Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Board of Directors

Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital, Derby
28 March 2018 13:00 - 28 March 2018 16:30

INDEX

NHS
Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – WEDNESDAY 28 MARCH 2017
TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOPMENT, 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	Sign up to the Armed Forces Covenant	Ifti Majid
3.	1:35	Minutes of Board of Directors meeting held on 28 February 2018	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.	1:40	Questions from governors or members of the public	Caroline Maley
6.	1:45	Chair's 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	Claire Wright/Amanda Rawlings/Carolyn Green/ Kath Lane
9.	2:30	Position Statement on Quality Learning from Deaths - Mortality Report	Carolyn Green
10.	2:40	Strategy Refresh 2018-21	Lynn Wilmott-Shepherd
11.	2:50	Business Plan 2018-19	Lynn-Wilmott Shepherd
3:00 B R E A K			
12.	3:15	Board Committee Assurance Summaries and Escalations: Quality Committee 8 March, Audit & Risk Committee 20 March, People & Culture Committee 22 March 2018 *(minutes of these meetings are available upon request)*	Committee Chairs
13.	3:25	Draft People Strategy 2018-21	Amanda Rawlings
14.	3:35	Staff Survey Results	Amanda Rawlings
15.	3:45	Gender Pay Gap	Amanda Rawlings
16.	3:55	Governance Improvement Action Plan Actions Embeddedness Update	Sam Harrison
17.	4:05	Board Effectiveness Survey	Sam Harrison
18.	4:15	Board Assurance Framework (BAF) fifth and final issue 2017/18	Sam Harrison
CLOSING MATTERS			
19.	4:25	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
2018/19 Board Forward Plan			-
Report from Council of Governors meeting 21 March 2018			-

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

The next meeting will be held at 9.30am on 1 May 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 • Elective member for CHETWYND, the Toton and Chilwell Neighbourhood Forum representing the community's interest in the HS2 high speed rail project.	(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 • 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.

Chief Executive's Report to the Public Board of Directors

Purpose of Report:

To seek approval from the Board of Directors for the Trust to pledge and support the *'Armed Forces Covenant'* for all current and former serving armed forces personnel who have contact with the Trust whether as patients, staff, carers or the general public.

Context

1. What is the Armed Forces Covenant?

The Armed Forces Covenant is a promise from the nation to those who serve or who have served, and their families, which says we will do all we can to ensure they are treated fairly and not disadvantaged in their day-to-day lives. The Armed Forces Covenant relies on the people, communities, and businesses of the UK to actively support it in order to make a difference.

The Government is committed to supporting the Armed Forces community by working with a range of partners who have signed the Armed Forces Covenant. The Covenant brings together the government, businesses, local authorities, charities and the public in order to support those who serve.

2. What does the Armed Forces Covenant mean for Organisations?

Organisations who wish to demonstrate their support for the Armed Forces community can sign the Covenant. Organisations can make a range of written and publicised promises to set out their support to members of the Armed Forces community who work in their business or access their products and services.

The level of support will depend on the size and nature of the organisation, but typically includes policies that: encourage reserve service; support employment of veterans and service spouses/partners; give the Armed Forces community a fair deal on commercial products and services. More than 800 businesses and charities have signed an Armed Forces Covenant to-date.

All Armed Forces Covenants are to be signed by a person in authority who can ensure that commitments are implemented and maintained. A draft copy of our covenant is attached as appendix 1 and the detailed document explaining the origins and aims of the covenants is at appendix 2

3. Fit with our Vision and Values

Our Vision is all about 'Making a positive difference to people's lives by improving health and wellbeing'. The signing of the covenant and associated pledges is the Board taking direct action to support the health and wellbeing of those who are serving, have served and their families.

It is absolutely about compassionately putting people first and doing so in a respectful way thus in line with and supportive of our values.

4. Benefits of employing ex-service personnel

Deloitte conducted research in 2016 to recognise the potential of ex-service personnel. It found that organisations that have employed members of the Armed Forces are very positive about the value they bring, as 72 per cent of organisations would definitely recommend employing veterans and 80 per cent say they understand how military skills fit in with their organisation's needs.

At a time when as a Trust we are keen to increase retention rates in our staff, research suggests that armed forces personnel stay up to twice as long on average in a role as the NHS 5 year average:

Research by Deloitte looking at armed forces personnel joining NHS organisations suggested that 44 per cent of respondents agreed with the statement that Armed Forces employees had lower rates of sickness absence in comparison to civilian employees. The remaining respondents felt that the rates of sickness absence were no different.
Two respondents were able to provide sickness absence averages for their reservists versus their organisation's average, which displayed a significant difference. The average reservist sickness absence equalled 0.093 compared to the whole workforce average of 4.65.

5. What are the pledges we sign up to?

All Organisations slightly tailor how they sign up to the pledges in the covenant. For our Trust I propose that we will endeavour to uphold the key principles of the Armed Forces Covenant, which are:

- No member of the Armed Forces Community should face disadvantage in the provision of healthcare services compared to any other citizen
- In some circumstances special treatment may be appropriate especially for the injured or bereaved.
- Promoting the fact that we are an armed forces-friendly organisation;
- Seeking to support the employment of veterans and working with the Career

Transition Partnership (CTP) and Military Step into Health programme, in order to establish a tailored employment pathway for Service Leavers;

- Striving to provide support services for Service spouses and partners; endeavouring to offer a degree of flexibility in granting special leave before, during and after a partner's deployment;
- Supporting our employees who choose to be members of the Reserve Forces, including by accommodating their training and deployment where possible;
- Offering support, where possible, through our Health Ambassadors programme to our local cadet units, either in our local community or in local schools;
- Seeking to support employees who are cadet force adult volunteers
- Aiming to support Armed Forces Day and actively demonstrating our support to the armed forces through promotion at Trust run events

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

Assurances

- We are upholding our values through creating meaningful partnerships
- We strive for inclusion and full engagement from all parts of our community

Consultation

The report has not been to any other group or committee

Governance or Legal Issues

There is a national recommendation that Health and Social Care Organisations agree to participate in the Armed Forces Covenant

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 Signing up to this covenant works in tandem with our equalities duty. We are showing that people who currently or have served in the armed forces either full time or as reservists and their families may on occasions need help and support to meet their full potential and to have the same health outcomes as the local population. We are pledging to make those adjustments wherever we can	

Recommendations

The Board of Directors is requested to agree to sign up to the Armed Forces Covenant

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

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

Derbyshire Healthcare
NHS Foundation Trust

We, the undersigned, commit to honour the Armed Forces Covenant and support the Armed Forces Community. We recognise the value Serving Personnel, both Regular and Reservists, Veterans and military families contribute to our business and our country.

Signed on behalf of:

Derbyshire Healthcare NHS Foundation Trust

Signed: _____

Name:

Position:

Date:

Signed on behalf of:

Ministry of Defence

Signed: _____

Name:

Position:

The Armed Forces Covenant

An Enduring Covenant Between

The People of the United Kingdom
Her Majesty's Government

– and –

All those who serve or have served in the Armed Forces of the Crown

And their Families

The first duty of Government is the defence of the realm. Our Armed Forces fulfil that responsibility on behalf of the Government, sacrificing some civilian freedoms, facing danger and, sometimes, suffering serious injury or death as a result of their duty. Families also play a vital role in supporting the operational effectiveness of our Armed Forces. In return, the whole nation has a moral obligation to the members of the Naval Service, the Army and the Royal Air Force, together with their families. They deserve our respect and support, and fair treatment.

Those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

This obligation involves the whole of society: it includes voluntary and charitable bodies, private organisations, and the actions of individuals in supporting the Armed Forces. Recognising those who have performed military duty unites the country and demonstrates the value of their contribution. This has no greater expression than in upholding this Covenant.

Section 1: Principles Of The Armed Forces Covenant

1.1 We **Derbyshire Healthcare NHS Foundation Trust** will endeavour in our dealings to uphold the key principles of the Armed Forces Covenant, which are:

- *no member of the Armed Forces Community should face disadvantage in the provision of healthcare services compared to any other citizen*
- *in some circumstances special treatment may be appropriate especially for the injured or bereaved.*

Section 2: Demonstrating our Commitment

2.1 We recognise the value serving personnel, reservists, veterans and military families bring to our healthcare delivery. We will seek to uphold the principles of the Armed Forces Covenant, by:

- *promoting the fact that we are an armed forces-friendly organisation;*
- *seeking to support the employment of veterans and working with the Career Transition Partnership (CTP) and Military Step into Health programme, in order to establish a tailored employment pathway for Service Leavers;*
- *striving to provide support services for Service spouses and partners; endeavouring to offer a degree of flexibility in granting special leave before, during and after a partner's deployment;*
- *supporting our employees who choose to be members of the Reserve Forces, including by accommodating their training and deployment where possible;*
- *offering support, where possible, through our Health Ambassadors programme to our local cadet units, either in our local community or in local schools;*
- *seeking to support employees who are cadet force adult volunteers*
- *aiming to support Armed Forces Day and actively demonstrating our support to the armed forces through promotion at Trust run events.*

2.2 We will publicise these commitments through our literature and/or on our website, setting out how we will seek to honour them and inviting feedback from the Service community, our staff and those who use our services on how we are doing.

MINISTRY OF DEFENCE

THE ARMED FORCES COVENANT

THE ARMED FORCES COVENANT

An Enduring Covenant Between

The People of the United Kingdom

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– and –

All those who serve or have served in the Armed Forces of the Crown

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Those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

This obligation involves the whole of society: it includes voluntary and charitable bodies, private organisations, and the actions of individuals in supporting the Armed Forces. Recognising those who have performed military duty unites the country and demonstrates the value of their contribution. This has no greater expression than in upholding this Covenant.

GUIDANCE ON THE ARMED FORCES COVENANT

Figure 1: The Covenant Diagram

This document accompanies the Armed Forces Covenant and provides guidance on how it is to be put into effect, by describing:

A. The parties to the Covenant.

B. A definition of the Armed Forces Community.

C. The scope of the Covenant, by outlining the areas in which it can be expected to apply.

D. Obligations and principles which flow from the Covenant.

This guidance note is available for the use of any organisation – Government Departments, the Armed Forces, local authorities, charitable bodies etc – which wishes to apply the Covenant to its particular circumstances. It will be updated as necessary.

The guidance note does not describe the actions being taken by the UK Government to support the Armed Forces Covenant. These are set out in a separate document, entitled **"The Armed Forces Covenant: Today and Tomorrow"**.

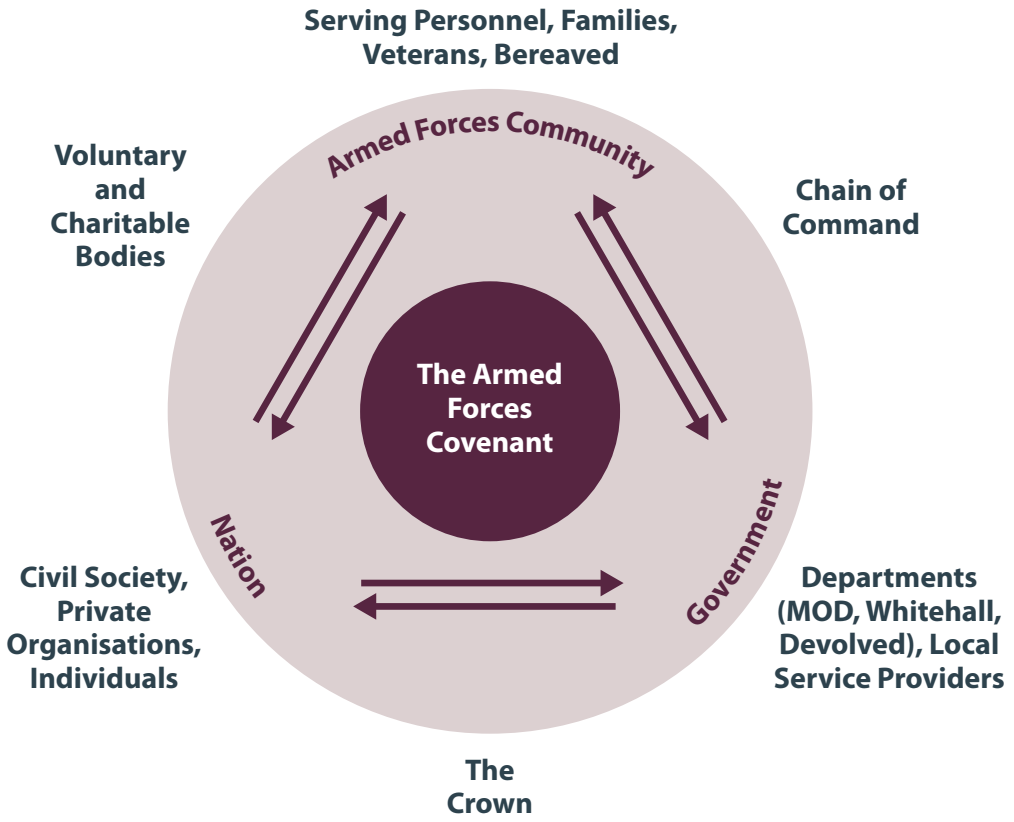
A. PARTIES TO THE ARMED FORCES COVENANT

The Armed Forces Covenant is a covenant between the Armed Forces Community, the Nation and the Government.

Figure 2, building on the core Covenant diagram, shows the place occupied by different groups in this context. It illustrates that some bodies and individuals are associated mainly with one role, but others have more than one role. The dual role of the Chain of Command, as both a part of the machinery of government and at the heart of each of the Services, is especially important to the effective operation of the Covenant. Voluntary and charitable bodies are part of civil society, but also embody the Armed Forces Community at commemorative events.

A more detailed definition of how the Armed Forces Community is made up is contained in the next section.

Figure 2: Parties to the Covenant



B. DEFINITION OF THE ARMED FORCES COMMUNITY

The Armed Forces Community is defined, for the purposes of the Armed Forces Covenant, as including all those towards whom the Nation has a moral obligation due to Service in HM Armed Forces. Inclusion in the community is neither dependent on nor limited by strict criteria, nationality, or legal definitions, and it does not confer any legal rights.

The whole of this community is covered by the Covenant and the obligations and principles which flow from it. The obligations are owed to the Armed Forces Community as individuals, as well as collectively. Being part of this community, of some 10 million people, entitles an individual to recognition and sometimes to support. However the level of support made available will vary. It will take into account the need for assistance, and may also reflect what an individual has contributed through Service. Inclusion in the community does not, therefore, mean identical entitlement to support.

The Armed Forces Community includes:

Regular Personnel – Individuals currently serving as members of the Naval Service (including the Royal Navy and Royal Marines), Army or Royal Air Force.

Reservists – Volunteer Reservists, who form the Royal Naval Reserve, Royal Marine Reserve, Territorial Army and the Royal Auxiliary Air Force, and Regular Reservists, who comprise the Royal Fleet Reserve, Army Reserve and Royal Air Force Reserve.

Veterans – Those who have served for at least a day in HM Armed Forces, whether as a Regular or as a Reservist.

Families of Regular Personnel, Reservists and Veterans – The immediate family of those in the categories listed above. This is defined as spouses, civil partners, and children for whom they are responsible, but can where appropriate extend to parents, unmarried partners and other family members.

Bereaved – The immediate family of Service Personnel and veterans who have died, whether or not that death has any connection with Service.

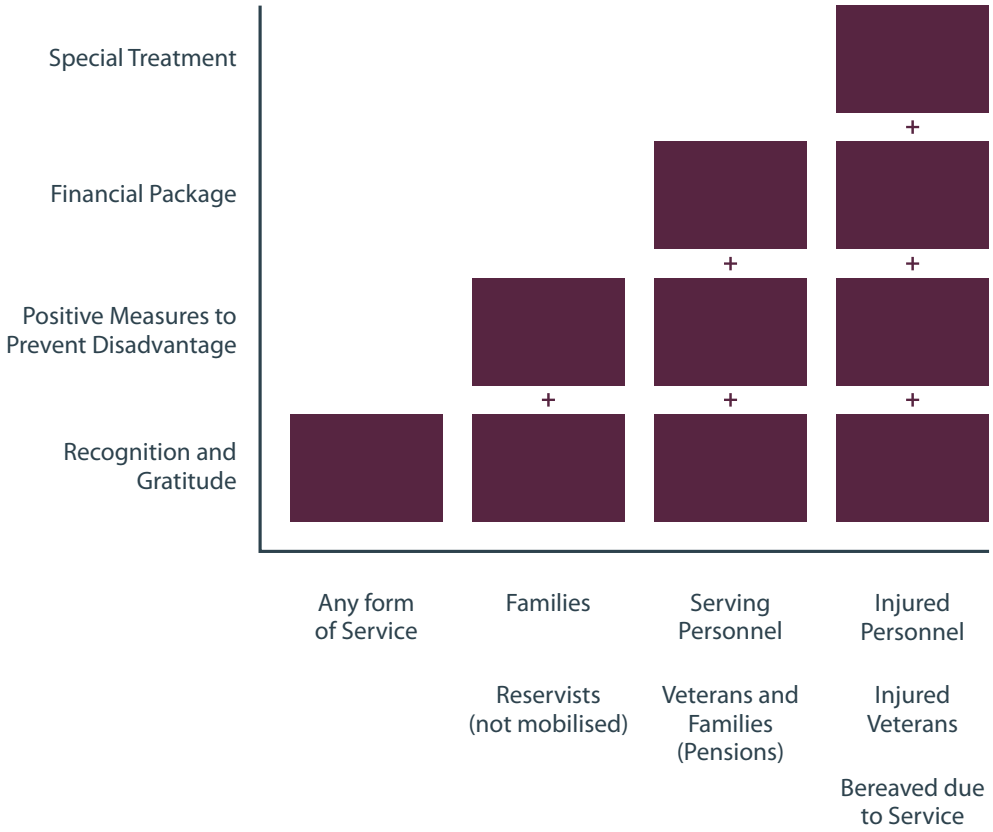
Levels of Support

As noted above, support to the Armed Forces Community will reflect the needs and commitment of individuals within that community and the moral obligation of society towards them. However it will generally be cumulative in nature, with members of certain groups receiving more levels of support than others. This is illustrated in Figure 3. Although a broad representation of this type can only be indicative, it shows for example that the support available to serving personnel would normally be in three areas – recognition and gratitude, positive measures to prevent disadvantage, and a financial package.

Reservists are in a special position, as although they receive the same level of support as their Regular counterparts when mobilised, the commitment they are making when not mobilised must be recognised. The Reservist has a greater liability than the wider civilian

population and they should be fully supported in meeting the additional challenges they face.

Figure 3: Levels of Support Available



The Supporting Civilian Community

Beyond the Armed Forces Community, and outside the scope of the Armed Forces Covenant, are other groups which play an important role in meeting defence objectives. These groups carry out an extremely wide range of functions, and include (but are not limited to) members of the Merchant Navy, the Royal Fleet Auxiliary, other defence civilians and contractor staff; cadets and the adult volunteers who support them; and the extended families of Serving personnel.

All supporting civilians, in very different ways, make valuable contributions for which they deserve recognition and in some cases support. Some groups support the Armed Forces directly, consistent with the Whole Force Concept. When members of these groups are deployed alongside members of the Armed Forces, they are entitled to increased levels of care and support, including in the event of injury or death, and often on a comparable basis to their Armed Forces colleagues.

C. SCOPE OF THE COVENANT

The Armed Forces Covenant sets a framework for how the Armed Forces Community can expect to be treated, but it is not possible to specify in detail how it should be applied in every case and at every time. The demands of Service and other constraints may prevent these expectations and aspirations being met in some circumstances. However the Covenant should influence policy, service delivery and standards in the areas and ways set out below. In many cases these will be a responsibility of Central Government Departments and Devolved Administrations but, in other cases, responsibility will lie with local service providers or organisations within the voluntary or commercial sectors. Particular attention will be required when public services are subject to reform or to greater local control.

This section describes the expectations and aspirations implicit in the Armed Forces Covenant, but not the specific actions being taken to achieve them. For the UK Government, these actions are being published separately in **"The Armed Forces Covenant: Today and Tomorrow"**.

1. Terms and Conditions of Service

Service personnel should be sustained and rewarded by Terms and Conditions of Service (TACOS) which recognise the freedoms and choices that they have voluntarily given up. These TACOS should be fair to personnel and wherever possible give flexibility to match family circumstances, whilst meeting the needs of the MOD and conforming to wider Government policy. They will be kept under regular review by the MOD.

The terms under which individuals serve, such as enlistment and engagements, are binding in every sense. The conditions offered, in return for the commitments and risks to which Service personnel are subject, should be fair in terms of both the financial and non-financial package. The recommendations of an independent body should constitute an integral part of the process used to determine pay.

2. Healthcare

The Armed Forces Community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live. For Serving personnel, including mobilised Reservists, primary healthcare is provided by the MOD, whilst secondary care is provided by the local healthcare provider. Personnel injured on operations should be treated in conditions which recognise the specific needs of Service personnel, normally involving a dedicated military ward, where this is appropriate for them, and medical rehabilitation in MOD facilities. For family members, primary healthcare may be provided by the MOD in some cases (eg when accompanying Service personnel posted overseas). They should retain their relative position on any NHS waiting list, if moved around the UK due to the Service person being posted.

Veterans receive their healthcare from the NHS, and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need. Those injured in Service, whether physically or mentally, should be cared for in a way which reflects the Nation's moral obligation to them whilst respecting the individual's wishes. For those with concerns about their mental health, where symptoms may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of Armed Forces culture.

3. Education

Children of members of the Armed Forces should have the same standard of, and access to, education (including early years services) as any other UK citizen in the area in which they live. The Services should aim to facilitate this in the way they manage personnel, but there should also be special arrangements to support access to schools if a place is required part way through an academic year as a consequence of a posting. For personnel posted overseas, the MOD provides early years and educational facilities where the numbers support it, although the range of provision and choice may not be as great as in the UK. In certain cases assistance will be available to support Service children's continuity of education, given the requirement for mobility.

Service personnel should expect to receive appropriate training and education for both personal and professional development, including the opportunity to gain nationally recognised civilian qualifications, in order to support them throughout their Service career and to prepare them for life after leaving the Service.

4. Housing

In addressing the accommodation requirements of Service personnel, the MOD seeks to promote choice, recognising the benefits of stability and home ownership amongst members of the Armed Forces where this is practicable and compatible with Service requirements, and also that their needs alter as they progress through Service and ultimately return to civilian life. Where Serving personnel are entitled to publicly-provided accommodation, it should be of good quality, affordable, and suitably located. They should have priority status in applying for Government-sponsored affordable housing schemes, and Service leavers should retain this status for a period after discharge. Personnel may have access to tailored Armed Forces housing schemes or financial arrangements, depending on their circumstances, to help them in purchasing their own property. Those injured in Service should also have preferential access to appropriate housing schemes, as well as assistance with necessary adaptations to private housing or Service accommodation whilst serving. Members of the Armed Forces Community should have the same access to social housing and other housing schemes as any other citizen, and not be disadvantaged in that respect by the requirement for mobility whilst in Service.

5. Benefits and Tax

Members of the Armed Forces Community should have the same access to benefits as any UK citizen, except where tailored alternative schemes are in place. They will also contribute through taxation, but the taxation system may be adapted to reflect their particular circumstances (a current example would be the Contribution in Lieu of Council Tax arrangements).

6. Responsibility of Care

The Government, working with the Chain of Command, has a particular responsibility of care towards members of the Armed Forces. This includes a responsibility to maintain an organisation which treats every individual fairly, with dignity and respect, and an environment which is free from bullying, harassment and discrimination. Special account must be taken of the needs of those under 18 years of age. The Government has a responsibility to promote the health, safety and resilience of Servicemen and women; and to ensure that they are appropriately prepared, in the judgement of the Chain of

Command, for the requirements of any training activities or operations on which they are to be engaged. However operational matters, including training and equipment, fall outside the scope of the Armed Forces Covenant.

7. Deployment

The special impact of operational deployment on both personal and family life should be recognised. Depending on the nature of the operation, this may include financial support to deployed personnel, welfare support to individuals and family members, and where possible facilities to enable good communications with home.

8. Family Life

Service families give up certain freedoms and choices in order to support the Service. To sustain family life, family members should have the same access to childcare, training and employment opportunities as any other citizen. Support should be available to minimise the impact of mobility caused by Service, drawing on active monitoring by the Chain of Command. Support should also take into account the effects of postings to remote locations, often away from family connections, for example in promoting transport and accessibility measures.

9. Commercial Products and Services

It is for the commercial sector to determine its approach to members of the Armed Forces Community. The Government should work with the commercial sector towards a situation where they have as good access to commercial products and services, including financial services, as any other citizen. Providers of products and services should be encouraged to understand and mitigate the circumstances faced by this community, such as mobility and deployment, and to welcome and cater for its members as good and valuable customers.

10. Transition

Support should be available for all Service personnel in order to assist their transition from Service to civilian life. Provision should include training, education, appropriate healthcare referral and job-finding preparation and assistance. It should also include information, advice and guidance on such matters as housing and financial management, and the availability of support from Government Departments and the Voluntary and Community sector. The level of support will be dependent upon individual circumstances.

11. Support After Service

The Covenant involves an obligation for life, and the commitment and sacrifices made by veterans in the past, as well as their continuing value to society, should be properly recognised in the support they receive. In accessing services, former members of the Armed Forces should expect the same level of support as any other citizen in society. Pension schemes should be fair and appropriate to the particular circumstances of Service personnel. All veterans will be able to access advice and in some cases additional support, from the MOD (Service Personnel and Veterans Agency), elsewhere in Government, and the charitable sector, although their access may be affected if they do not live in the UK.

Those who have been injured in Service, or have a health condition relating to Service, should receive additional support which may include a financial element depending on

their circumstances (eg through the Armed Forces Compensation Scheme or War Pension Scheme). Bereaved families should receive assistance commensurate with the loss that they have suffered, including help during the vital, but difficult, Inquest process.

12. Recognition

The Armed Forces Community is entitled to appropriate recognition for the unique Service which it has given, and continues to give, to the Nation, and the unlimited liability which the Service person assumes. This recognition will include national commemorations and celebrations such as Remembrance Sunday and Armed Forces Day. The award of campaign medals and individual gallantry awards will continue to be used in recognition of individual sacrifice and meritorious service. The HM Armed Force Veterans Badge is available to all veterans in recognition of their service.

13. Participation as Citizens

The Armed Forces Community should be able to participate as citizens to the same extent as any UK citizen, subject to the necessary constraints on the activities of public servants. This includes taking a full part in the electoral process. Members of the Armed Forces Community who are not UK citizens should be able to access routes to citizenship as easily as others seeking citizenship, unaffected by any Service overseas.

14. Changes in Defence

The Armed Forces will always need to evolve to meet the challenges they face. That will inevitably lead, from time to time, to turbulence and uncertainty in the lives of Serving personnel and their families. Such changes should be managed in a way which treats individuals fairly and minimises uncertainty wherever possible.

15. Recourse

Members of the Armed Forces Community should have means of recourse open to them, if they believe that they are not being treated in a fair and appropriate way. Established routes of recourse such as complaints processes or Ombudsmen should be sensitive to the particular circumstances of the Armed Forces Community. In addition, for Serving personnel and those who have recently left service, there should be a responsive system for handling complaints relating to their service in the Armed Forces, overseen by the Service Complaints Commissioner.

D. OBLIGATIONS AND PRINCIPLES

Figure 4 superimposes on the core Covenant diagram a summary of the obligations which the different parties to the Armed Forces Covenant owe to each other. It also illustrates that all these obligations must, to be effective, be underpinned by trust and goodwill on all sides. However the obligations are not conditional; the duty of a member of the Armed Forces to serve is never dependent on other considerations.

Figure 4: Obligations

These obligations do not require detailed explanation, but it is possible to derive from them a number of additional principles, which should similarly govern the actions of the Nation, the Government and the Armed Forces Community.

The Nation should:

1. Honour the commitment and sacrifice of the Armed Forces Community.

2. Celebrate the work of those charitable and voluntary bodies which help to support that community.

3. Strive to keep close the links between the Armed Forces and the society they defend.

The Government's aspiration for the Armed Forces Community should be:

4. No disadvantage due to Service in the provision and continuity of public services.

5. No disadvantage in dealings with wider society, eg in accessing commercial services, or in pursuing careers outside the Armed Forces (as spouses, Reservists, or veterans).

