual planning cycle to ensure strategic implementation remains a gap.

2. Management of risks, issues and performance

- Our review found a number of areas of good practice in relation to the management of risks, issues and performance. In particular, we would point to the use of the Board Assurance Framework and a consistent oversight of strategic risk at both Board and committee level.
- Performance management of divisions has also seen significant progress since our previous work with the Trust, and especially the development of divisional performance dashboards. Performance management at an individual level remains, however an area for development, with both the 2016 NHS Staff Survey and our conversations with staff highlighting a need for more consistent and meaningful career conversations.
- There is also an acknowledged need to revisit and review the quality impact assessment process for cost improvement plans. At present the process is viewed as cumbersome, and compliance may be effected as a result.

Executive summary (continued)

3. Learning, continuous improvement and innovation

- The Trust can demonstrate a number of examples of successful innovation and staff have noted that they are increasingly encouraged to innovate. However, in practice, staff do not always have the capacity to be involved in innovation activities, and a lack of stable leadership in some divisions has also impacted upon progress in some areas. The need to develop a standardised quality improvement methodology within the Trust has been recognised, and a lead has recently been appointed to develop this.

- A range of mechanisms are in place to support learning from issues, including an increasing use of peer reviews in response to particular issues. However, more work is required to ensure that processes to capture themes and trends and to share best practice are strengthened and that greater dissemination of learning across divisions is undertaken.

4. Reporting

- Board members agreed that significant progress has been made in the quality of the Trust's reporting structures and processes and we would agree with this view. Since our previous work with the organisation, the integrated performance report has become more embedded and a further review of metrics reported is planned. The maturity and availability of supporting dashboards and live data to manage performance is more advanced than in many similar trusts we have worked with. We would also underline the positive work being undertaken in relation to the 'QUESTT' early warning system to improve quality standards.

- In terms of areas for further development, staff at all levels described frustrations with the electronic patient record systems in place, particularly ease of access to the systems, interoperability and aspects of their functionality. These issues are being managed through a new clinical reference group.

- While the Trust has historically benchmarked well in terms of data quality, there is scope to clarifying underlying data quality processes and to more routinely report on the quality of data included in Board reporting. This is becoming the standard across many trusts with whom we are working.

Key recommendations and next steps

Throughout this report, we have raised a number of recommendations for consideration and approval by the Board, including:

- R1: With the planned refresh of the Trust strategy, the Board needs to ensure that: clear links are made to system-wide plans; SMART goals are defined; sufficient detail is included to facilitate implementation planning with teams; and that there is a clear process to ensure ongoing measurement of success.

- R5: Review and relaunch the quality impact assessment process for cost improvement plans, with a focus on ensuring that it is flexible enough to be relevant to schemes of various scales. The process should be clearly communicated to all managers and the Director of Nursing and Quality and Medical Director should sign off all schemes. Schemes which are risk-rated amber and red should be signed off by the Quality Committee.

- R7: The Trust should seek to supplement the current mechanisms in place to share learning throughout the Trust for example through the use of increased oversight at TMT, Divisional Clinical And Operational Assurance Team (COATs), and directorate meetings.

- R10: Reiterate the processes for data quality, ensuring all required aspects are in place. Also introduce data quality kite marks for key metrics reported in the committee and Board IPR.

Given the extent of work planned to define and implement a Quality Improvement Strategy, no specific recommendation has been made, although we concur with the need for further progress in this area.

We suggest that the Chair and CEO, in consultation with the Board, consider the findings outlined within this report and collectively agree a response to the matters raised. In particular, the Board should:

- define clear timescales for delivery;

- clearly align recommendations to executive leads; and

- align groups of recommendations to the appropriate committee to enable oversight of progress.

Summary of recommendations

Set out below is a summary of the recommendations contained within this report, including a reference to the section to which they relate. Recommendations for improvements should be assessed by the organisation for their full impact before they are implemented.