To achieve this, the Government should consider:

6. Measures to minimise the social and economic impact of military life for those currently serving and their families.

7. Positive measures to enable equality of outcome with other citizens.

8. Special treatment for the injured and bereaved, as proper return for their sacrifice.

Reflecting the Nation's respect, serving members of the Armed Forces should seek to:

9. Uphold the standards and values of their respective Services.

10. Not bring the Armed Forces into disrepute in any of their actions.

11. Engage with society, and understand their relationship with it.

12. Use their time in Service to build resilience and the skills needed in civilian life.

And the whole Armed Forces Community should:

13. Take pride in their status.

14. Identify themselves as members of the Armed Forces Community when appropriate.

15. Help themselves, including by understanding their rights and obligations.

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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 28 February 2018

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4:40pm

PRESENT:	Caroline Maley	Trust Chair
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director
	Geoff Lewins	Non-Executive Director
	Dr Anne 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
	Lynn Wilmott-Shepherd	Interim Director of Strategic Development
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Celestine Stafford	Assistant Director People and Culture Transformation
	Sue Turner	Board Secretary (minutes)
For item DHCFT 2018/081	Nicola Fletcher	
For item DHCFT 2018/018	Martine King	Early Intervention Service Dual Diagnosis Link Nurse and head of PARC Group
For item DHCFT 2018/018	Mark Wright	Early Intervention Service and member of PARC Group
For item DHCFT 2018/018	Joanna Griffiths	Student Nurse
For item DHCFT 2018/018	Nicola	PARC Group service receiver
For item DHCFT 2018/018	James	PARC Group service receiver
For item DHCFT 2018/018	Josh	PARC Group service receiver
For item DHCFT 2018/024	Joanna Miatt	Consultant Psychologist Adult Eating Disorders Service
For item DHCFT 2018/024	Elizabeth Banahan	Team Manager CAMHS (Child and Adolescent Mental Health Services) Eating Disorders Service
APOLOGIES:	Richard Wright	Non-Executive Director
	Amanda Rawlings	Director of People & Organisational Effectiveness
VISITORS:	John Morrissey	Lead Governor and Public Governor, Amber Valley South
	Surrinder Kaur	Care Quality Commission
	Sarah Bennett	Care Quality Commission

DHCFT 2018/017	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** Trust Chair, Caroline Maley, opened the meeting and welcomed everyone. Apologies were noted from Non-Executive Director (NED), Richard Wright, who had reached Kingsway site but had to return home due to concerns with travelling safely in the snow across Derbyshire.

	Apologies had also been received from the Director of People and Organisational Effectiveness, Amanda Rawlings. She was represented by Celestine Stafford, Assistant Director People and Culture Transformation. It was clarified that Celestine is employed by Derbyshire Community Healthcare Services NHS FT (DCHS) and is working with DHCFT under an honorary contract. Chief Operating Officer, Mark Powell, was running an emergency meeting to establish the safety of the Trust's services in Chesterfield and the High Peak given the current difficult weather conditions and would shortly join the meeting. Stacy Rach, Acting Lead Nurse from Morton Ward had been invited to shadow Caroline Maley at today's meeting but was unable to travel to Derby due to the difficult travelling conditions. Caroline Maley referred to the Declarations of Interest Register and suggested that Deputy Trust Chair, Dr Julia Tabreham's declaration in respect of her husband's inspection services carried out on behalf of Lloyds Register be removed as it was not considered that this would give rise to a conflict of interest. Julia Tabreham informed the Board that she was no longer involved with the Parliamentary and Health Service Ombudsman's contribution to establishing NHS complaints advocacy support in Ireland and this entry on the Register could also be removed. It was noted that Non-Executive Director, Richard Wright, was no longer Chair of the UTC Sheffield Multi Academy Trust. **ACTION: Declarations of Interest to be updated in respect of Julia Tabreham and Richard Wright**
DHCFT 2018/018	**<u>SERVICE USER STORY</u>** Assistant Director of Clinical Professional Practice, Nicola Fletcher, introduced Martine King, from the Early Intervention (EI) Service and founder of the PARC Group. Mark Wright from the EI Service and member of PARC, accompanied Martine along with Joanna Griffiths, a student nurse and Nicola, James and Josh, service receivers who had been invited to talk about their recovery through the PARC programme. The PARC (Psychosis and the reduction of cannabis (and other drugs)) is a group run as part of the EI programme in Derby. The Board heard how PARC believe in supporting people as a whole person. Their methodology is based on connectivity and this is the motivation for their clients which is the opposite of addiction. They also work towards achieving people's aspirations with them through weekly group sessions along with a sharing of life experiences which drives their approach through a twelve week recovery programme. Martine explained how a lot of PARC's work includes working with Adverse Childhood Experiences (ACE). Around 70% of people in the group have numerous ACE experiences which have affected their later life health and wellbeing. Josh described how he had broken down his childhood experiences that had caused him trauma. These childhood experiences that affected him could affect his future but he is determined not to let them. Nicola shared how support from PARC and other members of the recovery programme had enabled her to adapt her way of thinking in a more positive way and had empowered her to live independently. James talked about how the group format works towards recovery and was proud of being drug free for two years. Chief Executive, Ifti Majid, observed that the group sessions help to shift people's thinking and also provides support and learning from each other. He was interested to know how Board could improve access and support and heard about how difficult it is to describe how you feel in a ten minute appointment with your GP. Having support and empathy from psychiatrists and clinicians is important. The common theme is the need to be listened to as an expert in their own feelings and be allowed to be work with psychiatrists so they are equally involved in their recovery.

	Director of Nursing and Patient Experience, Carolyn Green, invited Josh, Nicola and James to work with her to help design a strategy for the Trust's dual diagnosis service that will ensure that mental health and physical health is better addressed within the Trust treating the whole person and all of their needs holistically. On behalf of the Board, Caroline Maley thanked Martine and members and service users of PARC for their inspirational story that had enabled to Board to reflect on the invaluable contributions that service users bring to our services by being experts by experience. **RESOLVED: The Board of Directors received and noted the innovative practices developed through the family first model**
DHCFT 2018/019	**MINUTES OF THE MEETING DATED 31 JANUARY 2018** The minutes of the previous meeting, held on 31 January were agreed and accepted as an accurate record subject to the third paragraph of the Chief Executive's Report item DHCFT 2018/006 being corrected to report that the Derbyshire GPFV (General Practice Forward View) STP (Sustainability Transformation Plan (Joined Up Care Derbyshire)) Workforce plan has been accepted by NHS England and the Derbyshire System was given an initial rating of "partial assurance". The word *'resulting'* in the final sentence of the fifth paragraph of the Integrated Performance Report (IPR) on page 6 under item DHCFT 2018/006 would be replaced with *'demonstrating'.*
DHCFT 2018/020	**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 2018/021	**CHAIR'S UPDATE** Caroline Maley's report provided an update on the recent meetings and visits to staff and services since the last meeting in January. She provided a verbal update on her meeting with Pauline Latham MP which had included discussion on the services the Trust provides along with the priorities and challenges we are facing. She and Pauline Latham also discussed the Dying to Work Charter and how support is given to staff with terminal diagnoses so they can continue to work with dignity. Caroline undertook keep Pauline Latham updated on how the release of IPP (Imprisonment for Public Protection) individuals will affect the people of Derbyshire as this was a cause of concern for her regarding her constituents. Caroline was pleased to report that she had also offered Pauline Latham and her staff mental health awareness training which is a service the Trust offers to other MPs and their staff in the county. Julia Tabreham questioned the cancellation of the Joined Up Care Derbyshire meeting and was provided with assurance that it was agreed that it would be more sensible to have a smaller group to plan and prepare for the NHS England/Improvement stocktake meeting on 7 March. **RESOLVED: The Board of Directors noted the activities of the Trust Chair throughout February**
DHCFT 2018/022	**CHIEF EXECUTIVE'S REPORT** The Chief Executive's report provided the Board of Directors with an update on developments occurring within the local Derbyshire health and social care community.

	The report also updated the Board on feedback from external stakeholders such as commissioners and feedback from staff. Ifti Majid's report was used to support strategic discussion on the delivery of the Trust strategy. Ifti made reference to the effects that Brexit might have on the Trust's workforce supply and the risks that could impact on the Trust. Although these issues are political in nature he emphasised how the Board remains sighted on risks relating to workforce issues and that they are covered in the Board Assurance Framework (BAF) and are kept under ongoing review through our risk assurance processes to enable the Board to decide on appropriate action to be taken when risks materialise or increase. Ifti shared with the Board his experience of visiting the children's services at the Lighthouse and Ivy House school. He described how nurses at Ivy House are supporting to the Trust's new vision and are working with children with challenging health conditions that enables these children to participate in school. The lessons to be learnt from this visit was to support these remote specialist teams to ensure that they feel part of our bigger organisation especially as they are located away from the main Trust sites. Ifti Majid referred to the Director of Public Health's annual report that was appended to his report. He introduced Cate Edwynn, Derby City Director of Public Health who had been invited to make a presentation to the Board on health inequalities in the Derby population through the fictional portrayal of two families - one in Allestree and the other in in Arboretum - that covered health issues and key statistics through a storytelling approach. A noticeable theme throughout the report and the presentation was the widening gap in health inequalities between the two wards in Derby and how by following the 'Marmot City' principle, the life expectancy gap between the poorest and most affluent residents can be reduced and improvements can be made in education, health outcomes, life satisfaction and employment. The Board heard that the strategic leadership of the Health and Wellbeing Board (HWB) will ensure that reducing inequalities would be a priority for the city and how the public health team at Derby City Council would like to work with the Trust to carry this strategy forward to reduce inequalities and improve the health and wellbeing of the local population. Anne Wright, Chair of the Safeguarding Committee, hoped that this strategy and working together in partnership with Derby City Council would help new and emerging communities as there is such a difference in their culture, education and language. Help was also needed to reduce the number of children under protection as numbers are increasing. Connecting these services would enable a system approach to provide joint needs at individual patient level. The Board supported having shared objectives with Derby City and hoped that the STP (Sustainability Transformation Plan) can also influence this objective. Ifti thanked Cate for giving the Board the opportunity to hear at first-hand what causes health inequalities which allowed the Board to think about austerity and how we can drive our strategy to enable us to do things differently. **RESOLVED: The Board of Directors noted and scrutinised the Chief Executive's update**
DHCFT 2018/023	**<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 January that focussed on workforce, finance, operational delivery and quality performance. Mark Powell was pleased to report that the Trust remains compliant against all Single Oversight Framework operational standards including continued progress with out of area placement and Data Quality Maturity Index. The financial position in terms of our end of

year position includes a surplus ahead of plan, a forecast over achievement of control total, a cash position that is better than plan and the delivery of our Cost Improvement Programme (CIP).

The report showed that our safety plan is progressing and the number of complaints under investigation is reducing. The Board noted that deep dive assurance reports on areas of concern will be received by the Board Committees during March. Outpatient clinic cancellations and delayed transfers of care will be reviewed by the Finance & Performance Committee and recruitment, retention and sickness absence hot spot areas will be continue to be monitored by the People & Culture Committee.

Anne Wright asked for assurance that patients who have their appointments cancelled are in fact seen by a consultant or clinician. Mark Powell informed her that cancellations are carried out well in advance of the appointment and the appointment is always rebooked. Unfortunately some patients do not attend their rescheduled appointment.

Julia Tabreham asked how the process of delayed transfers of care can be improved. Mark Powell explained the recently introduced process that is carried out though the Red2Green initiative under national guidance of delayed transfers of care. He is confident that the results of discussions that are taking place between the Trust and social care partners to ensure we help and support individuals will be seen over the next few months.

Ifti Majid questioned the level of parity of esteem regarding delayed transfer of care from a county and city perspective. Mark Powell responded that we have not had the same level of support for our inpatients in the city that we have had from the county. He is liaising with Derby City Council to ensure safe discharge and assured the Board that close work was taking place to ensure patients get the support they need for their safe and onward discharge.

Margaret Gildea, as Chair of the People & Culture Committee, referred to recruitment, staff retention and sickness absence hotspots and informed the Board that a report identifying hotspots where sickness absence is a symptom that may be linked to poor leadership is due to be received by the Committee in March that will allow us to start to put solutions in place to solve these problems' root cause.

The report showed that flu vaccination of Trust staff has increased. Julia Tabreham asked for assurance that we are focussing on front line staff. Celestine Stafford, Assistant Director People and Culture Transformation, advised that the increase in vaccinations is still quite heavily weighted to non-clinical areas and the target for next year will be 75%. Flu clinics have been set up at staff induction events to enable new starters to be vaccinated and it is expected that the additional resource that will be provided through the implementation of the new HR shared services will improve the effectiveness of the flu campaign.

Caroline Maley referred to medical agency spend as being a challenge and asked how our strategy to recruit to the medical workforce from India was progressing. Mark Powell was pleased to report that 2017/18 agency spend is likely to be £1m less than last year. A medic from India is due to transfer to Derby and there are more in the pipeline. The work we are doing in India is a shared approach and is a very positive initiative, and the onboarding of these individuals is an effective process.

Mark Powell reflected on the need to take the next stage of the workforce plan forward to address the strategic issues outlined in the IPR. Once the workforce plan has been developed for year two a review of year one will be undertaken to establish whether we have pursued the right objectives and that the right strategy is in place.

Medical Director, John Sykes, recognised that medical recruitment will be an ongoing challenge for some time. He was pleased to report that the study leave policy has now been finalised along with in-house training development. Job planning is being looked at

	in order to develop a more flexible workforce. It is hoped that in the long term we will have a much more integrated workforce to provide a service to patients. **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained limited assurance on current performance across the areas presented.**
DHCFT 2018/024	**<u>DEEP DIVE – JOINT EATING DISORDERS SERVICE</u>** Consultant Psychologist, Joanna Miatt from Adult Eating Disorders Service and Liz Banahan, Team Manager, CAMHS (Child and Adolescent Mental Health Services) Eating Disorders Service joined the meeting and talked to the Board about their experiences and challenges of operating the shared Eating Disorders service. The Adult Eating Disorders service was developed in 2007 and offers a range of treatments to improve the health and wellbeing of adults within Derbyshire. There are currently 128 service users currently in treatment cared for by approximately 10 whole time equivalent (WTE) staff. The current maximum waiting time is less than four weeks. Engagement and timeliness is key and the team are responsive to service users' needs. The Eating Disorders service was developed in 2016 for children and young people with a diagnosable eating disorder. The service has taken on 75 new referrals and has a caseload of 72 service users cared for by 6.7 WTE clinical staff. The criteria is based on early and family based intervention. They are currently meeting the access to waiting time of one week for urgent cases and four weeks for routine cases. Following the recent CQC formal visit to this service the teams received exceptionally positive feedback. The CQC confirmed that the service meets the five quality standards. The Board heard that the highlight from the CQC visit was being able to demonstrate a sense of caring which was also evidenced by service user feedback. In terms of achievements, the CAMHS service has seen a reduction in inpatient admissions. There has also been an 8% reduction in length of stay which is lower than the national benchmark. A high level of skills and training has taken place which has developed an ability to reflect and learn within the team. A national eating disorder conference is taking place later this month at which the team will be presenting. Joint working initiatives have also been developed with paediatricians and specialist inpatient units. Training is also being offered to all families involved and is something the team have been very committed to developing. Joanna and Liz talked about the challenges they face. Because the team is small and is of a specialist nature they feel vulnerable because they are significantly affected by sickness absence and maternity leave. Joanna informed the Board that she and the team felt criticised because they do not offer a service to people with a BME above 16.9. This is because the service is currently commissioned at this level and they do not have enough resource which means that the needs of about 75% of our adult population with eating disorders in Derbyshire are not able to be met by the service. LWS explained that a business case is currently being developed with Commissioners with a view to expanding the service if investment is available. Joanna would like to build up the workforce within the Eating Disorders service to meet this client group's needs to enable approximately 150 new referrals a year. Carolyn Green informed the Board that lack of resource had been raised a year ago with commissioners as the regions around Derbyshire had received extensive uplift to their adult services. The Board discussed the lack of funding to this service and Ifti Majid undertook to raise this matter with commissioners and with the Health and Wellbeing Boards as there is a cohort of people we are not reaching in Derbyshire, which is a much greater population than we were originally commissioned for. The issue of trying to deliver group intervention discussions and identifying facilities to carry out these sessions was raised. It was thought that use could be made of leisure

	centres or using the connections that the Trust has with fire service in Derby City could be followed up. The need to transfer clients into other specialist areas can be challenging for the service as this sometimes needs to be a combined initiative to ensure patients are return to recovery teams for an approach based on quality of life. Carolyn Green understood this challenge and agreed to support the Eating Disorders service by including this need in the new Eating Disorders Strategy. The Board congratulated the Joanna and Liz and Eating Disorders Service on the success of their recent CQC visit and committed to support them to resolve the challenges that were raised above. **ACTION: Funding for Eating Disorders to be escalated through the Health and Wellbeing Board and commissioners.** **ACTION: Introduction of a combined initiative with specialist areas to be captured in the new Eating Disorders Strategy.** **RESOLVED: The Board of Directors received and noted the presentation made by the Adults and CAMHS Eating Disorders Service.**
DHCFT 2018/025	**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's report included details of the publication of the National Inquiry into Mental Health and Carolyn Green was pleased to report that updated information shows that the Trust is placed below the national median for suicides, homicides and staff turnover. Data and a heat map on the incidences of mental health homicides enabled analysis of the risks in our county. A scorecard with the Trust's rate will be included in our Quality Account (2017-18). The report also highlighted the Trust's practice with mental capacity and decision making which has been reviewed and monitored by the Mental Health Act Committee. There has been a significant improvement in the application of the Mental Capacity Act in inpatient units following extensive practice development and quality improvement measures. Ifti Majid thought that the report highlighted the link between CPA (Care Programme Approach) and SI (Serious Incidents). Carolyn Green assured him that the revision of our care plan approach is something that the Quality Committee sought assurance on as well as the Board. The Committee is overseeing the intention to realign the CPA to the person's need. Good progress is being made in retesting this model which is the biggest change to be made to CPA within the Trust which will also be impacted by EPR (Electronic Patient Record) and compliance monitoring. **RESOLVED: The Board of Directors received the Quality Position Statement and gained significant assurance on safety with the Trust**
DHCFT 2018/026	**BOARD ASSURANCE SUMMARIES & ESCALATIONS** Assurance summaries were received from meetings of the Safeguarding Committee, Quality Committee and Mental Health Act Committee held in February. Committee Chairs summarised the escalations that had been raised and these were noted by the Board as follows: **Safeguarding Committee:** Committee Chair, Anne Wright, reported that the Committee continues to be focussed on the child protection plan and the impact that new and

	emerging communities are having on the community teams. She was pleased to report that the Committee is running well since its operational sub-group was formed which concentrates on the monitoring of operational issues. Compliance with Safeguarding Children and Safeguarding Adults training still remains an issue due to the difficulties in releasing staff when the teams are under pressure and this is being monitored by the People & Culture Committee. **Quality Committee:** Committee Chair, Julia Tabreham, informed the Board that she was pleased to report that continued improvement has been seen in reports received by the Committee which has aided challenge and discussion. The Committee remains concerned about the rise in violence to staff and is keeping this matter under close review. A challenge was raised through the Committee to ensure that transgender people are not 'outed' through data collection on PARIS (patient record system) unless patients wish to be known as 'transgender'. The Board understood that this is a complex issue that will need to be resolved within our data records process. **Mental Health Act Committee:** The assurance summary received from this Committee was the first to be issued in the new style format. Chair, Anne Wright, reported that the discussions and challenges held by the Committee are now more assurance focussed due to the effectiveness of the Mental Health Act Operational Group. The Committee received an excellent report on the use of the Mental Health Act (MHA) which also included data on the variances by ethnic grouping. Medical Director, John Sykes, undertook to produce a report for the Board summarising the trends of ethnicity relating to application of the MHA over a twelve month period. Caroline Maley thanked the Board Committee chairs for their feedback and asked the Board to reflect on the new style assurance summary to assess whether it provides assurance in an improved and more digestible format. **ACTION: Report on trends of ethnicity and the Mental Health Act to be submitted to the Board** **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries and Escalations**
DHCFT 2018/027	**<u>UPDATED CONSTITUTION</u>** Amendments to the Trust's constitution require the approval of both the Council of Governors and the Trust Board. This report presented by Director of Corporate Affairs & Trust Secretary, Sam Harrison, requests the Trust Board to approve changes to the constitution, previously approved by the Council of Governors (COG) at its meeting on 24 January 2018. Discussion had taken place with governors regarding constituencies within the Council of Governors as outlined in the Trust constitution and Sam Harrison gave a brief overview of the proposed changes. The number of public constituencies is proposed to reduce from 15 to 10 but there will be no difference in the overall number of the Trust's public governors or their roles. There is a proposal to increase the number of staff governors and this was considered to be a positive and helpful change by COG. There is a change to the partnership with organisations as Derbyshire Constabulary no longer wish to be involved in the COG but continue to work closely with the Trust for example through the Crisis Care Concordat. Minor changes relating to the quorum of COG from 20% to one third, with a minimum of six, was seen as an improvement by governors. There will be an increase in the membership of the Governor Nominations & Remuneration Committee from four to six members by one public and one staff governor. Reference made to Monitor is to be amended to NHS Improvement (NHSI) when it is not specific regulatory issues.

	John Sykes was concerned that Derbyshire Constabulary did not wish to be involved as a partnership organisation and was assured that this did not present an issue as they are already involved with the Trust from an operational perspective. The Board noted that it is good practice to refresh the constitution periodically and approved the changes to the constitution as set out in the report. The Board understood that because some changes in the constitution reflect the powers of duties of COG this will be formally raised at the Annual Members' Meeting in September and will involve at least one governor being in attendance to present the amendment. **RESOLVED: The Board of Directors:** **1. Considered and endorsed the proposed changes to the Constitution, previously approved by the Council of Governors on 24 January 2018:** • **Public Constituency** • **Staff Constituency** • **Partnership Organisations** • **Composition of the Council of Governors** • **Quorum** • **Termination of Tenure** • **Membership of Governors Nominations & Remuneration Committee** • **Significant transactions** • **Equality best practice** • **Regulatory body changes.** **2. Acknowledged that changing the termination of tenure voting will require a change to the Code of Conduct for the Council of Governors.** **3. Noted that once the Board has approved and endorsed the changes as agreed by the Council of Governors, the changes take immediate effect. The revised Constitution will be circulated to all directors and governors for information, and a copy sent to the regulator within 28 days of approval (this is the later of the two dates on which the Board and Council approved the changes). Copies on the Trust's website should also be updated.** **4. Noted that the changes to the composition of the Council of Governors (amendments to constituencies and an increase of staff governors) require presentation to the next Annual Members Meeting.** **5. Noted that the change to the powers of the Council of Governors related to quorum and termination of tenure require presentation to an Annual Members Meeting by a member of the Council of Governors where members will be given the opportunity to vote on whether they approve the amendment.** **6. Noted that should governors and/or members not agree with the changes regarding composition and powers as presented at the Annual Members Meeting, the Trust will revert back to the previous version of the Constitution.**
DHCFT 2018/028	**<u>LGBT+ COMMITMENTS UPDATE</u>** February is LGBT+ history month and Claire Wright's paper provided an update on the Board's LGBT+ commitments and priorities. Claire Wright highlighted the publicity and awareness of LGBT+ that is now being made through corporate induction, Connect and the staff magazine, social media, Derbyshire LGBT+ role model conference, all staff email interactions, meetings with LGBT+ colleagues, service users and others from inside and outside organisation. A lot of positive communication has resulted in empowered decision making regarding LGBT+ inclusive environment decisions such as the installation of gender neutral toilets at the Hartington Unit. The Trust will ensure continuing/expanding engagement and making connections including key LGBT+ events across the year and replacement of square rainbow stickers with rainbow heart stickers. An application will be made for appropriate Stonewall accreditation; there will be continued support to LGBT+ role models and allies along with

	the creation of vibrant a network to determine next key priorities. The Board recognised the progress being made in this area and appreciated that this work also supports the Trust's Equality Delivery System (EDS2) work. **RESOLVED: The Board of Directors:** **1) Received the update in line with their LGBT+ commitments** **2) Received significant assurance from progress with activity for LGBT+ inclusion**
DHCFT 2018/029	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** As a result of today's discussions it was agreed that risks associated with the Eating Disorders service not receiving appropriate funding will be included within the appropriate risk within the Board Assurance Framework. **ACTION: Reference to issues relating to the Eating Disorders commissioned resource to be incorporated within the established risk in the BAF**
DHCFT 2018/030	**MEETING EFFECTIVENESS** The Board was pleased that the Director of Public Health attended today's meeting which will ensure partnership working in improving the equality of people's health and wellbeing in the city of Derby.
DHCFT 2018/031	**2017/18 BOARD FORWARD PLAN** The 2018/19 forward plan will be submitted to the next meeting on 28 March.
The next meeting of the Board to be held in Public Session will take place at 1pm on Wednesday, 28 March 2018. **The location will be Conference Rooms A&B** **Research and Development Centre, Kingsway, Derby DE22 3LZ**	

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 28 March 2018

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on her activity with and for the Trust since the previous Board meeting on 28 February 2018. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

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

2. On Wednesday 21 February, I visited staff based at Walton Hospital in Chesterfield. The visit had been set up and hosted by Lynn Dunham. The visit enabled me to have a better understanding of the development of the CPA (Care Programme Approach) and the challenges on how to roll the changes out to all staff. I also was given my Triangle of Care badge which I wear with pride on my lanyard – again recognising the importance of carers in the work that we do.

   I was also pleased to join the Eileen Kinsella of the perinatal team for two visits to patients. This was really good for me to see how we work with mothers and babies who get great support from our team.

   The day ended with time with April Saunders, a staff Governor and the Trust's Physical Health Lead and James Walker, Smoking Cessation Advisor. They gave me an understanding of the challenges around our Smoking Cessation Policy and working with GP surgeries on the physical health agenda.

3. I attended a gathering on 19 March to celebrate the completion of the refurbishment of Kedleston Unit. We heard about the size and complexity of the task from the Capital Projects Team, who demonstrated how they seek to put the service requirements at the centre of their planning. We also had an insight into the future developments at the Unit and the plans for how to bring the Unit fully back up to operational capacity. As always, it is clear what passion and person centred leadership this Unit has from its senior nurse, Rebecca Mace.

Council of Governors

4. I attended the Governance Committee of the Council of Governors on 27 February, chaired by Gillian Hough. This Committee is becoming a strong vehicle for the Governors to use to shape the agenda for the Council of Governors meeting.

5. I met with Ruth Greaves, John Morrissey and Carole Riley on 8 March to review the training that the Trust has been providing to support Governors in their role of holding the Board to account through the Non-Executive directors. This training has been helpful, but will take some time to bed into our ways of working and thinking, whilst still encouraging the Governors to gather feedback from their communities and to bring that to the attention of the Trust. I recognise the commitment that all of our Governors have for the Trust and how hard it can be at times to see how to contribute to the work of the Trust, but I am confident that we are making good progress.

6. We continue to have vacancies in our Council of Governors' membership, through resignations of both elected and staff Governors. The Communications and Involvement Team provide support to our Governors and will be seeking to recruit new Governors over the coming months.

7. On 20 March, the Governors' Nominations and Remuneration Committee met, to consider the appraisals of the Non-Executive Directors, informal feedback on my performance gathered in the early summer of 2017, my objectives as Trust Chair, and other matters to do with the Non-Executive remuneration and time commitment, benchmarked against other trusts.

Board of Directors

8. Our last Board meeting was held on 28 February – at the start of one of the worst periods of winter this country and county have seen for years. I would like to thank all staff for the tremendous efforts put in to keep our services running against the odds. This was truly living the trust values.

9. On 6 March I supported the recruitment of our new Director of Business Improvement and Transformation, joined by Richard Wright, Julia Tabreham and Claire Wright with Ifti Majid on the panel. It was very positive to see the number of applications that we received for the role, and I look forward to welcoming Gareth Harry when he joins the Trust later this spring.

10. Board development on 14 March took the Non-Executive Directors and some of the Executive team through the Mental Health Act and Mental Capacity Act with some thought provoking role plays set up by Dr John Sykes. We were joined by four of the Associate Hospital Managers for this training. The Board also took some time to start to prepare for the CQC Inspection.

11. I continue to meet with Non-Executives on a one to one basis quarterly, and since the last report I have met with Margaret Gildea.