KLOE	#	Recommendation	Prioritisation	Lead Board Committee
Vision, strategy and planning	1	With the planned refresh of the Trust strategy, the Board needs to ensure that: clear links are made to system-wide plans; SMART goals are defined; sufficient detail is included to facilitate implementation planning with teams; and that there is a clear process to ensure ongoing measurement of success.	High	Board
	2	Refresh the annual planning process to include more oversight and scrutiny from the executive team in the development of plans to ensure consistent quality across divisions. Progress of implementation should continue to be monitored quarterly through TMT and more routinely at Divisional meetings.	High	Finance & Performance
Management of risks, issues and performance	3	Expand the existing Risk Assurance and Escalation Report so that information on mitigating actions is included for all open high and extreme-rated risks. This report should be received by the assurance committees alongside the BAF, and also by the Board (for information) on a six-monthly basis.	Medium	Audit & Risk
	4	A tiered risk management training programme should be developed for all Trust staff.	Medium	Audit and Risk
	5	Review and relaunch the QIA process for CIPs with a focus on ensuring that it is flexible enough to be relevant to schemes of various scales. The process should be clearly communicated to all managers and the Director of Nursing and Quality and Medical Director should sign off all schemes. Schemes which are risk-rated amber and red should be signed off by the Quality Committee.	High	Quality
	6	All staff need to have meaningful annual objectives which are monitored through a quality appraisal process. Once the Trust strategy has been refreshed, all objectives should be linked to this.	Medium	People & Culture

Learning, continuous improvement and innovation	7	The Trust should seek to supplement the current mechanisms in place to share learning throughout the Trust for example through the use of increased oversight at TMT and at Divisional COAT and directorate meetings.	High	Quality
	8	Further work is required to ensure that staff are encouraged to utilise Datix to capture incidents appropriately and to ensure that all are aware of the need to review and provide feedback in a timely manner.	High	Audit & Risk
Reporting	9	Further develop the IPR with a focus on: a) reviewing and rationalising the number of metrics included, b) aligning the metrics to the Trust's refreshed strategic objectives once these have been defined, and c) including clear trajectories where performance is off-track.	Medium	Finance & Performance
	10	Reiterate the processes for data quality, ensuring all required aspects are in place. Also introduce data quality kite marks for key metrics reported in the committee and Board IPR.	Medium	Finance & Performance

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 31 January 2018

Register of Trust Sealings 2017-18

Purpose of Report

This report provides the Trust Board with an account of the authorised use of the Foundation Trust Seal during 2017-18.

Executive Summary

In accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors the Foundation 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.

These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates and Agile Working Strategy.

There have been ten entries made to the Register of Trust Sealings for 2017/18. The Trust Seal was affixed as follows:

1. DHCFT44 Lease of The Mews, first and ground floor
2. DHCFT45 Lease of Old Vicarage, Bolsover
3. DHCFT46 Deed of Release (prior property disposal)
4. DHCFT47 Lease of first and second floor, Unity Mill
5. DHCFT48 Order form and call off terms between DCHFT and CIVICA UK Limited for the provision of clinical systems and hosting services
6. DHCFT49 Lease of St Paul's and St Michael's, Deed of Covenant St Paul's and St Michael's
7. DHCFT50 Improvement work to Kedleston Unit

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 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 – not applicable

Recommendations

The Board of Directors are requested to note the authorised use of the Foundation Trust Seal so far during 2017-18.

Report presented by: **Claire Wright**
Deputy Chief Executive and Director of Finance

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 31 January 2018

Report from the Council of Governors
22 November 2017

The Council of Governors has met twice since reporting to the September Public Board. The Council of Governors met on Wednesday 22 November 2017 at the Ashbourne Centre, Derby and on Wednesday 24 January 2018 at the Postmill Centre in South Normanton. The November meeting was attended by 14 governors. A summary of the January meeting will be presented to the February Trust Board.

Chief Executive's Report
Apologies had been received from the Chief Executive due to illness. The report updated governors on changes within the national health and social care sector as well as providing local updates within the health and social care community. The report supports the Council in its duty of holding the Board to account by way of informing members on internal and external developments. In the absence of the Chief Executive, the Council of Governors noted the report. The scheduled update on Joined Up Care Derbyshire was deferred to the next meeting.

Non-Executive Director Update on Finance & Performance Committee
Richard Wright, Non-Executive Director and Chair of the Finance & Performance Committee gave an update on the work of the Committee highlighting his role holding Executive Directors to account.

Integrated Performance Report
Caroline Maley presented the Integrated Performance Report to provide the governors with an overview of performance as at the end of September 2017. Each of the Non-Executive Directors Board Committee Chairs reported on how the report had been used to hold Executive Leads to account in their respective Board Committees for areas with regards to workforce, finance, operational delivery and quality performance.

Feedback & Next Steps on Holding to Account Training Session
The Council of Governors reflected on the training session, held on 8 November 2017 and agreed to produce a report for a future meeting in response to the recommendations made at the session.

Escalation Items to the Council of Governors
A number of items were escalated to the Council of Governors from the Governance Committee. Non-Executive Directors responded to the escalations, which will in turn be reported in full in the public minutes.