System Collaboration

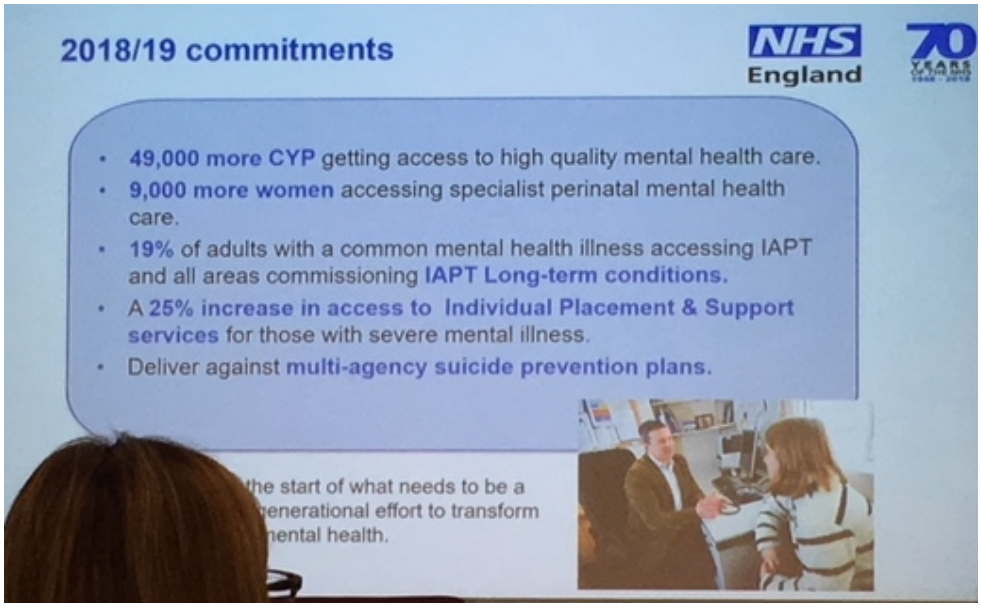
12. On 8 March, I met with Helen Philips, Chair of Chesterfield Royal, at our Kingsway site. This was an opportunity to share views on a diverse range of areas, including the progress with Joined Up Care Derbyshire, Trust, CQC visits and governance more generally. Helen and I are going to set up a visit to

Hartington Unit as part of my out and about around the Trust, and also engage with other Provider Chairs more directly about Joined Up Care Derbyshire.

13. Both Health and Wellbeing Boards have reviewed their terms of reference and membership, and I will no longer be attending these meetings. What this means is that there will be a more direct link to these boards through the Provider Alliance Group of Joined Up Care Derbyshire, and we will need to engage more directly with the Chairs of these boards outside of meetings.

Regulators; NHS Providers and NHS Confederation

14. The NHS Confederation Mental Health Network Conference on 15 March took place in London. I attended this, with Ifti Majid and about 130 other members from a cross sector of organisations who work across mental health. It was refreshing to hear from Claire Murdoch, National Mental Health Director from NHS England, on the progress being made against the priorities set out in the Five Year Forward View for Mental Health, along with the clear need to think ahead beyond the Five Year Forward View. It was also noted that the CCGs will need to deliver against the Mental Health Investment Standard, ensuring that the money flows to the providers. The 2018/19 priorities were set out.



The importance of appropriate housing provision was also a theme at the conference, with a number of Housing Associations and related organisations attending.

15. NHS Providers Chiefs and Chairs meeting takes place on 22 March in London and I will comment on this in my next report.

Beyond our Boundaries

16. On 7 March, I welcomed Professor Judith Tanner and Associate Professor Vivian Penney from Nottingham University School of Health Sciences, to the Trust. I was delighted to receive a copy of the latest student satisfaction report

following placements with our Trust. I have thanked Faith Sango for the work that she does in supporting the placements and she has passed this on to the team who work with her. We are making a positive difference to our students, and they are the workforce of the future. Here is a quote from the feedback:

"The placement was a fantastic experience for my learning and development, I was made to feel supported, encouraged and a significant part of the team at all times. I felt extremely lucky to be able to fulfil my management placement with this particular team and they really are a true credit to the mental health services. As well as to the nursing profession and to any student learning experience".

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	
Actions to Mitigate/Minimise Identified Risks – not applicable	

Recommendations

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

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

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

Chief Executive's Report to the Public Board of Directors

Purpose of Report

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

National Context

1. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all trusts to ensure that all executive and non-executive director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the Fit and Proper Persons Requirement (FPRR). The definition of directors includes those in permanent, interim or associate roles, irrespective of their voting rights at board meetings. These regulations were introduced in November 2014 and the fundamental standards came into force in April 2015. In January 2018, the Care Quality Commission (CQC) published its updated guidance in relation to FPPR following a consultation in 2017.

   CQC's guidance sets out the procedure for when it receives information that potentially alleges a director is not of good character. While there is no statutory guidance on what constitutes "good character", it names the following features that are "normally associated" with good character that trusts should take into account when assessing an individual under FPPR, in addition to the matters specified in Part 2 of Schedule 4:

   - Honesty
   - Trustworthiness
   - Integrity
   - Openness
   - Ability to comply with the law
   - A person in whom the public can have confidence prior employment history, including reasons for leaving
   - If the individual has been subject to any investigations or proceedings by a professional or regulatory body
   - Any breaches of the Nolan principles of public life
   - Any breaches of the duties imposed on directors under the Companies Act
   - The extent to which the director has been open and honest with the trust
   - Any other information which may be relevant, such as disciplinary action taken by an employer.

   Trusts also need to assure themselves that directors have not been complicit with serious misconduct or mismanagement. Helpfully in the new guidelines CQC sets out detail on how providers should interpret "serious mismanagement" and "serious ". It includes examples of the kinds of behaviours and situations that might constitute misconduct or mismanagement.

- Misconduct is described as a breach of “a legal or contractual obligation imposed on the director”, such as an employment contract, criminal law or relevant regulator requirements.

- Mismanagement is defined as “being involved in the management of an organisation [...] in such a way that the quality of decision making and actions of the managers falls below any reasonable standard of competent management”. For example, failing to interpret data appropriately, failing to learn from incidents or complaints, and failing to model standards of behaviour expected of those in public life.

Ahead of our annual FPPR and the annual CQC revised inspection regime visit the Board should assure itself that our procedures meet the revised requirements. In order to assure ourselves and CQC that we are not in breach of the regulation, we will be expected to demonstrate that we have robust processes in place for determining whether all new and existing directors are and continue to be fit, including:

- A process to ensure that all new director-level appointments are fit and proper as part of the recruitment process

- An annual process for regularly monitoring and reviewing the ongoing fitness of existing directors to ensure that they remain fit for their role, including consideration of serious mismanagement

- Principles for conducting investigations into concerns about the fitness of a director

- A process for the right of appeal for directors.

Our policy has been reviewed to ensure it remains compliant with the most up to date guidelines and members of the Board will be aware of the strength of our annual process.

2. The CQC were asked by Prime Minister to conduct a review of quality and access across mental health services for children and young people. They have now released phase two of the report. The report draws on evidence gathered from fieldwork in ten health and wellbeing board areas in England. The CQC spoke with staff working across these different parts of the system as well as to children, young people, parents, families and carers who use their services.

   They also reviewed policies and procedures, visited schools, hospitals, voluntary organisations and other services. I was particularly impressed that the CQC used a ‘case-tracking’ approach to examine in detail how individual children and young people with mental health problems moved through systems.

   In total, across phase two, more than 1,300 people through focus groups and one-to-one interviews were spoken to which I think gives the significant credibility.

   Three main aspects of the mental health system for children and young people were looked at :

   a) People’s experience of and involvement in care
   b) How partners plan and deliver services that offer high quality care that can

be accessed in a timely fashion

c) How partners in the local area identify mental health needs and what they do to start the process of getting the right support for children and young people

The CQC ound that many children and young people experiencing mental health problems don't get the kind of care they deserve. The system is complicated, with no easy or clear way to get help or support. The report mentions examples of services with caring and dedicated individuals who put children and young people at the centre of what they do. But these people are often working long hours, with limited money and an increasing demand for their services to overcome barriers to providing high-quality care. This chimes with our experiences in Derbyshire and cannot be maintained in the long run.

The CQC made a number of recommendations and suggested next steps

- The Secretary of State for Health and Social Care should make sure there is joint action across government to make children and young people's mental health a national priority, working with ministers in health, social care, education, housing and local government

- Local organisations must work together to deliver a clear 'local offer' of the care and support available to children and young people

- Government, employers and schools should make sure that everyone that works, volunteers or cares for children and young people are trained to encourage good mental health and offer basic mental health support

- Ofsted should look at what schools are doing to support children and young people's mental health when they inspect

- In 2019/2020, we will report on the progress the different organisations have made to act on the recommendations in the report.

We will be working with commissioners to understand how best to demonstrate improvements in these areas outlined.

Local Context

3. On 7 March I chaired the East Midlands Mental Health Clinical Transformation and Sustainability Network which is a gathering of senior clinicians and managers from across the East Midlands meeting together to share learning and where appropriate discuss what could be changed as a result of the learning – the discussions occur in STP footprint areas. The two main areas of focus were physical healthcare of people with serious mental illness and diagnosing adult ADHD. I was delighted that Derbyshire Healthcare were presenting some of the learning from the approach to physical healthcare improvements from our work supported by the local public health teams.

4. Partners from Joined up Care Derbyshire have been meeting over the last month to develop and define a plan that supports a reduction of the footprint deficit over the next two financial years. At the time of submission plans remain in the early stages of development and I would want to assure the Board that any plans that are looked to

take forward will be fully quality and equality impact assessed. The plans are likely to fall into four categories:

- What can be stopped – non statutory, limited clinical value services
- What can be limited – scope of services
- What can be moved to alternative setting – for example some of our drive to reduce out of area placements or repatriate people needing rehabilitation for intervention and support more locally
- What can be transformed – would apply to most pathways of care.

I am pleased to inform the Board I have met with the CEO of the Derbyshire CCGs, Dr Chris Clayton to discuss the requirement to adhere to the mental health investment standard where the percentage growth the CCGs receive should be as a minimum matched in terms of percentage uplift of mental health programme spend. He confirmed the intention of the CCGs to comply with this requirement.

5. The 8 March was the mental health workstream engagement event where we were able to engage with colleagues from the CCG, voluntary sector, independent sector and all providers to update on implementation progress and engage a significant number, in excess of 60 on this occasion, of committed mental health leaders and clinicians. The key areas of debate on this instance, was to agree and sign off the mental health workforce submission needed by NHS England and Health Education England. This is a complex template that details the changes to the mental health workforce required over the next three years in response to the mental health five year forward view. This primarily is to support education planning. The submission was then agreed at the March Joined up Care Board and the submission timetable met. I will share the submission with our Board next month.

   In addition we spent time as multi professional and multi organisational groups reviewing the plans for repatriation of people with complex needs from locked door rehabilitation settings to receive care locally in Derbyshire.

Within our Trust

6. On the 6 March and following a robust selection process the Remuneration and Appointments Committee approved the appointment of Gareth Harry as Director of Business Improvement and Transformation. Gareth demonstrated through the process his knowledge of, and commitment to, our portfolio of services. Importantly his style and approach was strongly in tune with our values and evidenced why putting people first was so important to him. I am sure the Board would join me in congratulating Gareth and welcoming him to Team Derbyshire Healthcare.

   I would also like to take a moment to thank Lynn Wilmott-Shepherd for her commitment, dedication and energy whilst she has been working with us. Lynn has been instrumental in developing our strategy and this latest refreshed version as well as being the driving force behind the success of the mental health workstream as part of Joined up Care Derbyshire. I know it was a very difficult decision for Lynn not to apply for the permanent post and I'm sure the Board will join me in wishing her well in the next stage of her career.

7. This month I met with our Chaplaincy development group. A fantastic opportunity to listen to the thinking of our multi-faith chaplains and staff from many disciplines who had an interest in spirituality and how to support people who use our services. There were some really energised discussions around the medical model and its benefits but

also a candid conversation about where it can be restrictive in considering whole person interventions. We also spoke openly about stigma and the historical taboo around engaging people who were very unwell in discussions about religion.

8. The Board will remember that during the last meeting the weather started to close in and over that and the next day we saw significant falls of snow, particularly in the North of the County. I would like to pay tribute to colleagues from all our services who ensured that despite the dreadful conditions all of our services continued to function, providing support to the most vulnerable in a time of need. We had some real heroic efforts to get to work, one staff member in Buxton arrived on a tractor her husband had borrowed and several others had parters and family members driving them around all day in 4 wheel drive vehicles. I was particularly impressed with the flexibility colleagues demonstrated in offering to carry out tasks that were not in their normal daily routine. I'm sure the Board would like to offer a formal note of thanks to all colleagues who worked so hard to keep our services operating in that difficult period.

9. I wanted to give the Board advanced notice of two very important events in our inclusion calendar. 25 April is our annual BME Conference at the Research and Development Centre, a great opportunity to celebrate the progress of our BME Network and to review our objectives in light of the outcome of our recent staff survey and the Workforce Race Equality Standard report. Tuesday 15 May is our LGBT+ mini conference held in conjunction with the Derbyshire LGBT+ network. The timing of this event is specific to coincide with IDAHO Day and is a great opportunity to understand more about how we can make the pledges we signed at both Board and Trust Management Team a reality.

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

Assurances

- Our strategic thinking includes national issues that are not immediately in the health or care sector but that could be of high impact.
- The Board can take assurance that Trust level of engagement and influence is high in the health and social care community
- Feedback from staff is being reported into the Board
- The Trust is actively striving to develop support networks for colleagues from protected groups.

Consultation

The report has not been to any other group or committee though content has been

discussed in various Executive meetings

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

That said some of the reports both nationally and within the Derbyshire system have the potential to have an adverse impact on people with protected characteristics for example as yet is unclear how schemes being developed to support increased sustainability will impact people from protected groups.(REGARDS).

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

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

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

The specific focus we have on assessing ourselves rigorously against the EDS2 key lines of enquiry supports us to understand more about areas for improvement and development.

Recommendations

The Board of Directors is requested to:

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 28 March 2018

Integrated Performance Report Month 11

Purpose of Report

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

Executive Summary

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

The issues identified in previous reports continue to be worked on through the plans that were previously referenced in the Integrated Performance Report.

1. Single Oversight Framework

The Trust is compliant against all Single Oversight Framework operational standards. This includes new standards relating to Out of Area Placements and Data Quality Maturity Index.

We continue to forecast a higher surplus than planned, over achieving the control total by £636k. Therefore the year end surplus position is forecast at £4.036m which is an overachievement of the Control Total of £1.3m (£636k additional surplus plus £636k additional STF 'bonus' income). This is in line with last month's forecast.

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.

Board members will note that more detailed assurance reports have been, or are due to be presented to different Board Committees. Committee assurance reports will provide an overview of the discussions and level of assurance received in each of the following;

- Outpatient Clinic cancellations (Finance and Performance)
- Delayed Transfers of Care (Finance and Performance)
- Recruitment, retention and sickness absence hot spot areas (People and

Culture)

Board members will also note that extra information regarding comparative workforce measures have also been added for this particular report. This information formed the basis of discussion at People and Culture Committee which Board requested to understand in more detail the level of assurance on workforce improvements in hot spot service areas.

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) (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

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
- 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
- New NHSi Out of Area indicators have been built into the dashboard
- The target for CPA Review in last 12 Months has been achieved despite the ongoing challenges with care co-ordination.

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
        - 5 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.
- Budgeted Fte vacancies remain high, but are reducing.
- Appraisal compliance rates remain low.

Quality Perspective

Highlights:
- Overall reduction in number of restraints, absconsions and seclusions through the quarter.
- Care plan audit nearing completion in neighbourhood teams. To be rolled out to campus teams during Q1 18/19.

Challenges:
- Increasing number of assaults on staff by patients
- Continued focus on compliance with CTO forms and MHA rights required
- Downward trend of staff in date with Clinical Safety Planning e Learning

FINANCIAL OVERVIEW – February 2018

Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Governance	Finance Score	**Finance Score**	YTD	1	1	G	→	At the end of February 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	

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	239	406	G	↓	At the end of February the surplus is ahead of plan by £2.1m. This is mainly due to non-recurrent income being received earlier in the year. Our forecast remains to over achieve the control total at the end of the financial year The normalised forecast takes out the non-recurrent income we have received as a one off in year and any non-recurrent expenditure. Without the non-recurrent income and expenditure we would still achieve the control total of £1.9m but we would not be able to overachieve the control total to the level we are forecasting.
			YTD	2,781	4,896	G	↑	
			Forecast	2,765	4,037	G	→	
		Control Total position ex STF £'000	In-Month	146	313	G	↓	
			YTD	2,079	4,194	G	↑	
			Forecast	1,971	2,607	G	→	
		Normalised Income and Expenditure position £'000	In-Month	146	341	G	↓	
			YTD	2,079	3,557	G	↑	
			Forecast	1,971	1,989	G	↗	
Liquidity	Cash	Cash £m	YTD	13.321	18.964	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	8.570	9.828	G	↑	
			Forecast	8.345	7.797	R	→	
	Capex	Capital expenditure £m	YTD	2.992	2.326	R	↓	
			Forecast	3.338	3.338	G	→	
Efficiency	CIP	CIP achievement £m	In-Month	0.321	0.343	G	↓	CIP is ahead of plan YTD and the forecast assumes an overachievement of £1.0m by the end of the financial year. A significant amount of CIP is non-recurrent in nature.
			YTD	3.529	4.394	G	↑	
			Forecast	3.850	4.843	G	↑	
			Recurrent	3.850	1.894	R	↑	

Key:

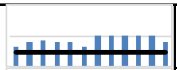
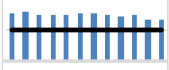
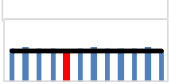
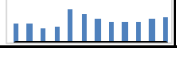
Period In-Month = Current Month
YTD = Year to Date
Forecast = Year end out-turn

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 – FEBRUARY 2018

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%	98.08%	G	↓			All NHS metrics are compliant. Out of Area Placements are now reported for PICU and Acute using four indicators, number of patients out of area in the month and average number of out of area patients per day during the month.
			Quarter	95.00%	99.17%	G	→			
		Data Quality Maturity Index (DQMI) - MHSDS Data Score (Q)	Month	95.00%	96.54%	G	→			
			Quarter	95.00%	97.78%	G	→			
		IAPT RTT within 18 weeks (Q)	Month	95.00%	100.00%	G	→			
			Quarter	95.00%	99.86%	G	→			
		IAPT RTT within 6 weeks (Q)	Month	75.00%	93.79%	G	↑			
			Quarter	75.00%	93.57%	G	↑			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Month	50.00%	93.33%	G	↓			
			Quarter	50.00%	92.68%	G	↑			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Month	50.00%	52.00%	G	↓			
			Quarter	50.00%	51.61%	G	↓			
		Patients Open to Trust In Employment (M)	Month	N/A	9.98%		→			
			Quarter	N/A	9.64%		→			
		Patients Open to Trust In Settled Accommodation (M)	Month	N/A	60.06%		↓			
			Quarter	N/A	58.65%		→			
		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%	50.34%	G	↓			
			Quarter	50.00%	52.32%	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 - Number of Patients Non PICU (M)	Month	N/A	2		↓			
			Quarter	N/A	8		↓			
		Out of Area - Number of Patients PICU (M)	Month	N/A	12		↓			
			Quarter	N/A	34		↓			
		Out of Area - Average Per Day Non PICU (M)	Month	N/A	0.8		↓			
			Quarter	N/A	1.3		↓			
		Out of Area - Average Per Day PICU (M)	Month	N/A	8.2		↑			
			Quarter	N/A	7.0		↑			

OPERATIONAL OVERVIEW – FEBRUARY 2018

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%	95.52%	G	→			A further paper was presented to the Finance and Performance Committee in March 2018. 8 patients were unable to be contacted within the 7 day timescale
			Quarter	90.00%	95.82%	G	→			
		CPA Employment Status	Month	90.00%	97.22%	G	→			
			Quarter	90.00%	97.22%	G	→			
		Patients Clustered not Breaching Today	Month	80.00%	74.96%	R	→			
			Quarter	80.00%	75.29%	R	→			
		Patients Clustered regardless of review dates	Month	96.00%	93.37%	R	→			
			Quarter	96.00%	93.39%	R	→			
		7 Day Follow-up - all inpatients	Month	95.00%	91.92%	R	↓			
			Quarter	95.00%	95.49%	G	↓			
		Ethnicity coding	Month	90.00%	90.83%	G	↓			
			Quarter	90.00%	91.13%	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%	95.00%	G	→			
			Quarter	95.00%	94.27%	R	↓			
		Clostridium Difficile Incidents	Month	7	0	G	→			
			Quarter	7	0	G	↓			
		18 Week RTT Greater Than 52 weeks	Month	0	0	G	→			
			Quarter	0	0	G	→			

Key:

Period

Month Current Month

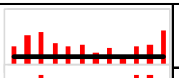
Quarter Current Quarter

Achieving target

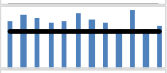
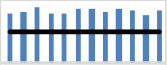
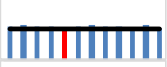
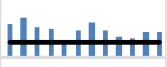
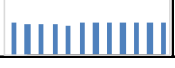
Not achieving target

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

OPERATIONAL OVERVIEW – FEBRUARY 2018

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%	13.16%	R	↑			The main reasons for cancellation were clinician absence from work and appointments having to be rescheduled to fit on more urgent appointments. A pilot is being undertaken in Derby City of telephoning patients to remind them of upcoming outpatient appointments.
			Quarter	5.00%	11.05%	R	↑			
		Consultant Outpatient DNAs	Month	15.00%	15.50%	R	↓			
			Quarter	15.00%	16.16%	R	→			
		Under 18 admissions to Adult inpatients	Month	0	0	G	→			
			Quarter	0	0	G	↓			
		Outpatient letters sent in 10 working days	Month	90.00%	91.17%	G	→			
			Quarter	90.00%	91.55%	G	↑			
		Outpatient letters sent in 15 working days	Month	95.00%	96.88%	G	→			
			Quarter	95.00%	96.56%	G	↑			
		Inpatient 28 day readmissions	Month	10.00%	7.14%	G	↓			
			Quarter	10.00%	7.49%	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 Email Sent in 24 Hours	Month							
			Quarter							Process under review
		Delayed Transfers of Care	Month	0.80%	3.32%	R	↓			
			Quarter	0.80%	3.86%	R	→			5 Patients were delayed
		18 Week RTT Less Than 18 Weeks - Incomplete	Month	92.00%	93.75%	G	→			
			Quarter	92.00%	93.41%	G	↓			

OPERATIONAL OVERVIEW – FEBRUARY 2018

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%	93.52%	G	↑			
			Quarter	92.00%	92.97%	G	↓			
		Mixed Sex accommodation breaches	Month	0	0	G	→			
			Quarter	0	0	G	→			
		Completion of IAPT Data Outcomes	Month	90.00%	96.33%	G	↑			
			Quarter	90.00%	95.69%	G	→			
		Ethnicity coding	Month	90.00%	91.61%	G	→			
			Quarter	90.00%	91.67%	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%	98.61%	G	→			Compliant with Targets.
			Quarter	98.00%	99.14%	G	→			
		% 6-8 Week Breastfeeding coverage	Month	98.00%	98.09%	G	↓			
			Quarter	98.00%	98.90%	G	↓			
	IAPT	Recovery Rates	Month	50.00%	50.34%	G	↓			Compliant with Targets.
			Quarter	50.00%	52.30%	G	→			
		Reliable Improvement Rates	Month	65.00%	67.89%	G	→			
			Quarter	65.00%	67.90%	G	→			
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	N/A	103.3%		↓			Detailed ward level information shows specific variances
			Quarter	N/A	103.9%		→			

WORKFORCE OVERVIEW – February 2018

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Feb-18**	10%	**10.60%**	↗	G	↑	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 11.90% (as at December 2017 latest available data). The monthly sickness absence rate is 1.93% lower than the previous month and compared to the same period last year (February 2017) it is 0.21% lower. The annual sickness absence rate is running at 5.39% (as at January 2018 latest available data). The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.18% (as at November 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounted for 22.91% of all sickness absence during February 2018, followed by cold / cough / flu at 11.51% and surgery at 11.26%. The Funded Fte vacancy rate has decreased by 0.08% to 4.95%. The number of employees who have received an appraisal within the last 12 months has decreased slightly by 0.17% to 78.43%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £751k. Compulsory training compliance has increased by 0.42% to 86.35%.
			Jan-18		10.14%		G		
		Sickness Absence (monthly)	**Feb-18**	5.04%	**5.40%**	↘	R	↑	
			Jan-18		7.33%		R		
		Sickness Absence (annual)	**Jan-18**	5.04%	**5.39%**	↗	R	↑	
			Dec-17		5.30%		R		
		Vacancies (including funded fte flexibility / cover)	**Feb-18**		**4.95%**	↘		↓	
			Jan-18		5.03%				
		Appraisals (**all staff** - number of employees who have received an appraisal in the previous 12 months)	**Feb-18**	90%	**78.43%**	↘	R	↑	
			Jan-18		78.60%		R		
		Appraisals (**medical staff only** - number of employees who have received an appraisal in the previous 12 months)	**Feb-18**	90%	**69.72%**	↘	R	↓	
			Jan-18		72.89%		R		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Feb-18**	£0	**£0.751m**	↗	R	↑	
			Jan-18		£0.733m		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Feb-18**	0%	**27.01%**	↘	R	↓	
			Jan-18		28.41%		R		
		Compulsory Training (staff in-date)	**Feb-18**	90%	**86.35%**	↗	A	↑	
			Jan-18		85.93%		A		

Key:

Period Current month and previous month

Plan Trust target

↗ Variance to previous month

Achieving target/within target parameters

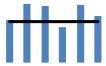
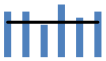
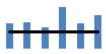
Approaching target/approaching target parameters

Not achieving target/outside target parameters

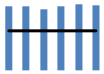
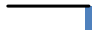
Trend based on previous 4 months

Turnover parameters (8% to 12%)

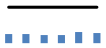
QUALITY OVERVIEW – FEBRUARY 2018

Sub-set	Metric	Period	Plan	Actual	Trend graph by month (rolling 6 months: Sep 17 - Feb 18)	Trend graph by quarter (last 3 qtrs: Apr - Dec 17)	Quality implications
Safe	No of incidents of moderate to catastrophic actual harm Plan: average last fin yr 2016/17 (month)	Month	29	33			There has been a slight decrease in the number of incidents resulting in moderate harm/injury, from 16 during Jan 2018, to 11 during Feb. The number of incidents resulting in major harm or death between Jan and Feb 2018 has remained constant
		Quarter	88	112			
	No of deaths of patients who have died within 12 months of their last contact with DHCFT Data as at 05/03/2018	No of deaths of patients who have	104	132			The increase between in Jan 2018 was due to data parameters now including deaths of people: open to IAPT services; whilst on waiting lists; and open to substance misuse services
		Quarter	312	339			
	No of serious incidents reported to the CCG	Month	5	7			Reducing trend influenced by peak reporting in May 17. Relative stability in reportable incidents since. Critieria for reporting still be applied consistently.
		Quarter	16	20			
	No of episodes of patients held in seclusion	Month	10	8			The decrease in episodes of seclusion during Feb 2018, relates mainly to the reduction in the number of episodes for two patients on the Enhanced Care Ward, Radbourne Unit
		Quarter	30	37			
	No of incidents involving patients held in seclusion	Month	16	11			
		Quarter	47	59			
	No of incidents involving physical restraint	Month	48	35			This is directly linked to the above metric
		Quarter	143	139			
	No of incidents involving prone restraint	Month	10	8			Prone restraint is usually at a time of enforced medication administration via an injection. We would often see an decrease in this in line with decreased use of seclusion. Prone restraint audit and report for Quality committee in plan for May 2018.
		Quarter	29	33			
	No of incidents of physical assault - patient on patient	Month	12	13			As we move forward, this data will be reviewed in line with how any trend might be attributable to the same individual. The majority of reported assaults take place on Cubley Court Female and Cubley Court Male. The incidence of assaults are currently equally split between these two wards, and are an indicator of the clinical needs of the current in-patients.
		Quarter	37	39			
	No of incidents of physical assault - patient on staff	Month	19	36			
		Quarter	56	89			

QUALITY OVERVIEW – FEBRUARY 2018

Sub-set	Metric	Period	Plan	Actual	Trend graph by month (rolling 6 months: Sep 17 - Feb 18)	Trend graph by quarter (last 3 qtrs: Apr - Dec 17)	Quality implications
Safe	No of falls on in-patient wards	Month	32	26			As we move forward, this data will be reviewed in line with how any trend might be attributable to the same individual. Falls audit completed on Cubley Court wards and reported to Quality committee.
		Quarter	96	99			
	No of incidents of absconsion	Month	33	9			Lower incidents monthly and quarter refelcting a general downward trend. There has been a significant decrease in absconsion across all wards at the Radbourne Unit during Feb 2018
		Quarter	99	68			
	No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	73.16%			Audit planned to look at quality and completedness of safety plans across campus and Neighbourhood services. Pilot planned in Derby City Neighbourhood team B to review robusteness of safety plans.
		Quarter	100%	73.09%			
	Of above, no of patients with a Safety Plan	Month	90%	60.17%			Steady increase in compliance being recorded. This is due in part to people completing safety plans after the final Face risk plan running out.
		Quarter	90%	53.94%			
	% of staff compliant with combined Level 3 Safeguarding Children and Think Family training Compliance figure now only relates to Safeguarding Children Level 3	Month	85%	NA			This consistently exceeds target, but over time this indicator will cease to be relevant due to its replacement with a focus solely on Level 3 Safeguarding Training. We expect to see it reported on until reporting is taken over by the Level 3 training.
		Quarter	85%	NA			
	% of staff compliant with Level 3 Safeguarding Children training New indicator from Nov 17	Month	85%	77.08%			Performance will be reduced initially now that this figure does not count Think Family training, although steady increase in compliance being recorded. Attendance to this course has been raised at the training meeting and is being explored.
		Quarter	85%	NA			
	% of staff compliant with Clinical Safety Planning eLearning	Month	95%	90.62%			This performance will be overseen and actioned as necessary by the Safety Planning Steering Group. The plan is to review the eLearning package in line with alterations to the Safety Plan post audit.
		Quarter	95%	NA			
	% 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%	94.22%			Increasing compliance in line with our work around physical healthcare. Very close to target this month
		Quarter	95%	NA			
	HCR20 assessment completed (Low Secure)	Month	100%	100.0%			The reporting of this will tend to be either 100% if we complete an HCR20 within the required timescale after someone has been admitted to Kedleston Unit, or 0% if we miss the timescale for that one person. The team are aware of requirements.
		Quarter	100%	NA			

QUALITY OVERVIEW – FEBRUARY 2018

Sub-set	Metric	Period	Plan	Actual	Trend graph by month (rolling 6 months: Sep 17 - Feb 18)	Trend graph by quarter (last 3 qtrs: Apr - Dec 17)	Quality implications
Caring	No of complaints opened for investigation	Month	12	17			Peak of 24 complaints in January 2018. Reduced in February 2018, back in line with overall trend. Monitored in the Feedback Intelligence Group and reported to the Patient experience report
		Quarter	37	40			
	No of concerns received	Month	35	31			Monitored in the Feedback Intelligence Group and reported to the Patient experience report.
		Quarter	104	107			
	No of compliments received	Month	100	68			Reduction in reported compliments February 2018
		Quarter	300	305			
	No of investigations by the Parliamentary and Health Service Ombudsman	2016/17	NA	6			One new investigation has been opened during Feb 2018 in relation to the decision to discharge a patient
		2017/18	NA	2			
	% of complaints upheld (full or in part) by the Parliamentary and Health Service Ombudsman	2016/17	NA	1			5 no further action
		2017/18	NA	0			2 ongoing
	% of responded to (orange) complaint investigations completed within 40 working days, opened after 01/04/2017	Year	100%	29%			168 (orange) complaints as at 06/03/2018. 80 not responded within 40 working days. 33 resolved within 40 working days. 55 ongoing. The majority of those defined as overdue are still within the timescale negotiated with the complainant.
	% of responded to (red) complaints investigations completed within 60 working days, opened after 01/04/2017	Year	100%	25%			7 (red) complaints as at 06/03/2018. 3 not responded within 60 working days. 3 ongoing. The majority of those defined as overdue are still within the timescale negotiated with the complainant.
	No of incidents requiring Duty of Candour	Month	1	0			One incident in January 2018, a referral delay for a young person with an eating disorder. This is being investigated.
		Quarter	2	3			

QUALITY OVERVIEW – FEBRUARY 2018

Sub-set	Metric	Period	Plan	Actual	Trend graph by month (rolling 6 months: Sep 17 - Feb 18)	Trend graph by quarter (last 3 qtrs: Apr - Dec 17)	Quality implications
Effective	% of in-patients with a recorded capacity assessment	Month	100%	93.92%			Ongoing work to both improve the quality and audit the evidence of this.
		Quarter	100%	95.37%			
	% of patients who have had their care plan reviewed and have been on CPA > 12months	Month	90%	94.95%			Care Plan audit in Neighbourhood services is almost competed. Tool revised for Campus services with roll out in Q1 18/19.
		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. As at 05/03/2018: 2 seclusions reported on PARIS, not recorded as incidents on Datix. Head of Nursing escalating.
		Quarter	0	0			
	% of CTO rights forms received by MHA Office	Month	100%	88%			This is lower than expected overall performance but is not a trust wide problem. Areas of lower performance will be specifically targeted for improvement work. Negotiations underway around joint training plan with Social Care.
		Quarter	NA	NA			
	% of in patient older adults rights forms received by MHA Office	Month	100%	92%			Performance of less than 100% is attributable to one ward. A focus on quality improvement work with this ward is underway
		Quarter	NA	NA			
Responsive	% of staff uptake of Flu Jabs	2016/17	45%	38%			Figure as at 25/02/2018. Performance as at 19th February is 50.2 %. Target for next year is 75%. No further updates will be provided until new campaign commences.
		2017/18	45%	50.26%			
	% of policies in date	Month	95%	94.48%			Monthly escalation in place.
		Quarter	NA	NA			
Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	100%	60.76%			All divisions have action plans around increasing the % of people receiving the target number of clinical and managerial supervision, but this remains a challenge.
		Quarter	100%	NA			
	% of staff who have received Management Supervision, within defined timescales	Month	100%	70.30%			
		Quarter	100%	NA			
	No of outstanding actions following serious incident investigations	Month	5	65			This is being monitored and actioned within the Serious Incident Group
		Quarter	0	NA			
	No of outstanding actions following complaint investigations	Month	5	22			Overall this continues to be an improving picture
		Quarter	NA	NA			
	No of outstanding actions following CQC comprehensive review report (2016	Month	0	12			Working through the final remaining actions over the next few weeks with operational management colleagues.

Financial Section

Exceptions month 11

- **Over achievement of the control total**

  We continue to forecast a higher surplus than planned overachieving the control total by £636k. Therefore the yearend surplus position is forecast at £4.036m which is an overachievement of the Control Total of £1.3m (£636k additional surplus plus £636k additional STF 'bonus' income). This is in line with last month's forecast.

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

  The Trust's capital expenditure is behind plan at the end of February by £666k. The forecast assumes that the full capital expenditure plan of £3.3m will be spent. The capital schemes have been reprioritised in year for schemes that are due to complete in the last month of the financial year. Therefore the current balance of £1.0m (30% of the plan) will be spent in the last month of the financial year as schemes complete. 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 £4.8m which is an overachievement of £1.0m against the target of £3.8m. Of the forecast £4.8m, £3.2m is non-recurrent in nature. The non-recurrent nature of this year's delivery poses a significant risk to next year's financial performance.

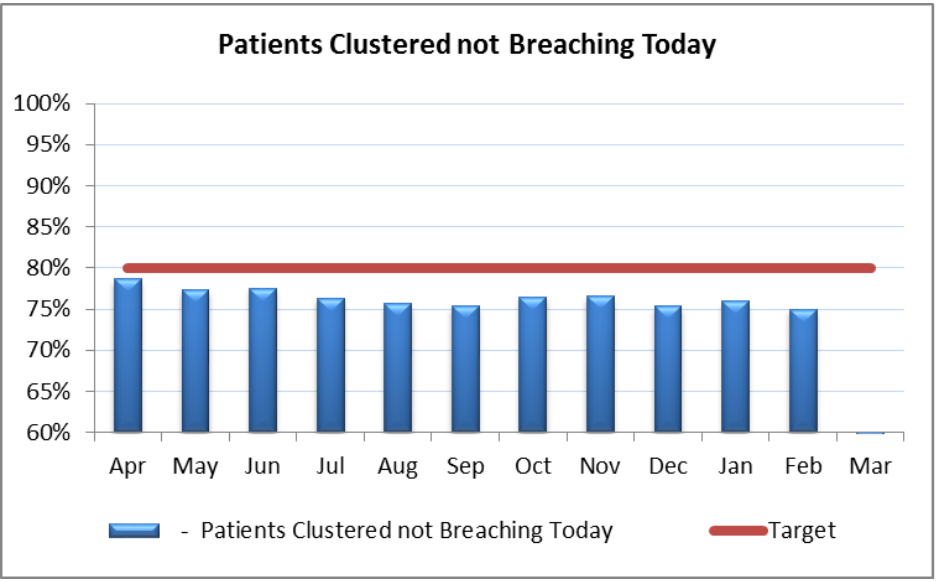
- **Agency expenditure**

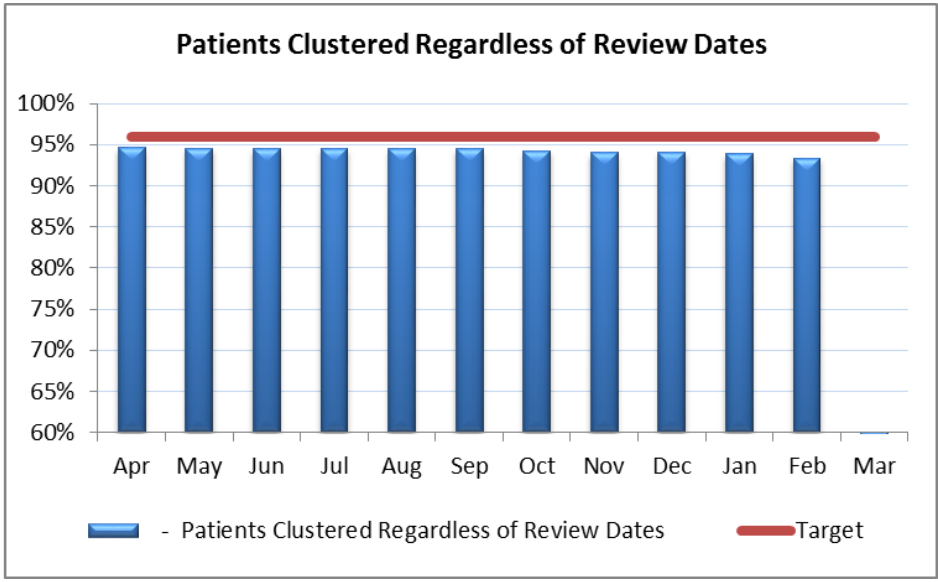
  YTD is above the ceiling by £649k (23%) which is generating a '2' on the agency metric. The agency expenditure is forecast to exceed the ceiling by £0.9m (29%) which is an improvement on last month's forecast. This is generating a '3' on the agency metric within the Finance Score.

  The forecast expenditure on medical agency is now below the medical agency target that was set by NHSI.

Operational Section

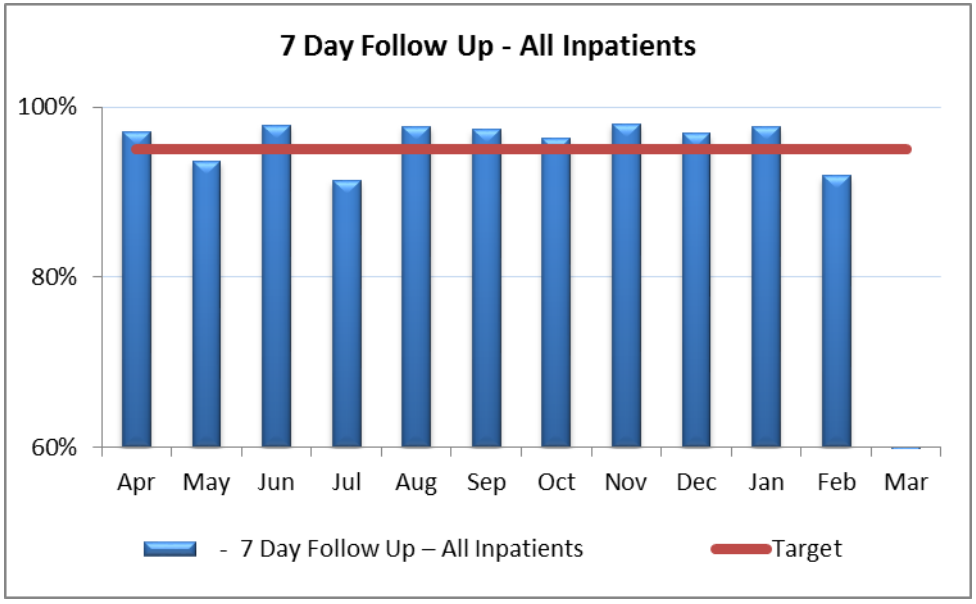
Patients Clustered not Breaching Today and Patients Clustered regardless of review dates





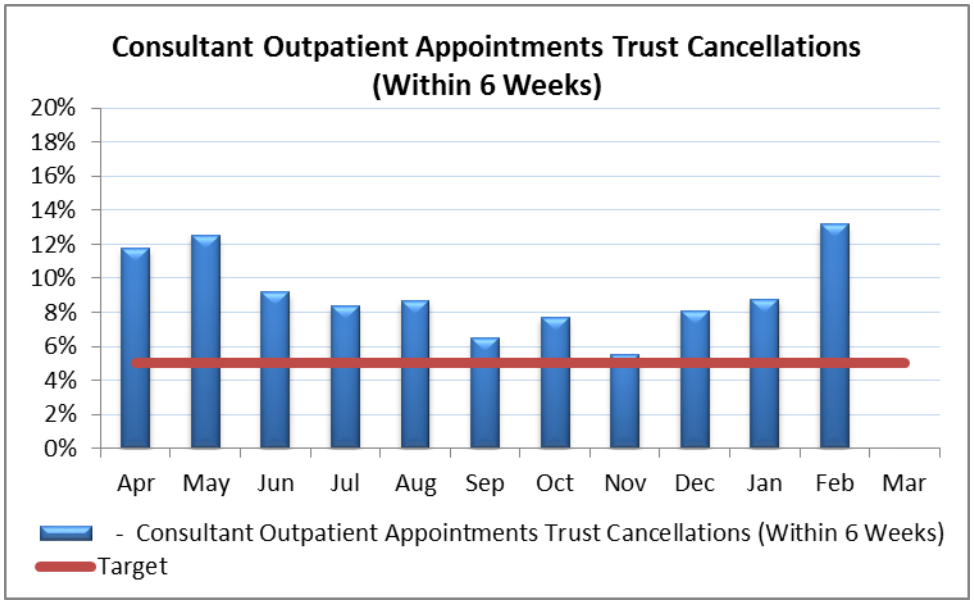
A further paper was presented to the Finance and Performance Committee in March 2018.

7 Day Follow-up - all inpatients



CCG Name	Discharge Date	Discharge Ward	Comments
NHS SOUTHERN DERBYSHIRE CCG	24 Feb 2018	RDH Ward 36 Adult Acute Inpatient	Patient returned to Latvia on discharge
NHS SOUTHERN DERBYSHIRE CCG	20 Feb 2018	Kingsway Cubley Court (male) OP	Patient currently at Derby Royal. CPN has contacted the Ward.
NHS NORTH DERBYSHIRE CCG	16 Feb 2018	Hartington Unit Tansley Ward Adult	Inreach attempted to follow up on 18.02.2018 - no response. To date it has not been possible to make contact. Family are believed to have moved to Wakefield.
NHS NORTH DERBYSHIRE CCG	13 Feb 2018	Hartington Unit Morton Ward Adult	Did not attend 2 day follow up. Subsequently arrested by police.
NHS NORTH DERBYSHIRE CCG	3 Feb 2018	Hartington Unit Morton Ward Adult	Patient returned to Romania on discharge. The ward pharmacist speaks Romanian and made telephone contact with the patient to ascertain their wellbeing.
NHS SOUTHERN DERBYSHIRE CCG	2 Feb 2018	Kingsway Cubley Court (female) OP	Discharge summary states that the patient was actually discharged on 26/1/18 and followed up at the nursing home on 1/2/18. The incorrect discharge date has been recorded on Paris.
NHS SOUTHERN DERBYSHIRE CCG	2 Feb 2018	Hartington Unit Pleasley Ward Adult	Patient was discharged to a care home. When the CPN attended for the follow-up appointment they were advised that the patient had passed away.
NHS SOUTHERN DERBYSHIRE CCG	1 Feb 2018	Hartington Unit Tansley Ward Adult	Patient was contacted by telephone by CPN to arrange a follow-up appointment, but subsequently did not attend the agreed appointment. To date we have been unable to make further contact.

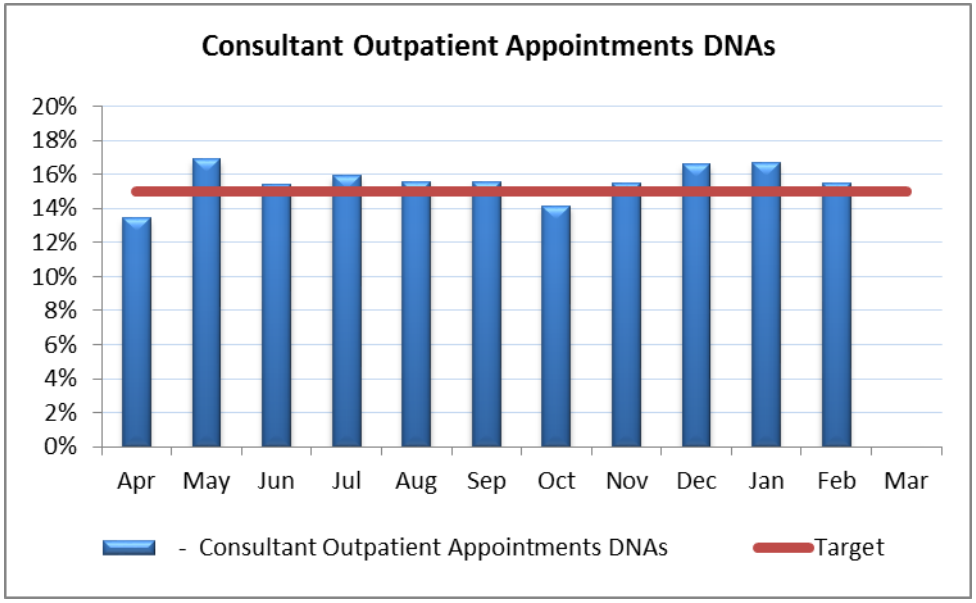
Consultant outpatient appointments Trust cancellations (within 6 weeks)



Reason	n	%
Clinician Absent From Work	257	49%
Moved - Trust Rescheduled	108	21%
Appointment Brought Forward	35	7%
Moved - Staff Issue	29	6%
Moved - Clinic Cancelled	28	5%
Clinician On Annual Leave	25	5%
Clinic Booked In Error	13	3%
No Consultant	9	2%
Estates Issue	9	2%
Jnr Dr Clinic No Consultant	4	1%
Moved - Location Issue	1	0%
Clinician Must Attend Meeting	1	0%
Must Attend Ward Round	1	0%
Grand Total	**520**	**100%**

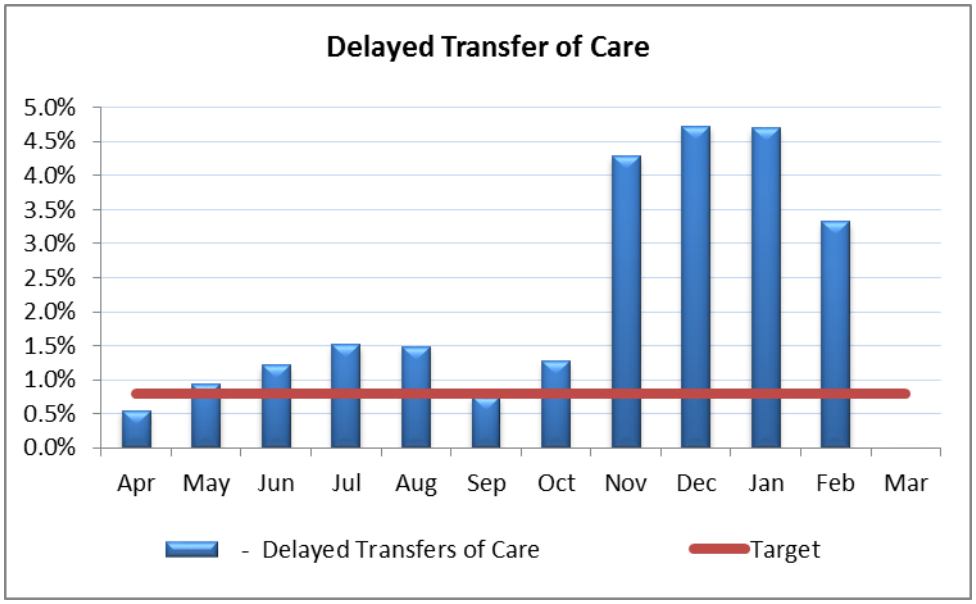
520 appointments were cancelled in February. The main reasons for cancellation were clinician absence from work and appointments having to be rescheduled to fit on more urgent appointments.

Consultant Outpatient DNAs



The original pilot in Derby City has once again been compromised by staffing issues. An alternative City area has now been identified and pilot commenced this month. Killamarsh and North Chesterfield medical secretaries are now telephoning patients to remind them of upcoming appointments and we will have a full month of data on the impact of this intervention in mid-April.

Delayed Transfers of Care



5 discharges were delayed in February, for the following reasons:

Current Ward	Delay Reason	Responsibility	Delay Start
Enhanced Care Ward	K2 - housing - awaiting emergency accommodation from local authority	Health and Social Care	11/12/2017
Ward 34	C1 – awaiting further non-acute NHS care	Health and Social Care	30/10/2017
Ward 36	C1 – awaiting further non-acute NHS care	Social Care	3/11/2017
Morton Ward	E1 - awaiting care package in own home	Social Care	1/1/2018
Tansley Ward	J2 - housing - awaiting supported accommodation	Health and Social Care	30/10/2017

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	75.71%	72.2%	162.1%	69.6%	0.0%	Yes	No change from last month
CHILD BEARING INPATIENT	56.55%	64.6%	102.0%	96.4%	142.9%	Yes	We have broken the current fill rate tolerances for day registered nurses due to backfill required for 1.4 WTE vacancy, 0.6 WTE maternity leave and short term sickness absence cover. Night care staff is due to high engagement levels and backfill for 0.8 WTE Nursery Nurse vacancy.
CTC RESIDENTIAL REHABILITATION	65.99%	136.3%	104.9%	100.0%	144.6%	Yes	Our figures at Cherry Tree Close remain higher than usual due to 2 service users remaining on level 2 observations (enhanced care) to maintain their safety and wellbeing – this requires a member of staff with them at all times on each shift. These observations are regularly reviewed however continued to felt necessary at present. There are discharge plans in place for the 2 service users however no exact discharge date set yet this is being followed up daily.
KEDLESTON LOW SECURE UNIT	39.11%	93.2%	66.2%	91.1%	86.6%	Yes	we continue to work on lower staffing levels due to one ward still being shut. We are recruiting to vacancies and are anticipating to open Scarsdale ward at the end of march 2018.
KINGSWAY CUBLEY COURT - FEMALE	36.11%	70.7%	71.0%	45.2%	108.3%	Yes	staffing level tolerance broken due to; vacancies and long term sickness.
KINGSWAY CUBLEY COURT - MALE	78.97%	77.3%	146.5%	94.6%	182.1%	Yes	Current fill rate tolerances have been failed as follows: Registered nurses during the day due to nurses being on long term sick and maternity leave currently NA during the day currently over as shifts with low nurse ratio has been compensated by NA, and also high level of observations currently on the ward requiring additional staffing NA during the night required additional staffing due to increased levels of observations
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	86.11%	76.2%	117.0%	94.6%	142.9%	Yes	No change from last month
HARTINGTON UNIT - MORTON WARD ADULT	90.33%	111.2%	104.5%	57.1%	246.4%	Yes	We are still waiting for some new starters to begin on Morton ward – most vacancies are now recruited into. One Band 5 remains on long term sick leave and we are back filling his shifts. One of our Band 5 nurses has been acting up into the Band 6 role and has just been successful in gaining the substantive post thus creating another Band 5 vacancy. Currently we are not always able to put on to night duty x2 Band 5s. This is covered by Band 2/3 HCAs.

WARD STAFFING

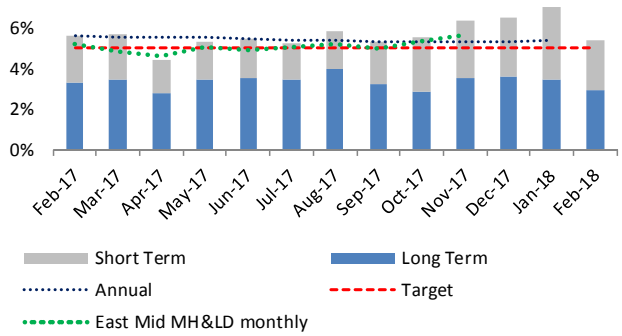
Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
HARTINGTON UNIT - PLEASLEY WARD ADULT	94.46%	85.6%	131.6%	48.2%	196.4%	Yes	The ward is currently carrying 2. 74 band 5 vacancies, on top of this, 3 band 5's have just commenced in position on the ward but are still supernumerary and so unable to be counted in the clinical numbers and a further 3 band 5 staff have been recruited but not commenced yet. As a result it has been difficult to ensure the recommended 3 x band 5 staff on day shifts or the 2 x band 5 staff on nights and this deficit has been backfilled with band 3 HCA's. This is the reason for showing low fill rate of Band 5 staff Nurses and a high fill rate for HCA's on all shifts. The situation should rectify itself as the new staff complete their supernumerary period or commence employment.
HARTINGTON UNIT - TANSLEY WARD ADULT	86.61%	78.6%	140.6%	60.7%	192.9%	Yes	There were 6.6 wte vacant registered nurse posts on Tansley Ward in February. Three of the posts have been recruited into with two nurses due to qualify in September and another nurse due to qualify in December. A small number of these shifts have been backfilled by contracted registered nurses offering to work additional hours on bank but the remainder have been covered by band 2 bank HCAs accounting for the poor skill mix evident in the report. In addition to the vacancies one part time (0.6 wte) registered nurse is on long term sickness absence and a further 1.0 wte nurse remains on special leave pending an HR process. There has been in addition a small amount of the usual winter short term absences. From 18/03/18 we will have filled another of our vacant 1.0 wte registered nurse posts when a registered nurse transfers from Ward 35 to work on Tansley Ward after moving to live locally and our OT post will be filled after the successful applicant qualifies in April. I am anticipating that the skill mix will be a gradually improving picture as the vacant posts are filled and staff already recruited commence. In appraisal I have not been made aware of any nurses who feel that they may be looking to move posts or have interests elsewhere so am hoping that retention will remain high this year.
ENHANCED CARE WARD	95.36%	80.7%	132.7%	60.7%	203.6%	Yes	I am still carrying RN vacancies. 4 of which are recruited into but awaiting Qualification. I have 1 RN on Mat leave due to return to work in June. We conrtinue to backfil with Bank NA and HCA shifts using bank staff familiar with ward and where available appropriate training for area.
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	94.82%	83.7%	131.4%	78.6%	246.4%	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	102.14%	75.4%	124.5%	75.0%	189.3%	Yes	We continue to have over 50% RN vacancies on the ward and are therefore unable to fulfil safer staffing requirements.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	103.75%	81.0%	141.6%	51.8%	146.4%	Yes	No change from last month
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	100.54%	91.0%	134.8%	50.0%	275.0%	Yes	No change from last month

Workforce Section

WORKFORCE DASHBOARD

Sickness Absence	Dec-17	Jan-18	Feb-18
(Monthly)	6.47%	7.33%	**5.40%**
(Annual)	5.30%	5.39%	**tbc**

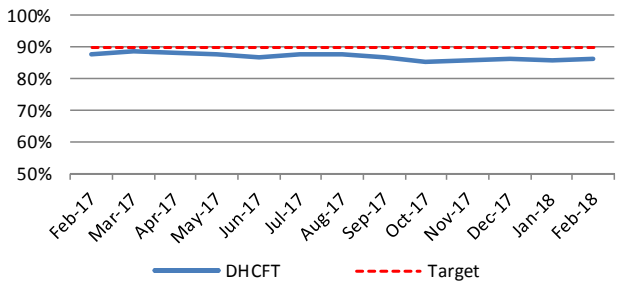
Target 5.04%



The monthly sickness absence rate is 1.93% lower than the previous month and compared to the same period last year (February 2017) it is 0.21% lower. The Trust annual sickness absence rate is running at 5.39% (as at January 2018 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounted for 22.91% of all sickness absence during February 2018, followed by cold / cough / flu at 11.51% and surgery at 11.26%. Compared to the previous month short term sickness absence has decreased by 1.35% and long term sickness absence has decreased by 0.58%.

Compulsory Training	Dec-17	Jan-18	Feb-18
(Staff in-date)	86.41%	85.93%	**86.35%**

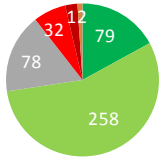
Target 90%

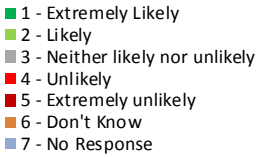


Compulsory training compliance continues to remain high running at 86.35%, an increase of 0.42% compared to the previous month. Compared to the same period last year compliance rates are 1.48% lower.

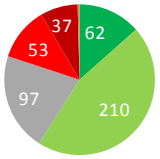
Staff FFT Q2 2017/18 (465 responses, 20.5% response rate) **& Staff Survey** 2017

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.