Staff Engagement Update
Margaret Gildea updated the Council of Governors on progress of the staff survey and on the Quarter 2 Pulse Check Survey.

Governance Committee Report
Carole Riley, Deputy Lead Governor, presented an update on meetings of the Governance Committee held on 18 October. The Committee had received the Annual Report of the Trust's volunteer Membership Champion, detailing activities and membership recruitment.

Nominations & Remuneration Committee Report
Caroline Maley presented the report to update the Council of Governors on the activities undertaken by the Nominations & Remuneration Committee. Three meetings had taken place, the main business of which had been the planning and process of the recruitment and selection of the Non-Executive Director who would chair the Audit & Risk Committee (Geoff Lewins was appointed to this role).

Elections Update
Following elections for four public governor vacancies, managed by Electoral Reform Services, three governors had been appointed. A vacancy remained in North East Derbyshire. And a resignation had been received for Amber Valley North.

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

2017-18 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
		Deadline for papers	**18 Apr**	**15 May**	**19 Jun**	**17 Jul**	**18 Sep**	**23 Oct**	**20 Nov**	**22 Jan**	**19 Feb**	**19 Mar**
CM	Apologies given		X	X	X	X	X	X	X	X	X	X
SH	Declaration of Interests	FT Constitution	X	X	X	X	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	FT Constitution	X	X	X	X	X	X	X	X	X	X
CG	Actions and learnings from patient stories.		X	X	X	X	X	X	X	X	X	X
CM	Board Forward Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X
CM	Board review of effectiveness of the meeting	Statutory Outcome 3	X	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE												
CM	Chair's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X
IM	Chief Executive's report	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X
MP/ CW	NHSI Annual Plan *TBC awaiting NHSI guidance*	FT Constitution/NHSI Risk Assurance Framework (RAF)										
CW	NHSI Compliance Return (Public) (subject to change (incorporated into Integrated Performance Report)	NHSI Single Operating Framework		X	X				X	X		X
JS	Information Governance - annual report April interim report November	Strategic Outcome 1 Strategic Outcome 3 Information Gov toolkit	AR					IR				
AR	Staff Survey Results and Action Plan	Strategic Outcome 3 and 4	X									
AR	Equality Delivery System2 (EDS2) & Workforce Race Equality Standard (WRES) Submission * (Jul & Sep 2017)	Strategic Outcome 3 and 4	AR		X *	X *	X Update		X Update			
AR	Pulse Check Results and Staff Survey Plan						X					
AR	Approval of Equality Delivery System2 (EDS2) 2017/18	Strategic Outcome 3 and 4					X					
SH	Review SOs, SFIs, SoD	FT Constitution Standing Orders					AR					
SH	Trust Sealings	FT Constitution Standing Orders	X							X		

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
SH	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	AR									
SH	Board Assurance Framework Update	Licence Condition FT4				X		X			X	
SH	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			X							
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance - Confidential - Mental Health Act Committee - Quality Committee - Safeguarding Committee - People & Culture Committee	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X
SH	Governance Improvement Action Plan	Licence Condition FT4	X	X	X	X	X	X				X
SH	Fit and Proper Person Declaration	Licence Condition FT4		X								X
MP	Emergency Planning Report (EPPR)								X			
SH	Board Effectiveness Survey			X			X					
SH	Report from Council of Governors Meeting (for information)		X	X		X	X	X		X	X	X
SH	Review of Policy for Engagement between the Board & COG										AR	
SH	Board Development Programme										X	
LWS	Business Plan 2017-18 Monitoring		X			X		X			X	
LWS	Measuring the Trust Strategy			X								
OPERATIONAL PERFORMANCE												
CG, CW, AR, MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	Licence Condition FT 4 Strategic outcome 1 Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
QUALITY GOVERNANCE												
CG	Position Statement on Quality (Incorporates Strategy and assurance aspects of Quality management) Quarterly publication of specicified information on death in Jan/Mar/Jun/Sep Includes Annual Review of Recovery Outcomes in November and Annual Looked After Children Report in December	Strategic Outcome 1 CQC and Monitor	X	X	X	X	X	X	X	X	X	x
CG/JS	Safeguarding Children & Adults at Risk Annual Report	Children Act Mental Health Standard Contract					AR					
CG	Control of Infection Report	Health Act Hygiene Code		AR								
JS	Re-validation of Doctors	Strategic Outcome 3			AR							
CG	Annual Review of Recovery Outcomes *							X				
CG	Annual Looked After Children Report *									X		

* Incorporated in Quality Position Statement