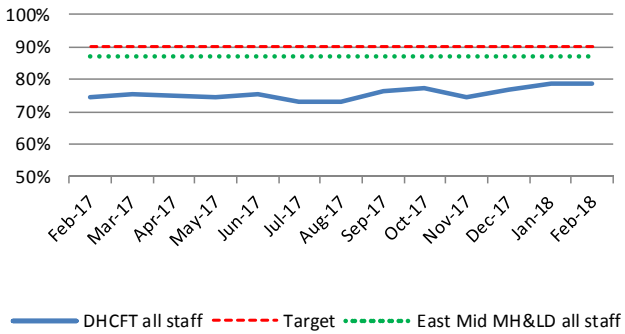


	2017	National average 2017	2016	National average 2016
Overall staff engagement (maximum score 5):	**3.74**	3.79	3.69	3.84

Appraisals (All staff)

Dec-17	Jan-18	Feb-18
76.78%	78.60%	**78.43%**

Target 90%

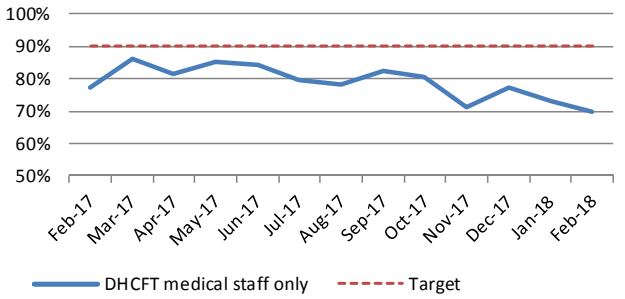


The number of employees who have received an appraisal within the last 12 months has decreased slightly by 0.17% during February 2018 to 78.43%. Compared to the same period last year, compliance rates are 3.81% higher. According to the 2017 staff survey results, the national average for combined Mental Health/Learning Disability & Community Trusts is 92% (Derbyshire Healthcare NHS FT scored 89% on this staff survey finding). Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 85.40%.

Appraisals (Medical staff only)

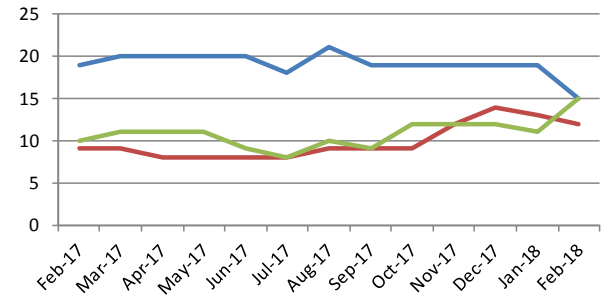
Dec-17	Jan-18	Feb-18
77.36%	72.89%	**69.72%**

Target 90%

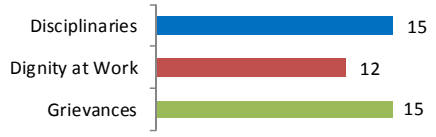


The number of Medical staff who have received an appraisal within the last 12 months has decreased by 3.17% to 69.72%. Compared to the same period last year, compliance rates are 7.64% lower. Junior Doctors on rotational training are excluded from the figures.

Disciplinaries/Dignity at Work/Grievances as at 28/02/2018

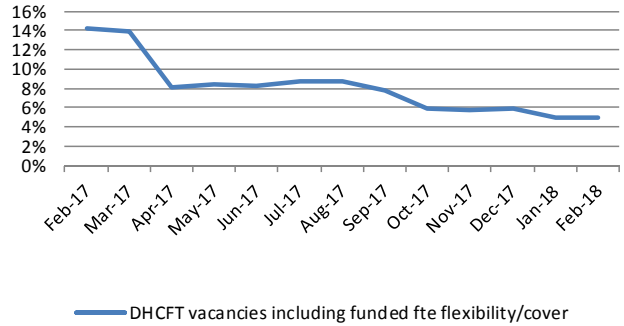


There are 15 Disciplinary cases, no new cases have been lodged and 4 cases have been resolved. There are 15 Grievance cases lodged at the formal stage with 4 new cases being lodged and none resolved in the period. There are 12 Dignity at Work cases, 1 has been resolved in the period.



WORKFORCE DASHBOARD

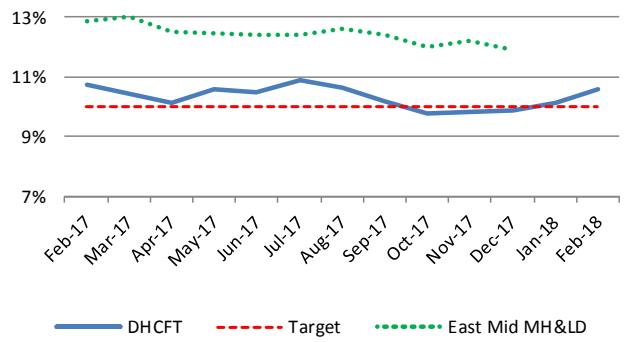
Vacancy	Dec-17	Jan-18	Feb-18
(Funded full time equivalent) Including funded fte flexibility/cover	5.94%	5.03%	**4.95%** ↘



The Trust vacancy rate includes funded Fte surplus for flexibility including sickness and annual leave cover. Funded vacancy rates have decreased by 0.08% to 4.95% in February 2018. 2017/18 budget changes included a large reduction in Fte from 2016/17 investment not materialising and Cost Improvement Programmes. During the period March 2017 to February 2018, 260 employees have left the Trust and 354 employees have joined the Trust.

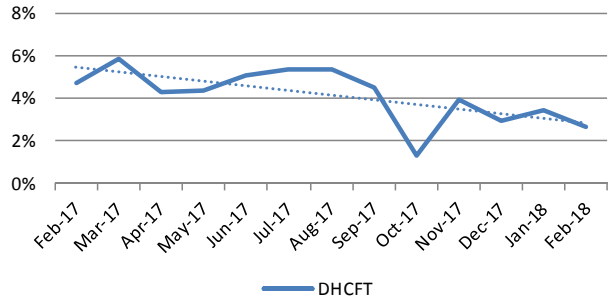
Turnover	Dec-17	Jan-18	Feb-18
(Annual)	9.90%	10.14%	**10.60%** ↗

Target 10%



Annual turnover remains within Trust target parameters at 10.60% and remains below the average for East Midlands Mental Health & Learning Disability Trusts (11.90%). The average number of employees leaving over the last 12 months has increased from 20.91 to 21.67. During February 2018 17 employees left the Trust which included 5 retirements.

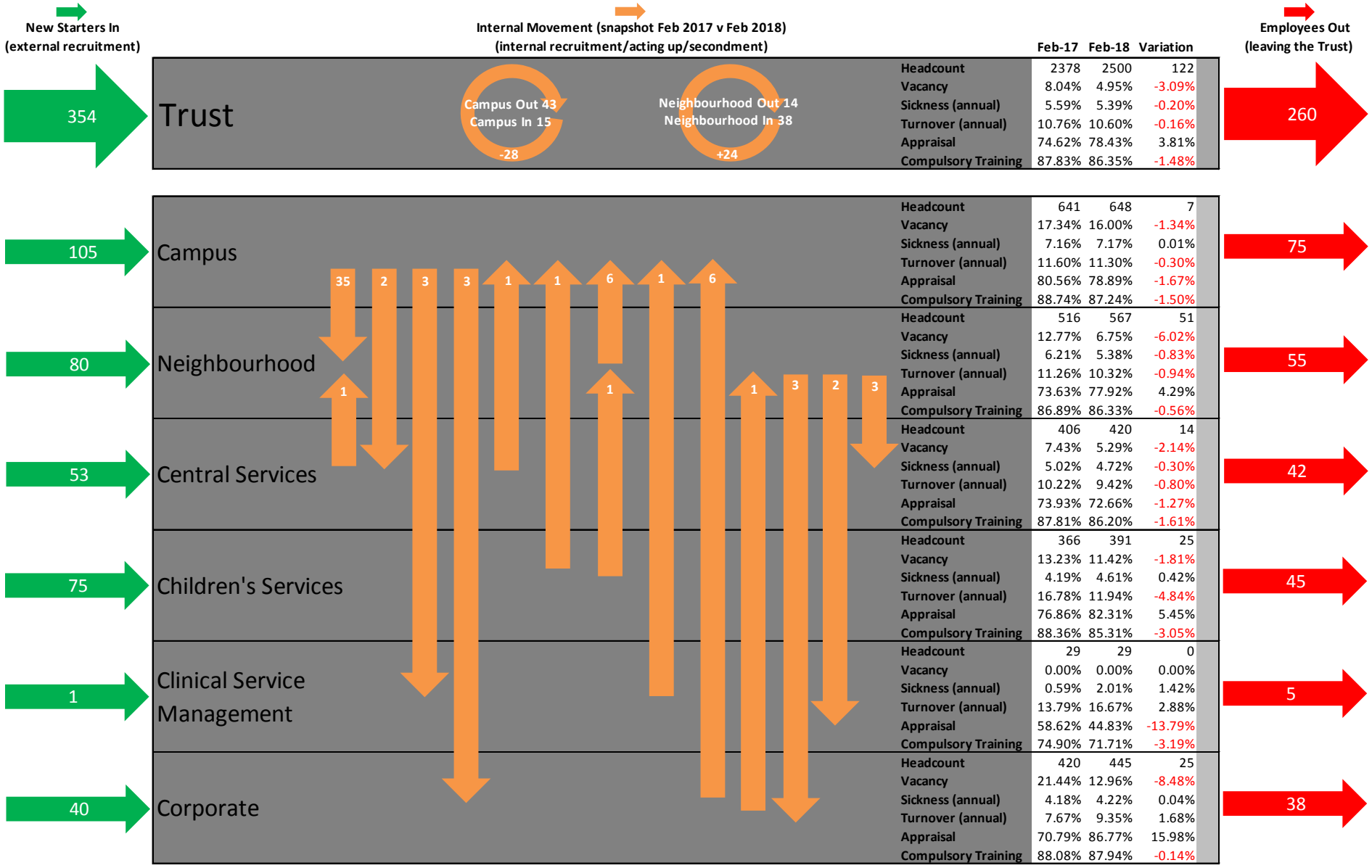
Agency Usage	Dec-17	Jan-18	Feb-18
(Spend)	2.93%	3.43%	**2.63%** ↘



Total agency spend in February was 2.63% (3.14% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 0.59%, Medical 1.93% and other agency usage 0.11%. Agency Qualified Nursing spend against total Qualified Nursing spend in January was 1.60%. Agency Medical spend against total Medical spend in February was 11.23%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £751k.

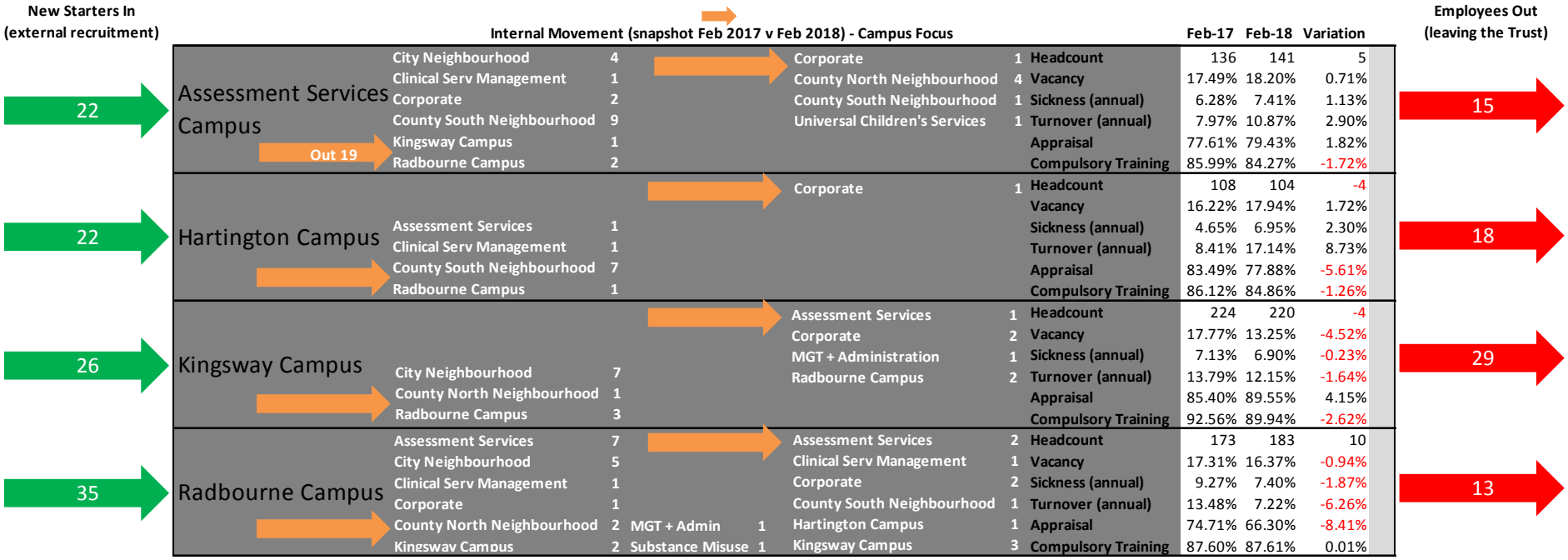
People Flow & Metrics

(Snapshot of people flow previous 12 months & metrics February 2017 v February 2018 - Campus & Neighbourhood focus)



	Feb-17	Feb-18	Variation
Trust			
Headcount	2378	2500	122
Vacancy	8.04%	4.95%	-3.09%
Sickness (annual)	5.59%	5.39%	-0.20%
Turnover (annual)	10.76%	10.60%	-0.16%
Appraisal	74.62%	78.43%	3.81%
Compulsory Training	87.83%	86.35%	-1.48%
Campus			
Headcount	641	648	7
Vacancy	17.34%	16.00%	-1.34%
Sickness (annual)	7.16%	7.17%	0.01%
Turnover (annual)	11.60%	11.30%	-0.30%
Appraisal	80.56%	78.89%	-1.67%
Compulsory Training	88.74%	87.24%	-1.50%
Neighbourhood			
Headcount	516	567	51
Vacancy	12.77%	6.75%	-6.02%
Sickness (annual)	6.21%	5.38%	-0.83%
Turnover (annual)	11.26%	10.32%	-0.94%
Appraisal	73.63%	77.92%	4.29%
Compulsory Training	86.89%	86.33%	-0.56%
Central Services			
Headcount	406	420	14
Vacancy	7.43%	5.29%	-2.14%
Sickness (annual)	5.02%	4.72%	-0.30%
Turnover (annual)	10.22%	9.42%	-0.80%
Appraisal	73.93%	72.66%	-1.27%
Compulsory Training	87.81%	86.20%	-1.61%
Children's Services			
Headcount	366	391	25
Vacancy	13.23%	11.42%	-1.81%
Sickness (annual)	4.19%	4.61%	0.42%
Turnover (annual)	16.78%	11.94%	-4.84%
Appraisal	76.86%	82.31%	5.45%
Compulsory Training	88.36%	85.31%	-3.05%
Clinical Service Management			
Headcount	29	29	0
Vacancy	0.00%	0.00%	0.00%
Sickness (annual)	0.59%	2.01%	1.42%
Turnover (annual)	13.79%	16.67%	2.88%
Appraisal	58.62%	44.83%	-13.79%
Compulsory Training	74.90%	71.71%	-3.19%
Corporate			
Headcount	420	445	25
Vacancy	21.44%	12.96%	-8.48%
Sickness (annual)	4.18%	4.22%	0.04%
Turnover (annual)	7.67%	9.35%	1.68%
Appraisal	70.79%	86.77%	15.98%
Compulsory Training	88.08%	87.94%	-0.14%

Please note that the number of starters and leavers may not balance to variation on headcount due to 28/02/17 terminations, movement in zero hours posts and 'snapshot' of people movement data.



	Feb-17	Feb-18	Variation
Headcount	136	141	5
Vacancy	17.49%	18.20%	0.71%
Sickness (annual)	6.28%	7.41%	1.13%
Turnover (annual)	7.97%	10.87%	2.90%
Appraisal	77.61%	79.43%	1.82%
Compulsory Training	85.99%	84.27%	-1.72%
Headcount	108	104	-4
Vacancy	16.22%	17.94%	1.72%
Sickness (annual)	4.65%	6.95%	2.30%
Turnover (annual)	8.41%	17.14%	8.73%
Appraisal	83.49%	77.88%	-5.61%
Compulsory Training	86.12%	84.86%	-1.26%
Headcount	224	220	-4
Vacancy	17.77%	13.25%	-4.52%
Sickness (annual)	7.13%	6.90%	-0.23%
Turnover (annual)	13.79%	12.15%	-1.64%
Appraisal	85.40%	89.55%	4.15%
Compulsory Training	92.56%	89.94%	-2.62%
Headcount	173	183	10
Vacancy	17.31%	16.37%	-0.94%
Sickness (annual)	9.27%	7.40%	-1.87%
Turnover (annual)	13.48%	7.22%	-6.26%
Appraisal	74.71%	66.30%	-8.41%
Compulsory Training	87.60%	87.61%	0.01%

Liam Carrier - Workforce Systems & Information Manager

Several initiatives to assist recruitment are in place and further developments planned.

- Recruitment fairs
- Local advertising
- Block advertising
- Retire and return scheme
- University link working encouraging students to commit to posts on completion of studies
- Enhanced Nurse placement support offered by practice facilitators
- Exploration of recruitment overseas
- Review of advertisements and "attractors"

This is resulting in some recruitment to all areas including Campus but there are options to move on to other trust areas and staff are opting to move from Campus for posts in community settings. This has always been a recruitment pathway, but the pace of movement is much faster currently. Skill mixing has been implemented in the inpatient areas, for example OTs working within ward numbers and work continues to develop alternative options.

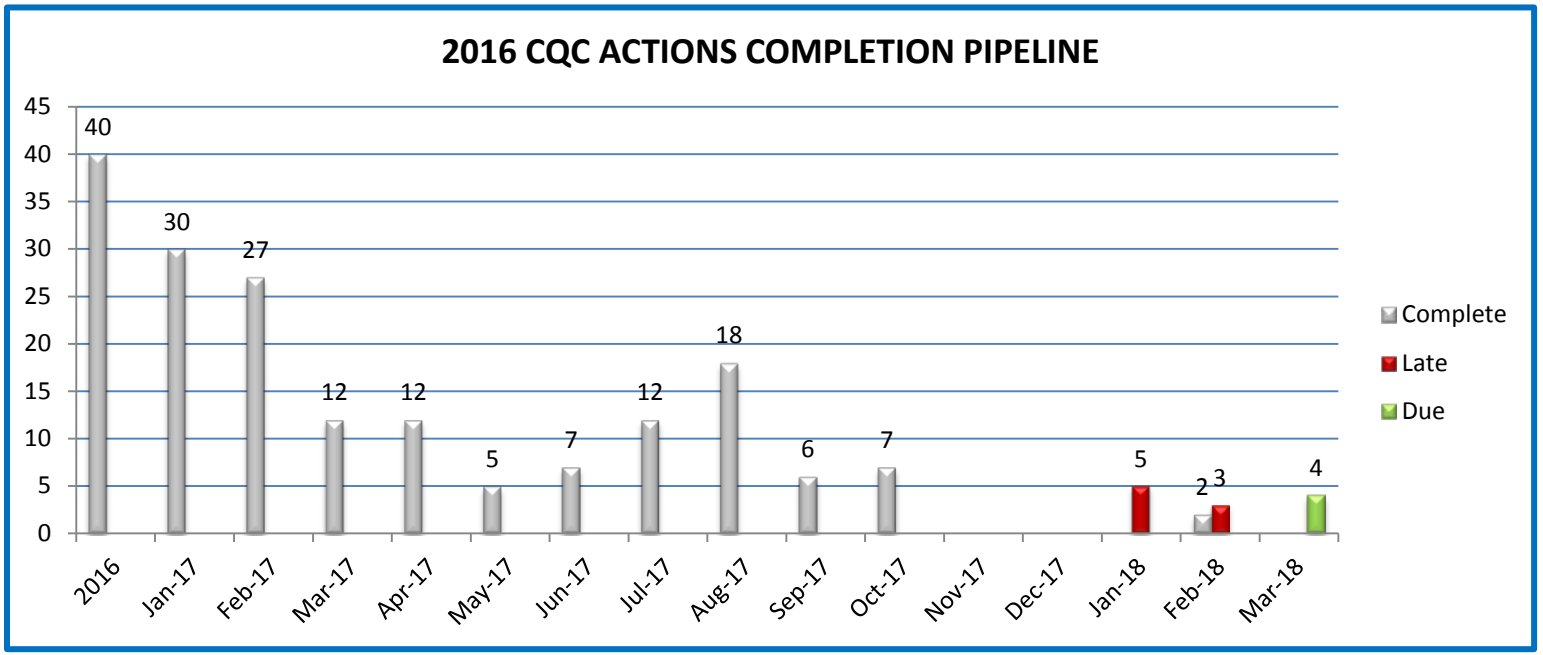
Retention on the inpatient areas is clearly a key issue.
Additional scrutiny is being placed on the delivery of supervision and appraisal in those areas of poor performance .
Sickness management processes are in place.
There is an awareness amongst the leadership of the need for cultural change and positive leadership.
Heads of Nursing posts have recently been recruited to and an OT lead for Campus is a relatively new post.
Schwartz rounds are embedded in practice.
Psychology drop in /consultation session have been established.

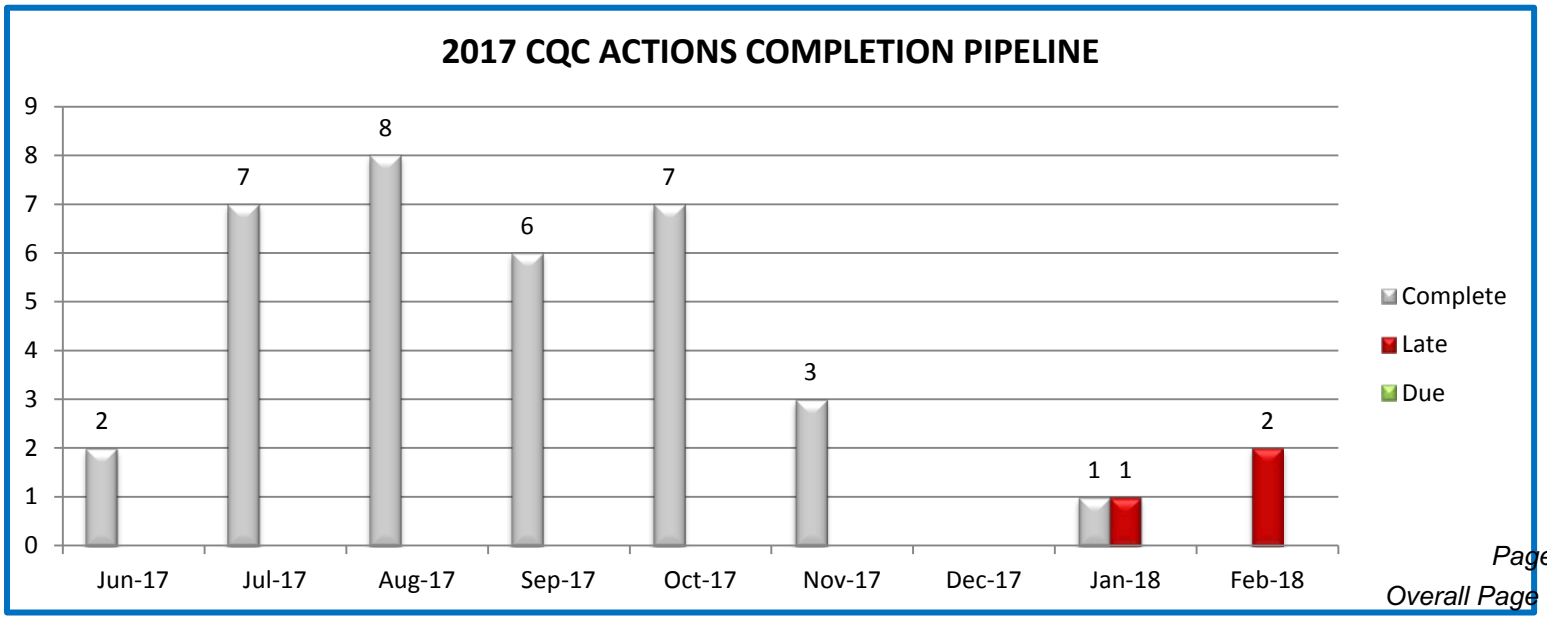
This is an area for ongoing focussed work and the responses to staff survey and pulse checks action planning will further inform local actions.

Kathryn Lane - Deputy Director of Operational Services

Quality Section

CQC ACTIONS STATUS REPORT – MARCH 2018





PROGRESS UPDATE

A final review meeting was held in February with the Deputy Director of Nursing & Quality Governance and the Leads to assess the progress of the last of the outstanding actions and to provide mutual support in meeting the completion date on them.

Two actions were completed in February. A further two actions are now ready for review for sign off (by the Deputy Director of Nursing & Quality).

Target dates were extended on five actions to allow for additional work to be completed and additional evidence to then be uploaded to the CQC Portal.

RISKS AND CONCERNS

Including the two actions awaiting review for sign off, there are 15 actions still outstanding (11 of which are late, including some that had extended target dates). Failure to meet agreed target dates for completion is a real concern. Detailed requirements for completion have been specified by the Deputy Director of Nursing & Quality Governance and all Leads have been reminded of the deadlines.

GOING FORWARD

A review of all outstanding actions will be undertaken by the Deputy Director of Nursing & Quality Governance mid-March. All actions must be complete by end of March.

Report prepared by: Kelly Sims, CQC & Governance Coordinator

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 28 March 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**: Always events developed in the United States by the Picker Institute now led by the Institute for Healthcare Improvement, laid the foundation for the IHI's Always event framework.

   An Always Event® is a clear, action-oriented, and pervasive practice or set of behaviours that provides the following:

   - A foundation for partnering with patients and their families;
   - Actions that will ensure optimal patient experience and improved outcomes;
   - A unifying force for all that demonstrates an on-going commitment to person and family-centred care.

   Always Events are aspects of the patient experience that are so important to patients, their care partners, and service users that health care providers must aim to perform them consistently for every individual, every time.

   NHS England are supporting NHS organisation are supporting. The Always Events Toolkit is designed to support leaders and point-of-care teams in partnering with patients/individuals and family members to co-design, reliably implement, and sustain and spread Always Events to dramatically improve the care experience. Our Lead professional for safety is leading a team of our staff to attend workshops on always events and design pathway specific improvement projects. The Executive Lead is John Sykes the named project sponsor is Carolyn Green.

2. **Caring and Patient / Parent Experience:** Learning from experts by experience in our organisational response to complaints. Our Trust learning and how this learning can be used in our Quality improvement developments and our Board offer of thanks to our experts by experience. The Executive Lead is Carolyn Green.

3. **Effectiveness and Responsiveness:** Presentations in Accident and emergency and our support to our acute colleagues is a key outcome and area of the Five year forward view for Mental Health. Providing acute colleagues with clinical advice in a responsive manner in the emergency team and ward. Is a key component of the current Mental Health Taskforce strategy. The Trust services

are currently complaint with this required standard due by 2020/21 The Executive Lead is Mark Powell

4. **Well Led – listening to our staff on teams feeling pressured- our new Quality visit model:** The changes to the quality visit programme are described and how we have made decisions to change the programme is included. The Executive Lead is Carolyn Green.

5. **Well Led – listening to our staff on teams on quality priorities:** A summary of feedback which has been received over the year and how we are listening to that feedback, how decisions and prioritised were made in defining Physical healthcare, Autism awareness, quality improvement and implementing ideas and the evidence have been chosen. This section also includes information and the posters we are using to inform our teams of our decisions. The joint Executive Leads are Carolyn Green and John Sykes.

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. We have had our informal visit to our Substance Misuse service in February. We have had targeted visits to the Older Adults ward in early March. We have improved our position against the CQC action plan in February.

   We have received the March 2018 publication Driving improvement which are the Case studies from seven Mental Health Trusts moving from requires improvement to a CQC rating of Good and their learning.

   This has been shared with teams in their preparation for inspections and is accompanied in additional documents for Board members. Our Trust Board was supported by Lincolnshire Partnership NHS Foundation Trust in a Board development day session on their learning and some of the themes shared with the Board are included in this publication. One key aspect of their success was the investment of leads in the divisional area/ core services areas dedicating two days of their working week at least on preparations for inspection focusing upon quality improvement. 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.

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 – Always Events

Safety – Always events developed in the United States by the Picker Institute now led by the Institute for Healthcare Improvement, laid the foundation for the IHI's Always event framework.

An Always Event® is a clear, action-oriented, and pervasive practice or set of behaviours that provides the following:

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- A unifying force for all that demonstrates an on-going commitment to person and family-centred care.

Always Events are aspects of the patient experience that are so important to patients, their care partners, and service users that health care providers must aim to perform them consistently for every individual, every time.

NHS England are supporting NHS organisation are supporting. The Always Events Toolkit is designed to support leaders and point-of-care teams in partnering with patients/individuals and family members to co-design, reliably implement, and sustain and spread Always Events to dramatically improve the care experience. Our Lead professional for safety is leading a team of our staff to attend workshops on the 21 March 2018 always events and design pathway specific improvement projects.

An Always Event must meet four criteria:

1. Important: Patients and family members have identified the event as fundamental to improving their experience of care, and they predict that the event will have a meaningful impact when successfully implemented.

2. Evidence-based: The event is known to contribute to the optimal care of and respect for patients and family members (either through research or quality improvement measurement over time).

3. Measurable: The event is specific enough that it is possible to determine whether or not the process or behaviours occur reliably. This requirement is necessary to ensure that Always Events® are not merely aspirational, but also quantifiable.

4. Affordable and Sustainable: The event should be achievable and sustainable without substantial renovations, capital expenditures, or the purchase of new equipment or technology. This specification encourages organizations to focus on leveraging opportunities to improve the care experience through improvements in relationship-based care and in care processes.

Action: the Quality committee will receive up-dates later in the year, on our progress and implementation of this model. Our named teams are Children's,

Substance Misuse and Campus, specifically Cubley Male. This will form part of our work towards Continuous Quality Improvement.

2. Caring

The Trust's Psychiatric Teaching Unit has won accolades for its programme of involving patients in the teaching and training of undergraduate medical students. Here, colleagues involved in the programme share how it works and why patient involvement is striking a chord with patients.

"People will forget what you said, people will forget what you did, but people will never forget how you made them feel," said Maya Angelou. It is no surprise that of the more than 4,000 complaints the NHS receives every week, staff attitudes and communication top the charts in the list of causes for complaint.

Almost two thirds are directed at medical and nursing staff members. Unresolved complaints lead to significant distress to patients, carers and staff extracting a significant human as well as financial cost.

Learning from complaints, completing the learning cycle. Feedback has the best evidence for bringing about sustainable change and forms the basis for any quality improvement (QI) programme. Patient complaints offer grassroots level raw data that can be used to change practice and improve patient experience and outcomes.

One would think that learning from complaints would be a staple of staff learning and development. In practice, clinicians are usually involved in individual complaints received but hardly ever get systemic feedback about the complaints at service or organisational level. Dealing with complaints at an individual level may resolve the individual case but misses the opportunity to make systemic changes to address the root causes of complaints.

Patient involvement in learning

Learning occurs best when it is set in the context of one's practice and when it creates an emotional resonance. Experiential learning creates deep learning and real patient narratives can bring to life an otherwise dry topic. This experiential learning can be made even more effective by combining it with feedback, as discussed above.

The Psychiatric Teaching Unit in Derby has won accolades for its award-winning programme of involving patients in the teaching and training of undergraduate medical students. A characteristic feature of the award-winning programme has been that expert patient involvement is not limited to sharing the personal narrative, but instead includes providing direct feedback to students on their skills and attitudes from a patient perspective.

Expert patient involvement has been consistently rated at over 90 per cent and is the highest-rated element in students' training.

What did we do?

Combining QI with educational principles, we decided to use themes from patient complaints to develop training for our colleagues. In line with our values, the training was co-produced. The result of the analysis was in consonance with national trends. Of the 159 complaints in the year, more than 60 per cent related to staff attitudes and communication and only 10 per cent related to lack of service provision.

Thematic analysis demonstrated hot spots around patient interaction with non-clinical staff and in staff interaction with patients with a diagnosis of personality disorder.

A half-day training programme was designed by the psychiatric teaching unit. Firstly, staff members were provided with local and national data – this challenged the belief that most complaints would be related to sustained cuts in mental health funding. Staff members were also surprised to learn that complaints from patients with personality disorder were more likely to be upheld. This was followed by the personal stories of two expert patients, who talked about their experience of services and related actual incidents where staff attitudes had made them feel ignored, anxious or otherwise upset and its impact on their self-esteem. The final session consisted of a role play of scenarios based on the themes derived from the complaints.

The scenario was enacted by role players and using the technique of forum theatre. The group was then asked to comment on what they thought needed to change. The scene was then replayed, this time inviting the attendees to stop the scene whenever they felt the ‘staff’ role did something wrong. The attendees would then direct the role player to play an alternative and more appropriate response. Expert patient teachers co-facilitated the learning experience with nursing and medical educators.

Sixty-five out of 68 delegates rated the training as excellent or very good and highlighted specific areas in which they would change their attitudes (more confidence/more empathy) or behaviour (more tolerant/more patient). This success led to the training being rolled out to other staff groups.

Take-home points

1. Use complaints as data for learning experience, not just for individuals but for staff groups.

2. Humanise the learning from complaints by involving patients in designing and delivering teaching tailored to address themes arising from complaints.

This post was co-authored by:

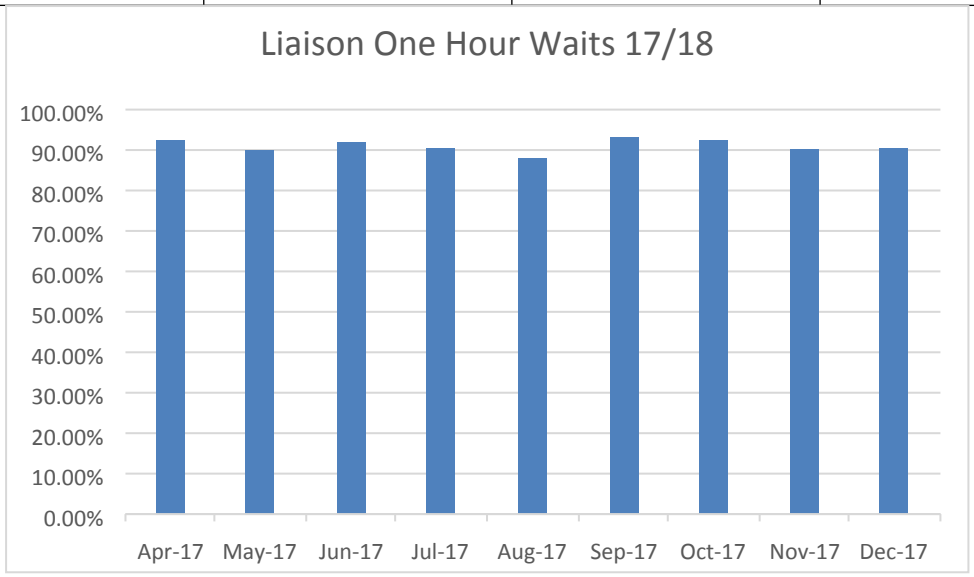
Dr Subodh Dave, Consultant Psychiatrist
Alexa Sidwell, Clinical Nurse Educator
Dr Sridevi Sira Mahalingappa, Consultant Psychiatrist
Simon Rose, Lived Experience Development Worker, Psychiatry Teaching Unit

In March 2018. Carolyn Green attended the Psychiatric Teaching Unit in Derby to offer our experts by experience a certificate of thanks on behalf of the Trust Board, for training our current and future workforce in their clinical training programme. A celebration lunch was held and very good attendance form existing and some new members of this effective expert by experience training programme.

3. Effectiveness and Responsiveness

Our accredited Psychiatric Liaison Teams at the Royal Derby Hospital and Chestefield Royal Hospital, provide comprehensive advice, support and a signposting service, where potential mental health and/or drug and alcohol issues are identified. Following referral from a health professional in Accident and Emergency (A&E) or an inpatient ward within the general hospital, the team will offer an evidence based intervention, assessment and discharge process that covers all aspects of mental health. The longer a person is waiting in A&E or in a bed within the general hospital will clearly not be a positive experience. Also, research shows that untreated mental health issues can lead to people spending longer in hospital and to poorer physical health outcomes. Working in partnership with other clinical colleagues, the Liaison Team is making sure that patients get the right help, at the right time, in the right place. They also provide a vital educational resource to staff throughout the hospital to raise awareness and understanding of mental health needs and recognising the signs and symptoms. The teams' continuing performance around seeing people referred within one hour is depicted in the tables below:

Month	Number of A&E Liaison Referrals	Number of referrals seen within one hour	% of referrals seen within one hour
Apr-17	364	336	92.31%
May-17	405	364	89.88%
Jun-17	374	344	91.98%
Jul-17	385	348	90.39%
Aug-17	343	302	88.05%
Sep-17	310	289	93.23%
Oct-17	332	307	92.47%
Nov-17	345	311	90.14%
Dec-17	355	321	90.42%



The NICE guideline and specification for mental health liaison would require services to meet the 1 hour standard.

A large number of accident and emergency teams across the country would not meet this standard.

The Mental Health standard and five year forward view states Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via inappropriate models. By 2020/21 no acute hospital should be without an all age mental health liaison services in emergency departments and inpatient wards.

In learning from other very serious incidents such as in Leeds, our two Trusts services provide in-reach and advice to all acute wards on the continuation of medicines and effective integrated clinical treatment.

Action. Although the trust is currently compliant with the Five year forward view, monitoring of the staffing, effectiveness and responsiveness of these teams is important to ensuring a safe and sustainable service.

4. Well led - Quality visits

The quality visit programme has been running for many years and after nearing eight years it is important to take time to take stock and reflect.

A number of listening events have taken place to listen to the views of individuals undertaking quality visits, listing to our staff who led quality visits and weighing up the benefits and added value of this Board, Governor and Commissioner Service visiting programme.

The model has been reviewed taking into account cross cutting themes and feedback. Overall one division in particular asked for a full cessation of quality visits, although the feedback provided by some of the neighbourhood teams has been listened too. The model has been adapted significantly on their feedback, the quality visit programme will continue with adaptations. This includes the removal of the performance data, the scoring and the move to inquisitive enquiry not of the CQC key lines of enquiry but to the named quality priorities only. A shortlisting panel, of a wider set of staff and trust wide voting of all colleagues on the winner of the Quality improvement awards.

We would like to offer thanks to all commissioners, governors and colleagues who have provided their time to run the quality visit programme and in providing their feedback.

The Nursing and Quality team will be confirming the next round of Quality visits and commencement dates in April 2018.

5. Well Led – listening to our staff on teams on quality priorities

Over the last year in trust management performance management meetings and in contact with Executive team members.

Divisional teams have feedback that they would like more feedback on the quality priorities and clarity on responsibilities

1. How are they developed?
2. Can they be divisional specific rather than weighted towards mental health?
3. Can they be published before the beginning of the year?
4. Can the specific measures be included how they are measured?
5. Can they be reduced and less of them?
6. Can we review them as we have achieved some of them, such as Think Family?
7. Can they be less operationally driven e.g. not all about CQUINs and clinically focused.
8. The Nursing and Quality directorate are responsible for CQUIN achievement, aren't they?

Derbyshire Healthcare Quality Priorities 2018 and 2019			Corporate	Children, young people and families	Learning Disabilities (Central)	Mental Health – Campus	Mental Health – Neighbourhoods	Central Services Substance Misuse
1.	**Physical Healthcare**	2018 2019	Developing EPR and technological solutions to help our teams	Meeting Physical Healthcare Strategy standards Delivering EHCP and conversions as per contract	Meeting Physical Healthcare Strategy standards Delivering compliance with Annual Health checks and Lead the Greenlight toolkit	Meeting Physical Healthcare Strategy standards and the CQUIN requirements for health checks	Meeting Physical Healthcare Strategy standards and the CQUIN requirements for health checks	Meeting Physical Health care Strategy standards Progress and work on the High need support group (157) offering interventions
2.	**Deliver all named specific CQUINs or contractual targets**	2018 2019	Offer leads for each CQUIN and enable teams to succeed	Complete the CYP Transiton CQUIN and succeed Undertake Autism awareness training	Work on all appropriate CQUINs Undertake Autism awareness training	Work on all appropriate CQUINs Undertake Autism awareness training	Work on all appropriate CQUINs Undertake Autism awareness training	Work on all appropriate CQUINs Deliver your TOPS outcomes Undertake Autism awareness training
3.	**Relapse reduction and harm reduction**	2018 2019	Developing EPR and technological solutions to help our teams care plan well	Contribute to one of the following: Achieving Baby Friendly status/ A personal health or family support plan / A plan to reduce deterioration which results in avoidable admission	A well-rounded personal health plan that identifies, prevention and reduction of avoidable admission	A well-rounded person-centred health plan that identifies, prevention and reduction of avoidable admission	A well rounded health and psychological plan that identifies, relapse signature and prevention reduction of avoidable admission	A well rounded psychological and health plan that identifies, relapse signature and prevention reduction of avoidable admission
4.	**Being effective** Implement existing NICE or best practice / Developing another teams good idea in your team	2018 2019	Revise the Quality Visit programme- to a new model	Implement on NICE guideline per team or a named piece of research, best practice from another team and show outcomes	Implement on NICE guideline per team or a named piece of research, best practice from another team and show outcomes	Implement on NICE guideline per team or a named piece of research, best practice from another team and show outcomes	Implement on NICE guideline per team or a named piece of research, best practice from another team and show outcomes	Implement on NICE guideline per team or a named piece of research, best practice from another team and show outcomes
5.	**Quality improvement- using your ideas** Develop and implement using recommended methodology	2018 2019	Design a new Quality Improvement strategy and define agreed methodology toolkit that can be used	Develop a pathway specific clinical strategy and undertake one QI project	Develop a pathway specific clinical strategy and undertake one QI project	Develop a pathway specific clinical strategy and undertake one QI project. CAMPUS – may use RED to GREEN	Develop a pathway specific clinical strategy and undertake one QI project	Develop a pathway specific clinical strategy and undertake one QI project

This year the Nursing and Quality team have endeavoured to ensure that contract discussions had progressed early enough to respect our commissioner's needs to input into these developments. This has occurred.

In addition we have taken themed learning from serious incidents as we have in previous years such as Think Family and Family inclusive practice which were identified as a specific need in a Serious case review, a very serious incident and it in serious incident reviews to identify Trust improvement areas.

1. We have specifically retained Physical Health as we have more work to do in this area and we have published a Physical Healthcare Strategy which has

cross cutting themes based upon prevention, intervention and our clinical team's contribution reducing the mortality gap which is founded in all of our services.

2. We are committed to achieving our contractual requirements and CQUINS, and we have developed CQUIN scorecards to help divisions to convey and measure their CQUIN performance and ensure Trust wide contribution and collective achievement of our contractual clinical standards.

3. The quality priorities have been widened to encompass our Trusts change from a focus upon achieving compliance. To maintain compliance and achieving continuous quality improvement and refining our effectiveness.

4. The Quality priorities have been published in mid-March and they were developed by listening to feedback (Team based quality improvements and sharing practice NICE, SIRI – Relapse prevention/ reduction plans), consideration of safety and learning needs (Autism), learning from complaints (Autism) and the joint directors who are accountable for quality defining the Trust priorities.

5. The quality priorities have been reduced and achievements and learning over a two year period have been consolidated and a more significant change to the Quality priorities has been undertaken.

6. The feedback that the quality priorities should be less operationally driven and focused upon clinically quality improvement and focused upon the evidence and learning has been implemented. This also incorporated feedback from surveys and feedback in the Quality improvement strategy.

7. The Nursing and Quality directorate are responsible for co-ordinating the CQUIN programme and enabling achievement, and the new model has more definition on how we achieve and measure our Trust required objectives.

CQUIN score card – which CQUINs will you be working on?

Key	Core part of division:		Division contributes:				
	National CQUIN 2018/2019	**Campus**	**Neighbourhood**	**Children's**	**Central**	**Corporate**
CQUIN 1a:	Improvement of health and wellbeing of NHS staff					
CQUIN 1b:	Healthy food for NHS staff, visitors and patients					
CQUIN 1c:	Improving the uptake of flu vaccinations for front line staff within Providers					
CQUIN 3a:	Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with psychoses					
CQUIN 3b:	Improving physical healthcare to reduce premature mortality in people with SMI: Collaborating with primary care clinicians					
CQUIN 4:	Improving services for people with mental health needs who present to A&E					
CQUIN 5:	Transitions out of Children's and Young People's Mental Health Services (CYPMHS)					
CQUIN 9a:	Preventing ill health by risky behaviours - tobacco screening					
CQUIN 9b:	Preventing ill health by risky behaviours - tobacco brief advice					

7. Well Led - Care Quality Commission Comprehensive – Completing Our Action

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 2017 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 outstanding recommendation's. There has been limited movement in February 2018.

Action: 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 an ever increasing solution focused approach to our staff and our 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 8 March 2018

Learning from Deaths - Mortality Report

Purpose of Report

To meet the requirements set out in the 'National Guidance on Learning from Deaths[1]' which outlines that the Trust is required to collect and publish on a quarterly basis specified information on deaths.

Executive Summary

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'*. 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

Progress to date includes:

- Production of a *Learning from Deaths Procedure*
- Development of a Mortality Review Group which has been focusing on developing the systems and processes to support review and learning from deaths
- Appointment of a Mortality Technician to support processes for learning from deaths
- Self-assessment against requirement for family and carer involvement in deaths
- Implementation of new database which now captures:
  - Improving access to psychological therapies (IAPT)
  - Deaths of patients who had died on a waiting list
  - Ability to capture all patient deaths
- Provision of data to date to enable analysis and review
- Application to NHS Digital

Challenges include:

- Reviewing of all deaths as outlined in the national guidance
- Time constraints
- Delay in obtaining cause of death

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

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

Assurances

- Supports Board Assurance Risks re failure to achieve clinical quality standards required by our regulators which may lead to harm to service users
- Assurance that the Trust is following recommendations outlined in the National Guidance on learning from Deaths – *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*

Consultation

Deputy Director of Nursing and Quality Governance , Medical Director and Executive Director of Nursing and Patient Experience

Governance or Legal Issues

- There are no legal issues arising from this Board report
- Care Quality Commission Regulations - this report provides assurance to:
  - Outcome 4 (Regulation 9) Care and welfare of people who use services
  - Outcome 14 (Regulation 23) Supporting Staff
  - Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
  - Regulation 20 Duty of Candour

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

We are making an assertive effort to ensure that there is attendance from the multi-disciplinary team to ensure a quorum. This is been monitored through the Mortality Review Group and Executive Serious Incident Group

Recommendations

The Quality Committee is requested to accept this Mortality Report and agree for it to be published on to the Trust website prior to end of March 2018, as per national guidance.

Report prepared and presented by:

Rachel Williams
Lead Professional for Patient Safety and Patient Experience
Aneesa Alam
Mortality Technician

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[2]'. 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 Trust's policy and approach (by end of Q2) 2017-2018 and publication of the data and learning points by Quarter 3 2017/18.The Trust should include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subject to review, we are asked to consider how many of these deaths were judged more likely than not to have been due to problems in care.

This report outlines the information required to be reported by the end of Quarter 4.

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 this allows the Trust to gather cause of death from a national database.
- The Mortality Review Group has chosen to use an amended form based on a national review tool called PRISM, as the alternative Structured Judgement Review tool did not meet the requirements for Mental Health case note reviews.
- Since the publication on the last Mortality Report, the Trust has implemented a new database which now captures:
    - People receiving a service from Improving Access to Psychological Therapies (IAPT)
    - Deaths of patients who had died whilst on a waiting list
    - All children deaths

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

3. Data Summary

Month	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Total
Total Deaths Per Month	195	212	229	178	204	194	184	169	224	260	145	2194
Deaths of patients on a Waiting List	49	45	36	41	48	51	30	38	48	62	32	480
Inpatient Deaths	0	2	0	4	0	1	0	1	1	1	0	10
Learning Disability Deaths	2	1	1	2	4	4	0	5	4	4	2	29

Correct as at 27.02.2018
Since April 2017 the Trust has received 2194 death notifications of patients who have been in contact with our service. Initially, the Trust recorded all deaths of patients who had contact within the last 12 months but this was changed after discussion with Commissioners to contact within the last 6 months. This took effect from 20th October 2017.

4. Review of Deaths

From 1st April to 27 February 2018, 183 deaths were reported through the Trust incident reporting system (Datix). Of these, 177 have been reviewed through the process of the Untoward Incident Reporting and Investigation Policy and Procedure, and 6 (new) incidents were awaiting review. 22 incidents warranted a further investigation (extended Initial Service Management Review (ISMR) / Peer Review / two person investigation) and 72 incidents had been closed to the Serious Incident Group. 83 incidents remain open to the Serious Incident group.

The Trust has recorded ten inpatient deaths, of all which have been reviewed under the Untoward Incident Reporting and Investigation Policy and Procedure.

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*;
Any patient open to services within the last 6 months who has died and meets the following:

- Homicide – perpetrator or victim. (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 inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / The Ombudsman, or where staff have raised a significant concern about the quality of care provision
- Death of a child (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 13 deaths. This was undertaken by a multi-disciplinary team and it established that of the 13 deaths reviewed, 11 have been classed as unavoidable and 2 have been sent for further investigation under the Untoward Incident Reporting and Investigation Policy and Procedure. The Mortality Review Group is currently reviewing deaths of patients who fall under the following ‘red flags’:

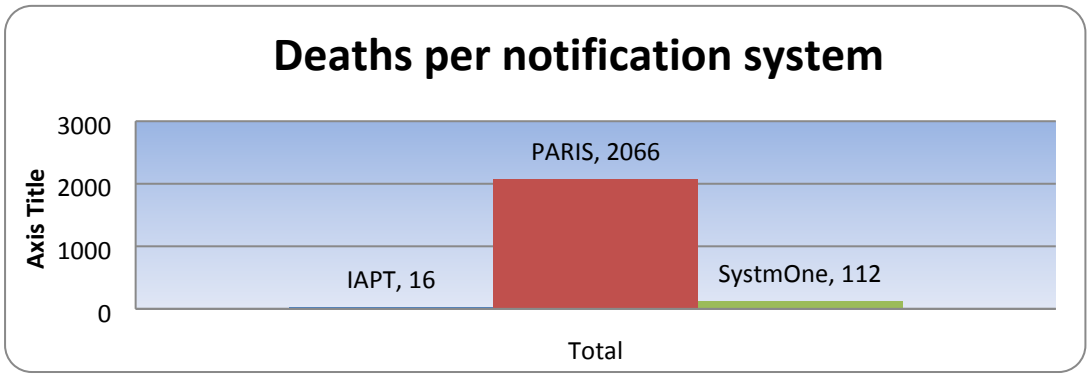
- Patient on end of life pathway, subject to palliative care
- Anti-psychotic medication
- Referral made, but patient not seen prior to death
- Death of patient on Clozapine

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

- Alzheimer’s Dementia
- Old Age
- Pneumonia

6. Analysis of Data

6.1 Analysis of deaths per notification system

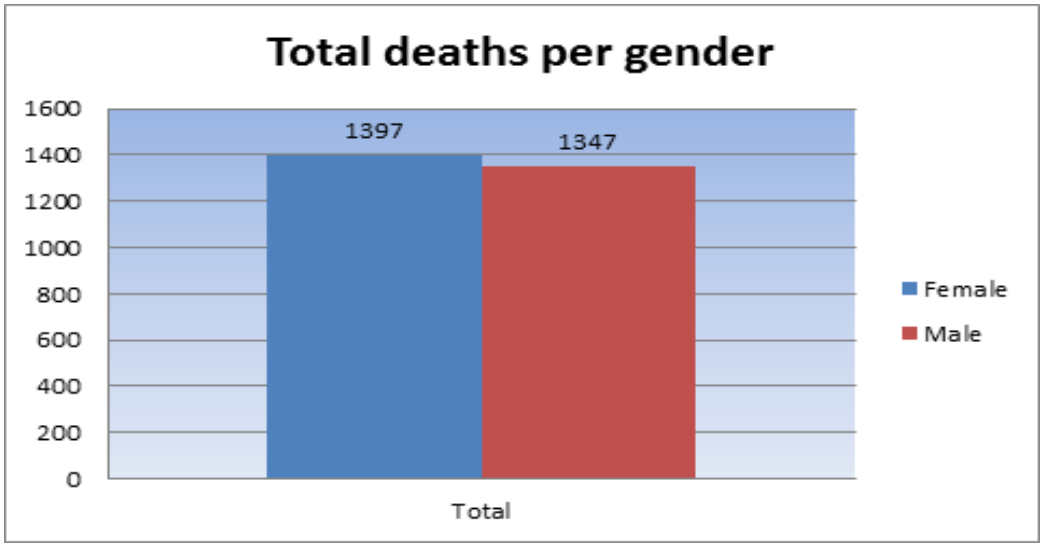


	IAPT	PARIS	SystmOne	Total
System	**16**	**2066**	**112**	**2194**

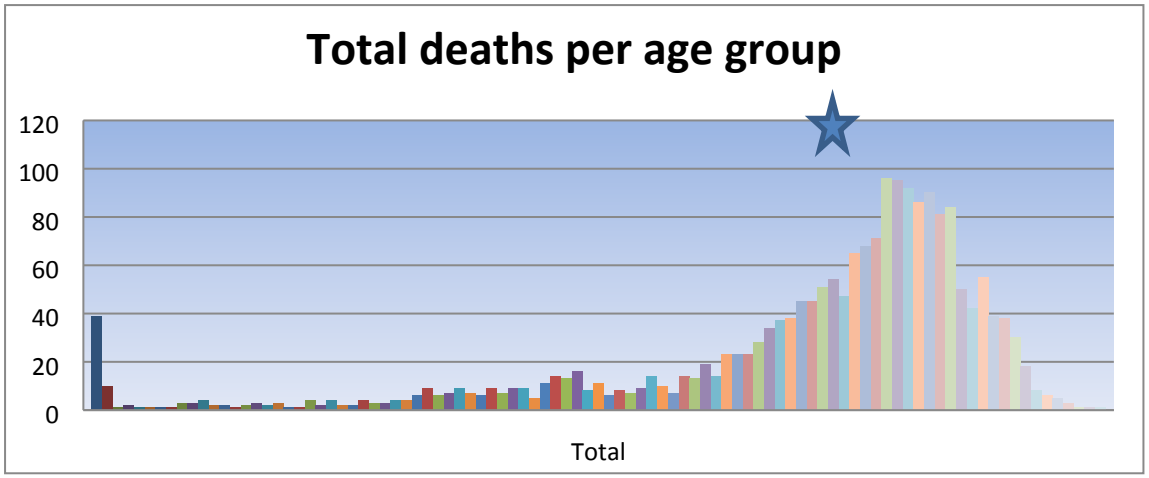
The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS, as we would expect as this clinical record system is aligned to our largest population of patients and a population at greatest risk of death. 112 death notifications were pulled from SystmOne and 16 from IAPT.

6.2 Deaths by gender

The data below shows the total number of deaths by gender. There is very little variation between male and female deaths; 1101 male deaths were reported compared to 1093 female



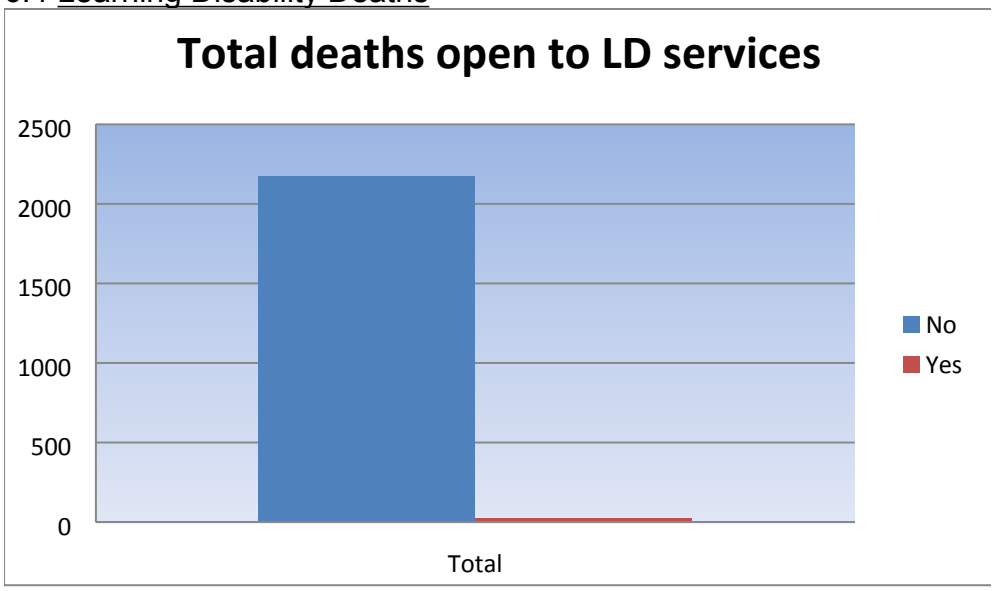
6.3 Death by age group



The youngest age was classed as 0 and the oldest age was 107 years, an increase from the previous report of 105 years. Most deaths occur within the 85-90 age groups(indicated by the star).

15 children's deaths had been investigated by the Child Death Overview Panel (CDOP) and have been closed.

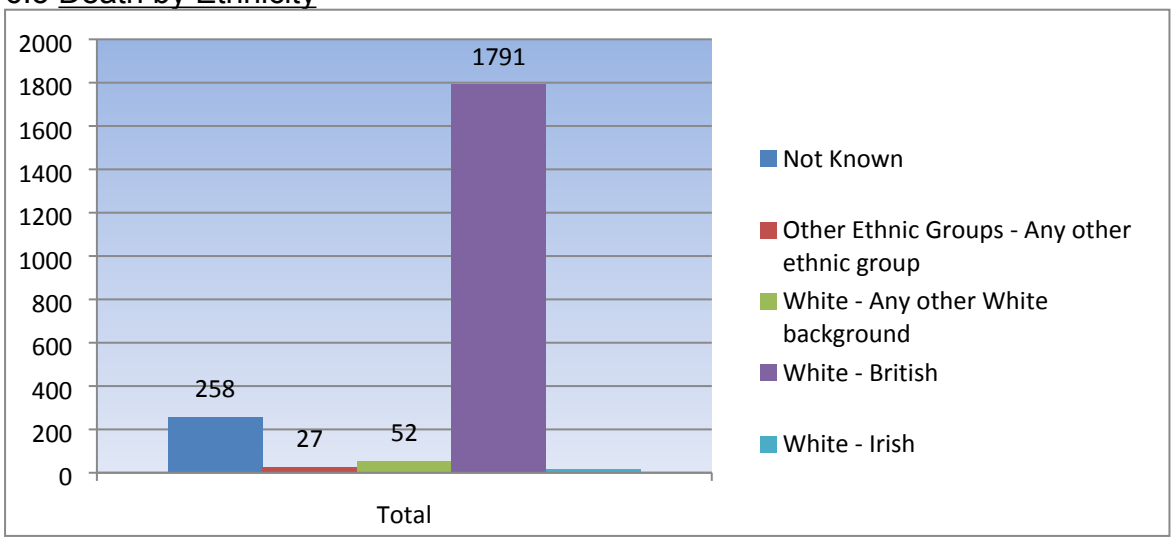
6.4 Learning Disability Deaths



Known to LD	Count of deaths
No	2172
yes	22
Total	**2194**

The Trust currently sends all Learning Disability deaths that have been reported through the DATIX system to the Learning Disabilities Mortality Review (LeDeR) Programme. Currently the Trust are unable to ascertain how many of these deaths have been reviewed through the LeDeR process. LeDeR only look at a sample of overall deaths, and are unable to tell us if our patients have been part of that sample. The Trust however reviews all Learning Disability deaths.

6.5 Death by Ethnicity



The top 5 recorded deaths per ethnicity group are highlighted above. White British is the highest recorded group with 1791 recorded deaths, 258 deaths had no recorded ethnicity assigned. The chart below outlines all ethnicity groups.

Ethnicity	Death count
Asian or Asian British - Any other Asian background	7
Asian or Asian British - Bangladeshi	2
Asian or Asian British - Pakistani	3
Pakistani	**1**
Indian	14
Caribbean	12
Mixed - White and Black Caribbean	5
Mixed - Any other mixed background	5
Other Ethnic Groups - Any other ethnic group	27
Other Ethnic Groups - Chinese	1
White - British	1791
White - Irish	16
White - Any other White background	52
Not Known	230
Not stated	28
Grand Total	**2194**

7. Recommendations and learning

Below are examples of the recommendations that has been undertaken following the review of deaths either through the *Untoward Incident Reporting and Investigation Policy and Procedure* or *Learning from Deaths Procedure.* These recommendations are monitored by the Patient safety team and are allocated to specific team and individual's to be completed. This is not an exhaustive list.

1. Briefing to be circulated regarding `Duty of Candour` and the MHA 1983: Code of Practice (Department of Health, 2015),`patients should be fully

involved in decisions about care, support and treatment`, and that the `views of families, carers and others should be fully considered when taking decisions.

2. Inpatient teams to be re-briefed on the principles of Clinical risk management and relapse planning, specifically in relation to inpatient care planning and discharge planning.
3. Inpatient team to be briefed on record keeping standards, specific involvement of patient and views of carers.
4. The Clinical Operational Assurance Team (COAT) to consider/review the communication problems identified in the report between the Inpatient and Outpatient team and advice as to systems that need to be in place to overcome/address potential communication barriers
5. The Clinical Operational Assurance Team (COAT) to consider the need for identifying patients who due to their complexity require a comprehensive case summary to inform clinicians in situations (frequent occurrence) when it would not be possible to review all records in the time span available, for example, admitting Doctors/Nurses.
6. Confirmation required in relation to requirements for the trust when a patient has a diagnosis of Hepatitis C positive and our responsibilities to notify statutory bodies
7. To review the arrangements within the team where the Care Co-ordinator is a part-time worker.
8. Access across both Paris and SystmOne for all children's services staff to be considered.
9. A communication system in the team to be considered which is consistent and includes a back up to ensure the team know messages have been received such as a 'read message' response set up as a default on the email system for all clinicians.
10. Consideration needs to be given to maximum caseloads and workload in general and the impact of this
11. Liaison Team Wi-Fi and accessibility to main computer to be reviewed.
12. It is recommended that CRHT develop how they offer support and make contact with families and carers at assessment, including an information leaflet.
13. The depth and assessment of suicidal thoughts need exploration alongside consideration of protective factors when assessing suicidal ideation
14. Exploration of consent regarding families and carer with the service receiver, especially when a person has not given consent to contact.
15. To approve an Operational Policy for Liaison South.
16. To scope the possibility of being able to share information between Paris and SystmOne for community patients
17. The lead for Positive and Proactive Support Training to review the training requirements for all Rehabilitation services
18. Service planning for people with highly complex non-psychosis mental illness to be included in the responsive communities sustainability and transformation plan
19. The purpose and quality of inpatient admissions to be addressed collectively through the Bed Optimisation Project and the CRHT [Crisis Resolution Home Treatment Team] review

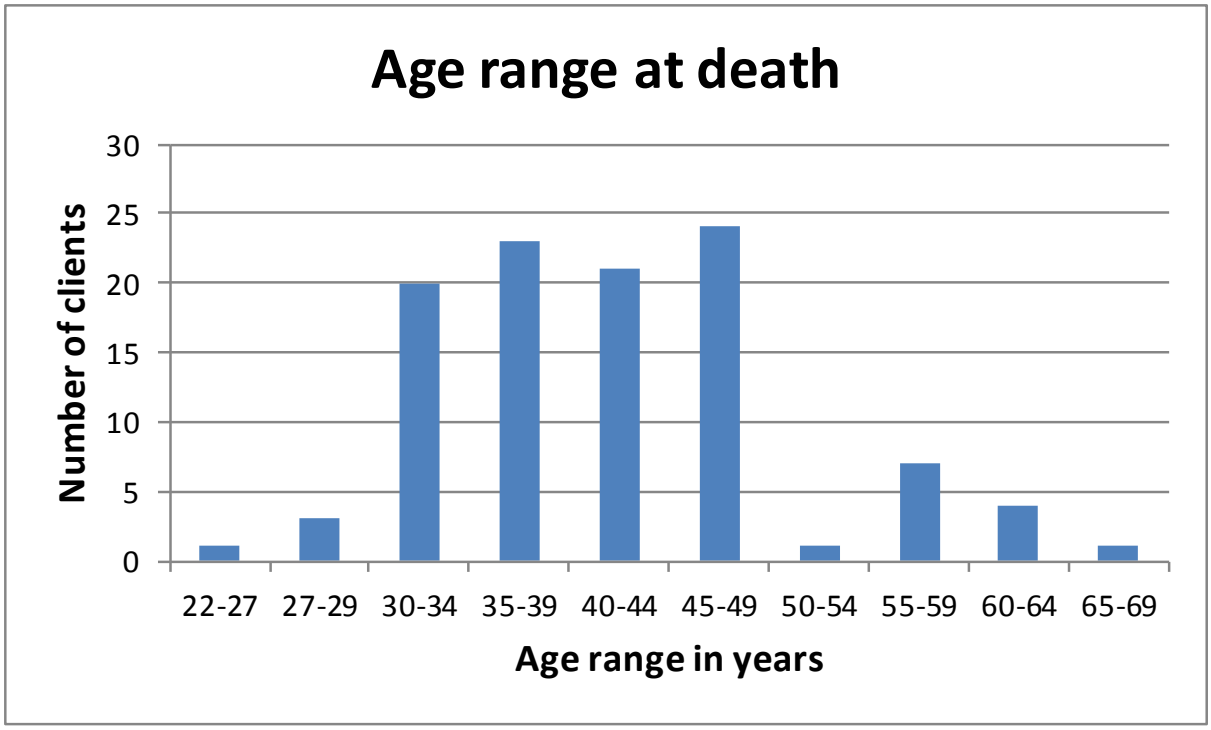
20. To review policy in relation to relapse signature and guidance on relapse reduction, care planning and reviewing clinical history
21. Possibility of an information sharing agreement to be pursued with Pennine Care Trust. This would include reciprocal system access.
22. Learning review to discuss importance of exploring family/ carer concerns regarding relapse indicators, when it is advisable to access previous paper records and reciprocal communication with other organisations that work with service users on clinician caseloads.
23. Scope an improvement project with 3 outcomes:
    a. Staff support in waiting list management
    b. Improvement on patient flow and discharge
    c. Improvement work on support worker role including scope of practice on what work cannot be undertaken
24. Information sharing from Derbyshire Constabulary in relation to the Peer Review has been identified as an issue and will need to be addressed within the multi-agency partnership
25. For Substance Misuse services to undertake an audit to establish if physical health monitoring is undertaken on assessment and at least annually, which would include staff ensuring annual reviews have been completed via the GP.
26. It is recommended that there is greater exploration around family involvement when a person is open to CRHT. There needs to be a change with regards to viewing family involvement on a continuum rather than a 'yes or no' answer.
27. Scope the possibility of a message system built into Paris which is easily accessible and which flags up urgent messages.
28. Liaison Team South to utilise a standard assessment proforma.
29. Consider the notification system for MHA expiry of detention as well as the regularity of reviews of the Safety Assessment for inpatients
30. Revisit policies in relation to transfer, both operationally and clinically, to ensure that they include systems – particularly in relation to communication that would mitigate against such gaps in care occurring in the future.
31. Paris to develop a way of tracking actions related to admission or care stays.
32. Re-iteration of standards for assessment of Waterlow Score as an assessment for Tissue Viability as per Trust policy
33. Body Map to be completed within 4 hours of admission

Drug Related Deaths

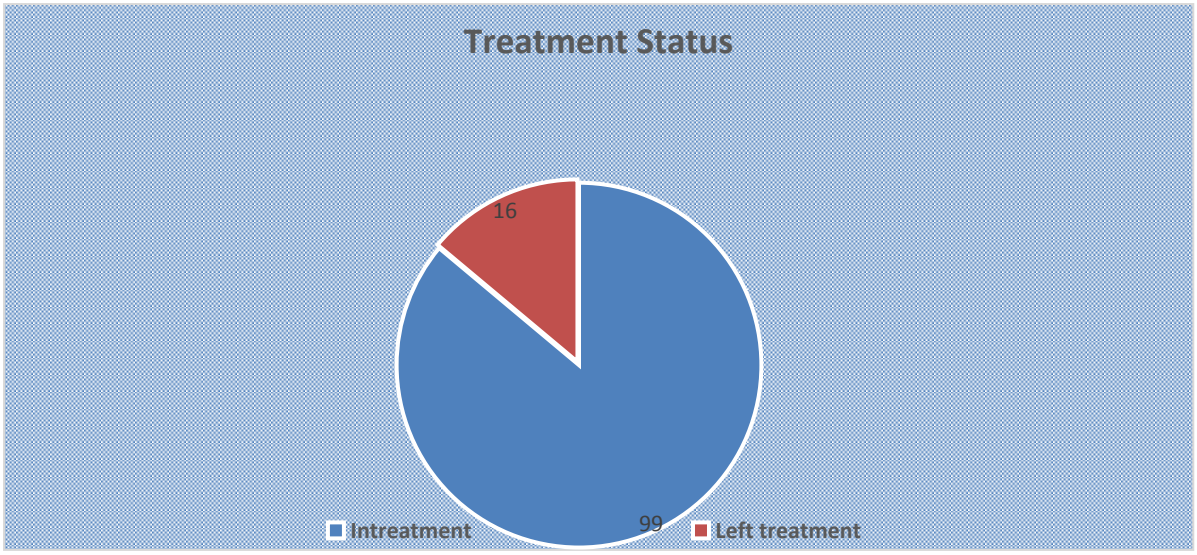
The Trust has undertaken a six year review of drug related deaths (DRD). The Trust receives notifications of deaths from the police, hospital, family, General Practitioner and through SystmOne and the DRD alert.

All DRD are reviewed through the DRD steering group. The Trust has a compressive strategy which is evidence based, has recovery focussed interventions and aims to:

- Reduce illicit and other harmful drug use
- Increase the rates of people recovering from their dependence
- Integrating prison and community
- Recruitment of National Recovery Champion answerable to the Home Secretary and a new Home office board.



The graph above outlines the number of DRD by age group from 2012-2017
The below graph shows the deaths of those who were engaged in treatment at the time and those who had left treatment in both planned and unplanned ways



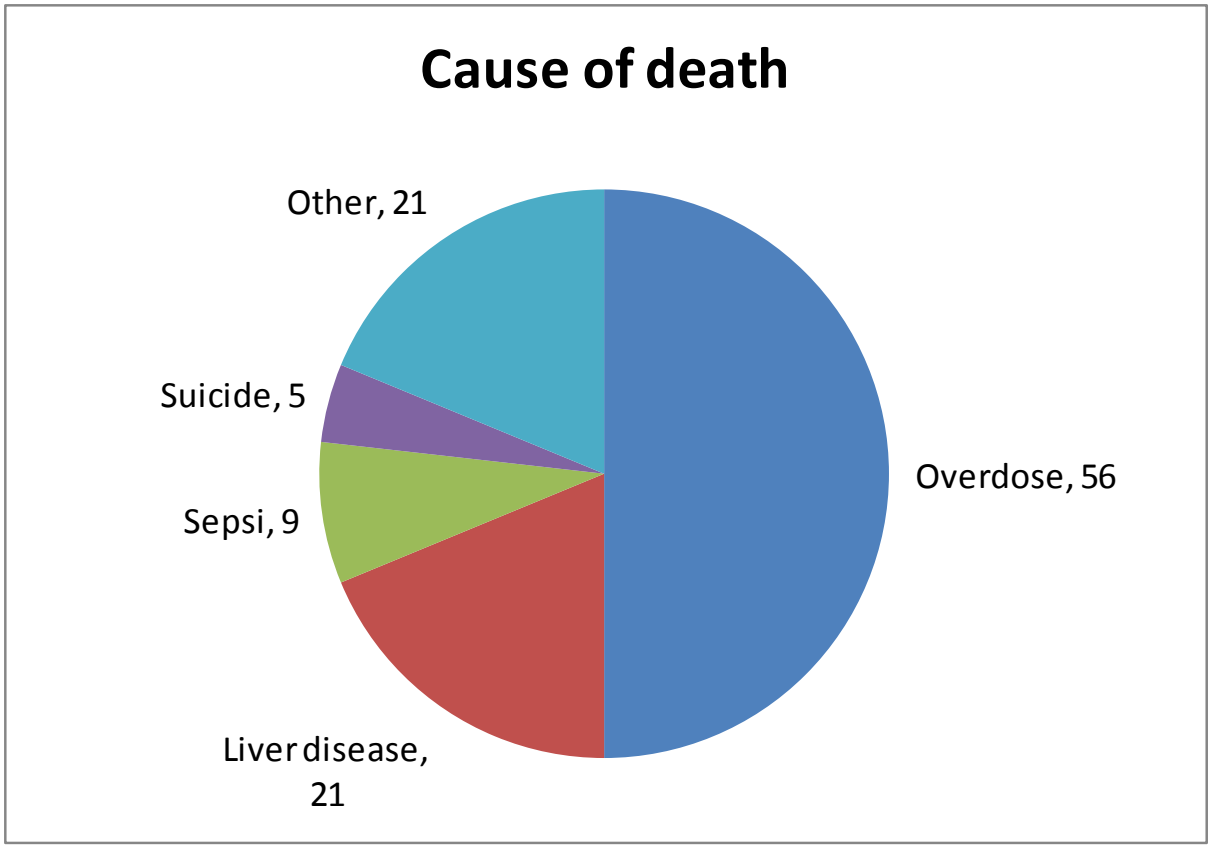
In total 86% (99) died whilst in treatment and 14% (16) died within the first 12 months after exiting treatment.

In Derby City 46% (53) of patients died whilst engaging in services and 7% (8) died after leaving treatment.

Derbyshire county recorded that 42% (48) of patients died during treatment and 5% (6) died after leaving treatment. A total of 15% (17) service users died whilst not in receipt of opiate substitution therapy (OST), the reasons for this varied but included incidence of nonattendance and failure to pick up medication from the chemist.

To further understand the circumstances surrounding these deaths, a review of patient's treatment progress was undertaken for those in treatment and a review into the present circumstances for those discharged from treatment.

From the 99 in-treatment deaths reviewed, (62) 53% were having their medication reduced. Within the group who were reducing their medication, (32) 62% of them were regularly testing positive to opiates and other drugs. Information was not available for everyone due to a lack of data.



Further Analysis of the 115 deceased patients:

- 20 people died of liver disease. Of these 16 were known to have a diagnosis of Hepatitis C.
- 64 were parents (at the time of triage)
- 108 were recorded as unemployed / on benefits (at the time of triage)
- 61 were recorded as drinking alcohol daily (at time of triage or evidenced in recent key work sessions)
- 109 were recorded as being smokers (in ISMRs or key work sessions). Eight had no data.
- 79 were recorded as living in isolation (at the time of triage) – such as living in hostels, B&Bs, and sofa surfing or on their own
- The total number of people diagnosed with Hepatitis C was 37.

Key recommendations following review of Drug Related Deaths

Treatment System

- To segment the treatment population to gain a better understanding of the recovery potential of different groups and target interventions more appropriately. (Medications in Recovery 2010).
- To consider implementing prior to discharge a check list that ensures each service user has sufficient recovery capital. An individual's recovery capital is one of the best predictors of sustained recovery. (Medication reductions alone will nearly always result in relapse).

- Treatment should be more attentive to the comorbid health conditions faced by older adults, unique prescribing / health clinics need to be considered for this group.
- Recognition needs to be given to liver disease and Hepatitis C. This group require more joined up working and a different approach needs to be applied.
- Review current practice to identify gaps and where appropriate provide training
- All clients with an unknown Hepatitis C status should be tested
- Clients with an existing active Hepatitis C positive status to be referred for treatment
- For clients who refuse to be tested, the reason should be recorded and counter signed by the service user, and re-testing should also be reoffered every 6 months.
- Clients who continue to be involved in high risk behaviour should be routinely retested
- Review existing Hepatitis C treatment pathways
- Set up an Hepatitis C prescribing clinic where appropriate in order to maximise health gains and to embed expertise within this clinic from external sources.
- To influence local authorities to take this public health issue more seriously.
- To ensure Hepatitis C literature is available on assessment and where possible we need to develop intervention materials for all.
- Roll out of dry blood spot testing that includes rapid blood testing for positive reactions to the blood spot testing.
- Always check the Hepatitis status of females requesting pregnancy tests.
- Develop a vision and framework for recovery that is visible to people in treatment, owned by all staff and maintained by strong clinical leadership.
- Create space for staff to discuss and share concerns / good practice within a backdrop of targets that can challenge safe practice.
- Optimisation of opiate substitution therapy should be standard for all those that require it
- Treatment providers to be more community facing, in line with the Trust's vision, and work more effectively with community based organisations.
- There are weekly Multidisciplinary meetings (where staff from several different professional backgrounds come together to share information). In practice, these are limited to only Trust staff coming together. Once per month the multidisciplinary meetings need to be dedicated to social care cases where Health Visitors and Social Workers are invited as routine. This approach needs to be normalised and embedded into practice.

<u>Prescribing</u>

- There was little evidence of rationales around prescribing decision making. When making a medication choice with an opioid dependent patient the NICE TA114 recommends that prescribers consider three factors.
    - Risk and Benefits of each treatment, (Safeguarding children)
    - Diversion and Misuse (Risk of death to others if medication is passed on)
    - Mental and Physical Health (Comorbidities, Cognitive and Emotional Effects, Mortality Risks)

- Drug Interactions (Interactions with other medications including alcohol, benzodiazepines and other prescribed medication). Both consultants to ensure all prescribers justify their prescribing decisions by taking into account the above as in line with NICE guidance.
- This report has highlighted a growing theme of medication reductions regardless if the patient is still using drugs. A reduction in medication has the potential to cause more harm to the patient and to the community. A review of all reductions would be clinically prudent to ensure this is being managed in a safe and effective way.
- Derby City to review the use of Daily Supervised Consumption and to ensure it is in line with NICE guidance and is being used as a supportive measure.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 28 March 2018

Strategy Refresh 2018-21

Purpose of this Report

Following agreement by the Trust Board in November 2017 to refresh the strategy and to revise the vision and values it was necessary to update the current document – The Trust Strategy 2016-21. The purpose of this report is to present the DRAFT Strategy Refresh for 2018-21 to the Trust Board for approval.

Executive Summary

Our strategy was developed in early 2016 to meet the needs of our service receivers and to help colleagues understand their role in achieving the vision. It set out the direction of travel for Derbyshire Healthcare NHS Foundation Trust for the five years 2016-21 within the context of the wider health and care agenda, both nationally and locally. The strategy was written to provide a clear and concise vision for the future in order to deliver a *"…proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services" (Five year forward view for Mental Health – Feb. 2016, NHS England).*

However, since that time a number of things have happened which has meant that it was necessary to update the strategy to make it appropriate to our colleagues and external stakeholders.

There were three key reasons for refreshing the strategy:

- The Trust's vision was updated in December 2017 as a result of feedback from our colleagues. Colleagues told us that they wanted a simpler, clearer vision of what the Trust will achieve in the years ahead. This was taken into account along with ideas on what makes Derbyshire Healthcare special.
- The proposed merger with Derbyshire Community Health Services NHS FT was not progressed following a Board decision in July 2017. It was agreed that with the proposed changes at a system level many of the clinical benefits could be achieved without a full merger. Therefore the strategy needed to reflect this change.
- In the original strategy (2016) reference was made to how the Sustainable Transformation Partnership (STP - now Joined-up Care Derbyshire) objectives would be delivered. However, much of the STP progress was stalled. The STP structure was reformed in the spring/summer of 2017 and this has made it clearer on the part Derbyshire Healthcare plays in the wider health and care economy.

We have taken the opportunity through the strategy refresh, to more clearly articulate intentions around:

- How we aim to put people first in order to live our values
- How we develop our leaders to create the environment where people experience our values

- How the work of Derbyshire Healthcare fits within system-wide and partnership working.

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 Refreshed Strategy 2018-21 takes into account the views of our colleagues through wide consultation
- The refreshed strategy will enable the Integrated Performance Report to link to key measures and provide monthly progress to the Trust Board
- It is aligned to the work of Joined-Up Care Derbyshire and provides a clear link to system plans

Consultation

The refreshed strategy has been widely consulted on internally via the following groups of staff:

- Executive Leadership Team
- Trust Management Team
- Trust Medical Advisory Council
- Staff Forum

A number of other colleagues have commented and assisted with the development of the refreshed strategy.

All comments have been considered and incorporated.

N.B. Please note that following Trust Board approval the plan requires further design work and branding.

Governance or Legal Issues

There are no direct legal or governance issues associated with this plan. Where the changes or actions identified within the plan are implemented the specific governance or legal issues will be considered.

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:

1) Note the contents of the plan and be assured that there has been wide consultation.
2) Approve the Refreshed Trust Strategy for 2018-21 (subject to final design work and branding)

Report prepared and presented by: , **Lynn Wilmott-Shepherd**
Interim Director of Strategic Development

NHS
Derbyshire Healthcare
NHS Foundation Trust

Trust strategy (Refresh)
2018-2021

DHCFT @derbyshcft
www.derbyshirehealthcareft.nhs.uk

Making a positive difference

Introduction and Background

Welcome to our refreshed Trust strategy (2018 – 2021)

We find ourselves at an exciting point in the development of our Trust. This strategy is important because it identifies the common purpose all of us who work in the Trust share, the way we go about doing business and what outcomes people can expect to see from us over the next few years.

It is important to refresh our strategy because as a Board of Directors we have recognised the absolute need to focus on 'people first' and by that we mean colleagues who work in the Trust. We are clear that only by doing this, can we together, create a culture that supports continuous improvement, that learns from mistakes and promotes innovation. Focusing on people will enable us to attract colleagues to work with us and will ensure we create new and exciting roles to give more opportunity for personal development.

Whilst we have identified four broad strategic objectives or areas for action, we will, together, constantly review what the 2 or 3 key priorities under each area are, if we have made improvements and if we need to change our focus.

TEAM
Derbyshire Healthcare

Things are changing in our wider health and social care environment too, a focus on delivering care as close to home as possible, more collaboration across clinical pathways and a focus on prevention; all things we need to take into account when working together to refine and improve how we deliver our services

Our strategy should be read in conjunction with our Divisional 'plans on a page' that add more detail to how each area will deliver the vision and objectives

I look forward to working together to make our strategy a reality for the people of Derbyshire

Ifti Majid
Chief Executive

Background and context

What is a trust strategy?

Our strategy was developed in early 2016 to meet the needs of our service receivers and to help colleagues understand their role in achieving the vision. It set out the direction of travel for Derbyshire Healthcare NHS Foundation Trust for the five years 2016-21 within the context of the wider health and care agenda, both nationally and locally. The strategy was written to provide a clear and concise vision for the future in order to deliver a *"…proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services" (Five year forward view for Mental Health – Feb. 2016, NHS England).*

However, since that time a number of things have happened which has meant that it is important to update the strategy to make it appropriate to our colleagues and external stakeholders. There were three key reasons for refreshing the strategy:

- The Trust's vision was updated in December 2017 as a result of feedback from our colleagues. Colleagues told us that they wanted a simpler, clearer vision of what the Trust will achieve in the years ahead. This was taken into account along with ideas on what makes Derbyshire Healthcare special.
- The proposed merger with Derbyshire Community Health Services NHS FT was not progressed following a Board decision in July 2017. It was agreed that with the proposed changes at a system level many of the clinical benefits could be achieved without a full merger. Therefore the strategy needed to reflect this change.
- In the original strategy (2016) reference was made to how the Sustainable Transformation Partnership (STP - now Joined-up Care Derbyshire) objectives would be delivered. However, much of the STP progress was stalled. The STP structure was reformed in the spring/summer of 2017 and this has made it clearer on the part Derbyshire Healthcare plays in the wider health and care economy.

There is now an opportunity through the strategy refresh, to more clearly articulate intentions around:

- How we aim to put people first in order to live our values
- How we develop our leaders to create the environment where people experience our values
- How the work of Derbyshire Healthcare fits within system-wide and partnership working.

How has the trust strategy been developed?

We have considered our commitment to colleagues, our performance, what services are core and which are strategically important to us (core plus). We have consulted with our colleagues, stakeholders, commissioners, governors and Trust Board members to gather ideas for strategic direction and these are detailed in this document. We have circulated the draft content to our colleagues, via the Staff Forum, to ensure that it clearly represents the views of the whole organisation.

We have also ensured that our strategy takes into account the wider health and care environment in which we work.

Our vision

The Trust's vision was updated in December 2017 as a result of feedback from our colleagues.

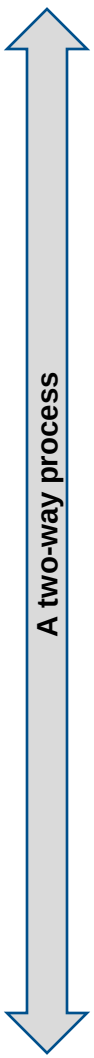
Colleagues told us that they wanted a simpler, clearer vision of what the Trust will achieve in the years ahead. This was taken into account along with peoples' ideas on what makes Derbyshire Healthcare special. Therefore the revised Trust vision is:

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

This strategy covers the period 2018 - 2021

Background and context

How will the Trust Strategy be implemented?



Sustainability and Transformation Partnership (Joined-up Care Derbyshire)

This outlines system level objectives in-line with the Five Year Forward View and national level planning documents

Derbyshire Healthcare NHS Foundation Trust Strategic Plan (Refresh) 2018-21

Our Trust Strategy clearly outlines how we are contributing to Joined-Up Care Derbyshire and the changes that we need to make in order to achieve our own vision working with our partners

Supporting Strategies
- Quality
- People
- Information Technology
- Estates

These 'enabling' strategies will clearly outline how we will change our structures and processes in order to meet our vision. These will set-out how we will make the changes and how things will 'look different' in 2021

Annual clinical/operational business plans
- Sets objectives for services and corporate areas each year of the strategy

- Annual clinical/operational business plans will enable teams and individuals to see how they are contributing to the overall strategy.
- Team and personal objectives will be aligned to the plans.
- Plans will allow us to track our progress.

Introduction

Derbyshire Healthcare NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust (DHCFT) is a provider of community, children's and mental health services across the city of Derby and wider county of Derbyshire. We also provide a range of children's physical and mental health services in Derby and specialist services across the county including substance misuse, eating disorders and learning disabilities.

The Trust provides services to a diverse population, including areas of wealth alongside significant deprivation. The Trust's catchment includes both city and rural populations, with 71 languages being spoken. To demonstrate the diversity of our population it should be noted that 4% of the population of the County and 25% of population of Derby City are Black or another ethnicity. We have the second largest Deaf community outside of London. It is estimated 4-7% of local population are lesbian, gay or Bisexual.

The Trust works to the Equality Delivery System 2(EDS2) which is the national NHS performance framework designed to deliver better outcomes for patients, communities and better working environments for colleagues, which are personal, fair and diverse'. We have adopted EDS2 framework and will use it as a key enabler to support the delivery of this strategy, to ensure we consider equality in everything we do, including ensuring services and employment are equally good for everyone.

Successful partnership working is key to the delivery of many of our services. The Trust works in close collaboration with our commissioners and fellow providers of local healthcare services, together with local authority colleagues at Derby City Council and Derbyshire County Council, and voluntary and community sector organisations.

Our services

The Trust started to restructure its clinical services during 2015/16, following a large scale transformation programme that commenced in July 2013, when nearly 500 people took part in sessions to define how our services across Derbyshire might look in the future. From there, a vision was developed:

- Services will be wrapped around the needs of the patient and their community, they will be easy to access and re-access. The way in which we deliver care will be in line with an individual's needs and not simply dictated by how the service pathway is designed. We will not 'discharge' patients but will support their transition between services based on the individual's needs.
- Models of care will be service receiver needs led, not simply diagnostically led. Services will interconnect with other organisations to ensure that care is delivered in a truly integrated co-produced way.
- We will have fewer beds and instead care for service receiver within their communities as much as possible; services will support and enable the development of community, family and service receiver resilience. Our workforce will be flexible to support the service receiver's journey.

To date, hundreds of colleagues, service receivers, carers and external partners have been involved in deciding how this vision could be achieved. This has resulted in the identification of:

- A neighbourhood-based, needs-led approach to our community mental health services, with neighbourhood team members working closely with each other and other local health professionals, wrapping care around the person to keep them at home as long as possible. The teams draw on local community resources to help people rebuild their lives after an episode of mental ill health; and
- A campus based approach where our inpatient mental health services and the wider teams that support inpatients will focus on delivering high-quality care, as well as support within the community to prevent hospital admissions.

Derbyshire Healthcare NHS Foundation Trust (Continued)

78,244 service users seen

271 Inpatient beds

Number of staff **2,384**

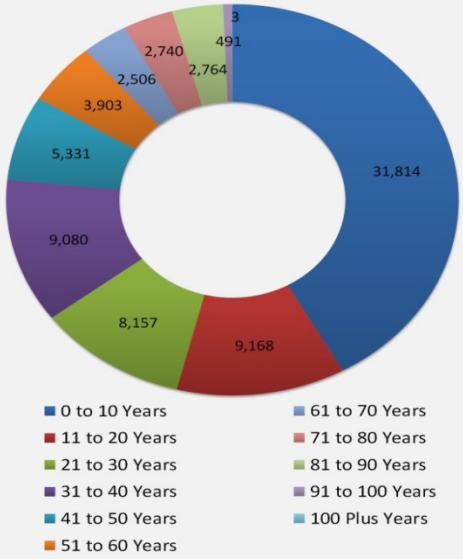
- 189 Scientific and technical
- 398 Additional clinical services
- 503 Administrative and clerical
- 117 Estates and ancillary
- 889 Nursing and midwifery
- 137 Medical
- 148 Allied health professionals
- 3 Students

The Trust cared for **3,172** babies born in Derby City

8,629 members

- 2,401 Staff members
- 6,254 Public members
- 22 Governors

75,957 service users open to Derbyshire Healthcare services on 31 March 2017



6 years ago we were licensed as an NHS Foundation Trust

1,014 Square miles covered

£ 136 million Annual operating income

During **2016/17** we reported an overall financial surplus

Background and context – to '*make a positive difference*' we must understand the wider system

Developing the Sustainability Transformation Plan

In response to the *NHS Shared Planning Guidance* (December 2015) it was agreed by health and care leaders across both City and County that all parties would contribute to the Sustainability Transformation Plan (STP) making it a truly system wide plan. The 12 organisations (NHS and Local Authority) agreed to create an ambitious local blueprint for accelerating the implementation of the Five Year Forward View (5YFV). The plan was submitted in October 2016 . However, owing to a number of changes nationally there was a 'pause' which meant that the STP was relaunched in spring/summer 2017 as the Sustainability and Transformation ***Partnership***. This has since been rebranded 'Joined-up Care Derbyshire'.

Joined-up Care Derbyshire continues to be developed based on the needs of local citizens and communities. Clinicians, professionals, colleagues and wider partners are central to the development of the plans. The Trust strategy needs to be in-line with the emerging system wide plan and be flexible in its approach. The strategy is aimed at providing the framework for the next three years whilst recognising that the health and care landscape will change for providers, commissioners and service receivers. A key feature of the system plan will be the move towards 'place based systems of care'. The emerging STP can be diagrammatically shown as:

Moving to Place Based Systems of Care

The move towards place based systems of care will enhance the concept of 'the team around the person' leading to a more integrated service, a reduction in duplication and greater efficiency. For a **defined geographical community with similar characteristics** all services – primary care, mental health, community services, social care and third sector sectors will operate as a **single team to wrap care around a person and their family.** There will be an equal focus to **empowering citizens** to self care and participate in shared decision making and promoting healthy lifestyles and well being, as there is to providing direct care. Links with the local community will be fostered, recognising that communities have a range of complex and inter-related needs, but also have **assets at the social and community level** that can help improve health and strengthen resilience to health problems. This integrated approach will meet the specific needs of local communities it will be **not one size will fit all** and will recognise that different communities will start with different services and facilities (including general practice).

Our communities

Derby City perspective

Derby City public health profile summary: Source narrative from Public Health England published June 2015.

Derby at a glance:

Health in summary - The health of people in Derby is generally worse than the England average. Deprivation is higher than average and about 23.8% (12,100) children live in poverty. Life expectancy for both men and women is lower than the England average.

Living longer - Life expectancy is 12.4 years lower for men and 8.9 years lower for women in the most deprived areas of Derby than in the least deprived areas.

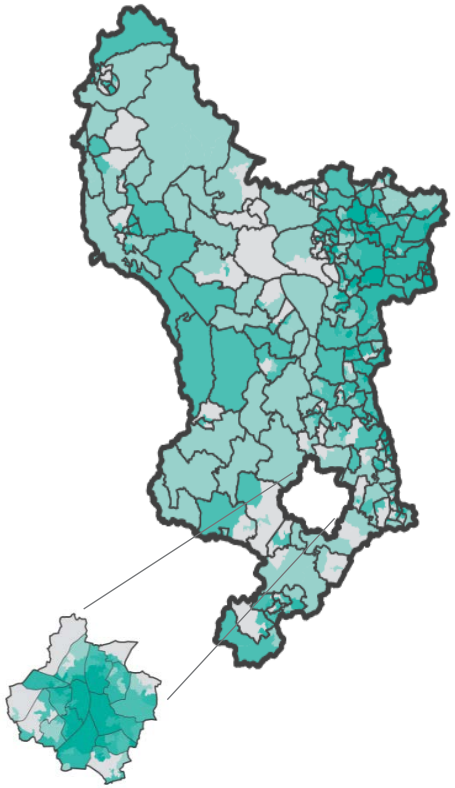
Child health - In Year six, 20.5% (545) of children are classified as obese. The rate of alcohol specific hospital stays among those under 18 was 44.1*. This represents 25 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

Adult health - In 2012, 24.3% of adults are classified as obese. The rate of alcohol related harm hospital stays was 801*, worse than the average for England. This represents 1,856 stays per year. The rate of self-harm hospital stays was 291.0*, worse than the average for England. This represents 760 stays per year. The rate of smoking related deaths was 303*. This represents 374 deaths per year. Estimated levels of adult smoking are worse than the England average. The rate of sexually transmitted infections is worse than average. The rate of people killed and seriously injured on roads is better than average.

Local priorities - Priorities for Derby include reducing inequalities, giving children the best start, risky behaviour change and substance misuse.

* *Mental health locality profiles - Derby City overview (East Midlands Public Health Observatory)*

Deprivation in Derbyshire: darker wards represent areas of higher deprivation.



Source: Derby City and Derbyshire County 2014 Public Health Profiles

Our communities

Derbyshire County perspective

Derbyshire public health profile summary: Source narrative from Public Health England published June 2015.

Health in summary - The health of people in Derbyshire is varied compared with the England average. Deprivation is lower than average, however about 16.3% (21,900) children live in poverty. Life expectancy for both men and women is similar to the England average.

Living longer - Life expectancy is 7.9 years lower for men and 5.8 years lower for women in the most deprived areas of Derbyshire than in the least deprived areas.

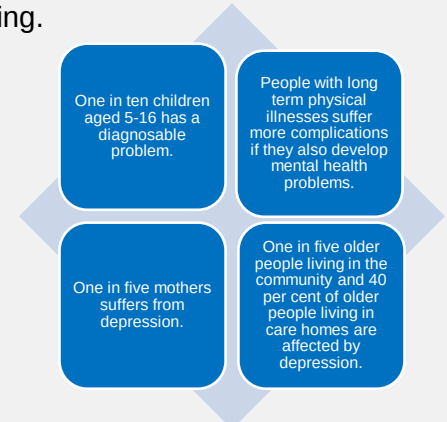
Child health - In Year 6, 17.1% (1,258) of children are classified as obese, better than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 45.4*. This represents 70 stays per year. Levels of GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average. Levels of teenage pregnancy are better than the England average.

Adult health - In 2012, 24.7% of adults are classified as obese, worse than the average for England. The rate of alcohol related harm hospital stays was 718*, worse than the average for England. This represents 5,632 stays per year. The rate of self-harm hospital stays was 274.2*, worse than the average for England. This represents 2,076 stays per year.

The rate of smoking related deaths was 283*. This represents 1,301 deaths per year. Estimated levels of adult excess weight are worse than the England average. Rates of sexually transmitted infections and TB are better than average. Rates of statutory homelessness, violent crime, long term unemployment and drug misuse are better than average.

Local priorities - Priorities for Derbyshire include reducing smoking in pregnancy, reducing inequality in life expectancy and healthy life expectancy within the area and increasing breastfeeding.

In England:



* *Mental health locality profiles - Derbyshire overview (East Midlands Public Health Observatory)*

Drivers for change

We have assessed the internal and external drivers for change in the development of this strategy. Examples of the drivers for change are listed below.

Internal	Our service receivers and families
• Need for clear direction - clear message to all colleagues, service receivers, partners and stakeholders. Promote a can do and creative approach in setting mutual expectations. • A strategy that assists with decision making. • Understand the direction of travel – how we can change to work in a changing health and care system. • Changing the culture of our organisation – putting our people first. • Embedding a listening, learning and solutions focused approach to all aspects of the organisation. • Managing and reducing the demand for our services. • Developing appropriate partnerships and collaboration.	• Services that put people at the centre – joined up and easy to access. • 'I tell my story once'. • Local services where possible. • Services within my own home where possible. • People that understand me and my needs. • Choices for service receivers and their carers. • Developing and embedding family and care inclusive practice. • Developing and setting mutual expectations. • 'Nothing about me, without me'.
System Level	**National**
• System wide sustainability – meeting the 'three gaps' - health and wellbeing, care and quality and finance and efficiency. • Move towards an Accountable Care System • Not progressing the merger with DCHSFT • Greater alignment of physical and mental health – parity of esteem. • More integrated services – 'I tell my story once'. • Developing seven day services. • Delivering high quality services. • Increasing demand for services linked to demographic change e.g. ageing population. • Delivering financial sustainability	A number of documents have been produced by NHS England, NHS Improvement and other national bodies which either provide guidance or are clear on the things we must do over the next five years. Examples of important documents are: • Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 (December 15). • Five Year Forward View for Mental Health (February 2016) and 5YFV One Year On (March 17) • NHSE MH Delivery Plan (Summer 17) • NHS Constitution. • NHS Outcomes Framework. • Carter Review (February 2016). • National Standard Contract and National tariff • National 'must do's'. • The 'three gaps' - health and wellbeing, care and quality and finance and efficiency . **N.B.** *Documents available via NHS England or NHSI website*

Creating our vision

Our vision, values and strategic objectives

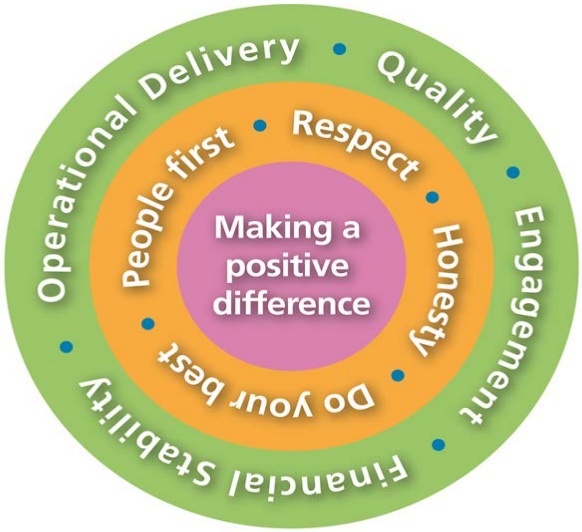
Our Vision

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

Our Values

Our vision is underpinned by four key values, which were developed in partnership with our patients, carers, colleagues and wider partners. Our values were launched in May 2012, following consultation with colleagues, service users and partner organisations. They were refreshed in November 2017 as a result of feedback from colleagues.
We can only provide good quality services through our dedicated colleagues, working together with a common purpose. Our values reflect the reasons why our colleagues choose to work for the NHS and Derbyshire Healthcare.
Our Trust values are:

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



Our Strategic Objectives

1. Quality Improvement
2. Engagement
3. Financial Sustainability
4. Operational Delivery

Our Vision

Engaging and Respecting Colleagues

To deliver our shared commitment to make a positive difference, we must work in capable teams where colleagues feel empowered, confident to be themselves and to raise concerns, share ideas for innovation and make decisions as close to the front line as possible. Our Team Derbyshire Healthcare engagement initiative provides a range of opportunities for engagement , support and development.

- Colleague Forum
- Team Brief
- Team Derbyshire Healthcare – Leaders
- Colleague magazine – 'Employee Voice'
- CEO drop in sessions
- Schwartz Rounds

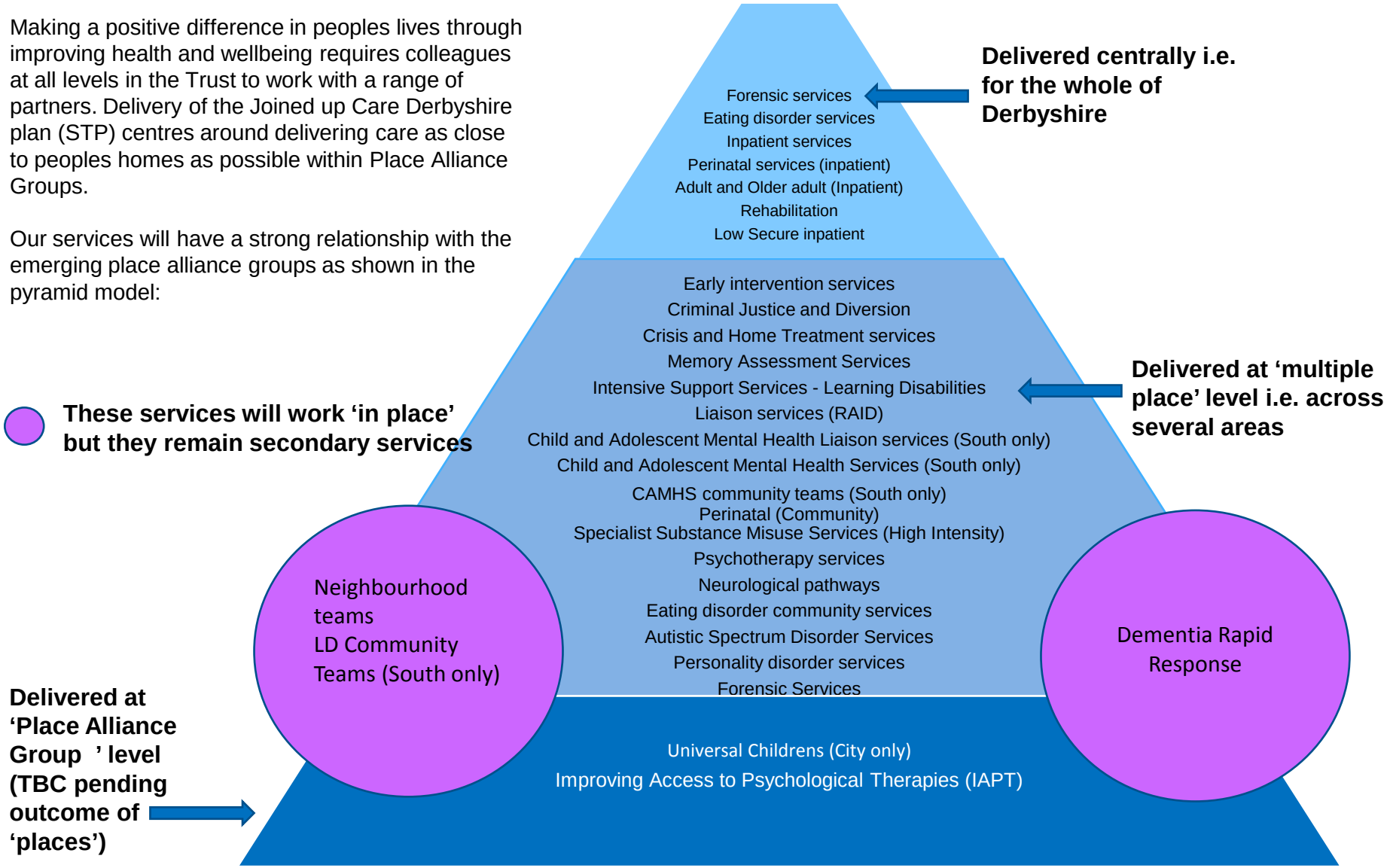
We are committed to active inclusion to support colleagues to have the opportunities to 'do their best' and succeed in their ambitions

- BME colleagues network
- Commitment to LGBT+ inclusion
- Charter for Brutish Sign Language (British Deaf Association)
- Reverse mentoring
- BME reverse commissioning.

Derbyshire Healthcare NHS Foundation Trust in 2021

Making a positive difference in peoples lives through improving health and wellbeing requires colleagues at all levels in the Trust to work with a range of partners. Delivery of the Joined up Care Derbyshire plan (STP) centres around delivering care as close to peoples homes as possible within Place Alliance Groups.

Our services will have a strong relationship with the emerging place alliance groups as shown in the pyramid model:



Closing the Gap - Health isn't just about health and care

We know that peoples health and wellbeing is effected by many things in todays society. To make a positive difference means thinking differently and if we are truly going to put people first we need to contribute to wellbeing as early as possible in peoples lives, as well as deliver services when things don't go so well.

The table below gives some examples of how we can make a difference under the four key areas that have been identified as contributing to peoples wellbeing.

How can Derbyshire Healthcare make a difference to the health and well-being gap?

Worklessness and Low Skills	Children and Young People	Crime and Offending	Health and Social Care
• Development of the Recovery College – learning new skills	• Early diagnosis of mental illness to allow young people to take ownership of their health	• Work closely with the police to help them understand the issues people with a mental illness or learning disability may face	• Making our services as accessible as possible – links to GP's and local facilities
• Individual Placement and Support (IPS) – helping people with serious mental illness or a learning disability back into work	• Working with other organisations to ensure we 'join-up' and know the whole person	• Work with people who have high levels of need so that they get support from mental health, the police and social care	• Making the links with other organisations so that people feel supported and not 'lost in the system'
• Rehabilitation in community settings for people who have had long periods of inpatient care	• Working with families and helping parents to give their children a good start in life both with their mental and physical health e.g. childhood obesity	• Support people who are in the criminal justice system	• Linking physical and mental health – making sure that people with a mental health or learning disability get good physical health checks
• Adopt best practice around personal and community resilience	• Continue to develop our Family first initiative	• Help people who have offended re-integrate into society by giving them the right support	• Work with our Commissioners to deliver the Five Year Forward View for Mental Health

Achieving our vision

What we need to achieve

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

Meet our strategic objectives

1. **Quality improvement**
2. **Engagement**
3. **Financial sustainability**
4. **Operational delivery**

Our Focus for 2018/19

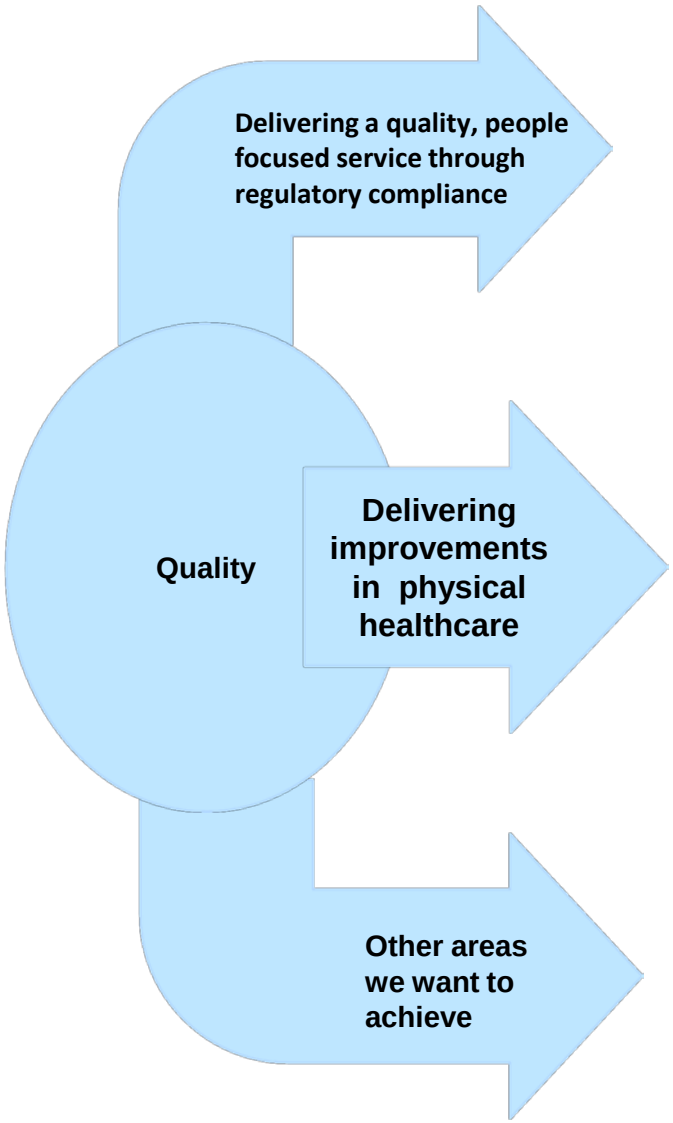
1. **Quality improvement**
    1. Completing the CQC action plan and the preparedness plan for next year
    2. Deliver physical healthcare CQUIN
2. **Engagement**
    1. Developing empowered and compassionate leaders
    2. Enhancing colleague voice through action
3. **Financial sustainability**
    1. Create and deliver a recurrent cost improvement plan
    2. Achieve agency ceiling
4. **Operational delivery**
    1. Reduce vacancies to 5%
    2. Redefine our Urgent Care and Neighbourhood Pathways.

National 'must do's'

- **Focus on quality** – achieving the best results for service receivers within the resources available. Reducing variation in services and achieving 'good' or 'outstanding' in the Care Quality Commission ratings. Services will be delivered services seven days a week.
- **Focus on access** – meet the access standards for Improving Access to Psychological Therapies (IAPT) and Early Intervention. Improve access to other services.
- **Focus on finance** – rise to the efficiency challenge both internally and working with system partners to implement the Carter Review recommendations.

Achieving our vision

What we need to achieve - quality



- We will continue to change the balance of power in our clinical services and embed a contemporary inclusive health service, based upon **informed choices**, **time limited care , with focused measured outcomes** in line with regulatory standards
- We will maintain patient safety in our clinical care services, we will review levels of service and **focus expectations,** which may ultimately impact on patient experience
- We will reflect on our care delivery, learn the lessons and adopt our knowledge and systems from this learning.
- We will do our best **to improve our performance,** maintain our compliance with CQC clinical quality standards and embed them into the fabric of our organisation.

- We will implement our **Physical Healthcare Strategy**, both in our Mental Health and **Child Health plans (EHCP)** and implement **the Green light toolkit**
- We will eliminate **unwarranted variation** in the delivery of clinical services.
- We will use data and analysis to understand the **mortality gap** affecting those with serious and enduring mental ill health, working in an integrated way with our physical health and care partners.
- We will continue to develop our clinical interventions and embed our approach to **treating people in their community as close to home as possible**.
- We will **work with primary care** on a focused approach to annual health checks. Leaning from our Health facilitators and our intensive focused support in Substance misuse

- We will deliver a consistent, accessible and quality service. We will improve our knowledge and application of working with people with Autism
- **We will focus on our effectiveness,** both in adopting known research, NICE guidelines and sharing other teams good practices within our Trust
- We will refine our **clinical leadership**, ownership and **performance management** through a **defined accountability model** which champions an outcomes focus and **quality improvement**.
- We will continue work in improving clinical outcomes, and reducing the impact of ill health, through focused work on **reducing the likelihood for relapse**

What we need to achieve - engagement

Engagement – Focusing on our people

Develop empowered, compassionate and inclusive leaders

- Development of a new, focused management and leadership development programme for Team Derbyshire Healthcare Leaders
- Provide a management development offer that supports all managers of people and services to have the skills and knowledge to be able to successfully fulfil their role
- Build leadership capacity and capability to take Team Derbyshire forward
- Provide continuous learning and support; coaching mentoring and peer to peer support
- Revitalise our recruitment ,induction and appraisal process to the Team Derbyshire Leaders expectations
- Deliver on our inclusion ambitions by focused leadership, aligned actions through executive sponsorship, supported and developed networks, reverse commissioning and mentoring

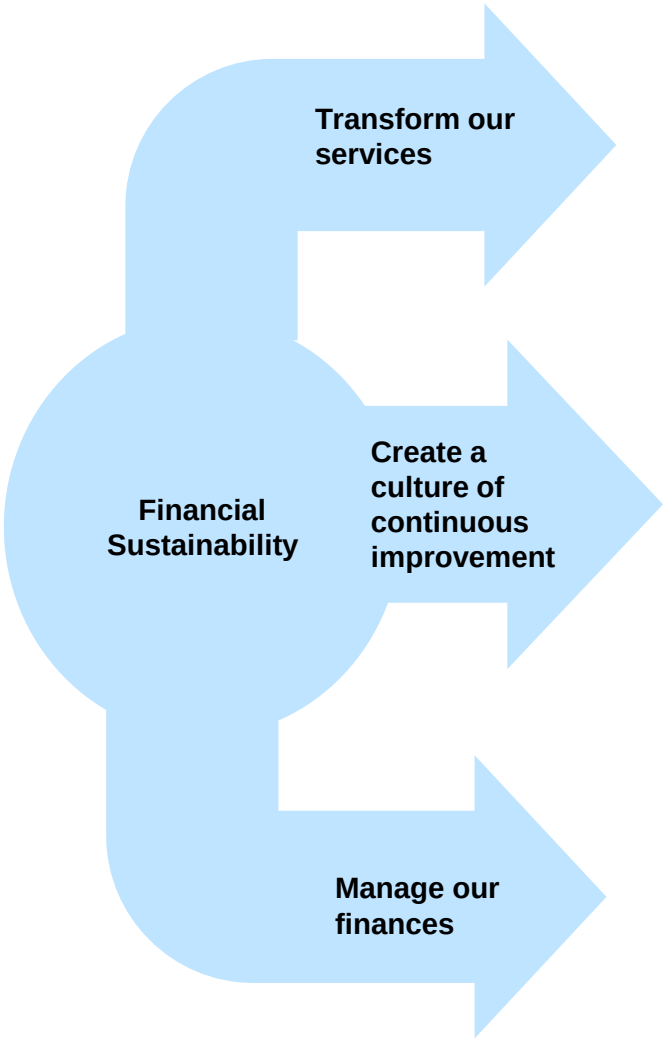
Enhancing colleague voice through action

- Provide mechanisms to recognise and celebrate employee achievements
- Co-create with colleagues a set of agreed expectations and responsibilities about what is required of members of Team Derbyshire Healthcare
- Provide clear opportunities for Trust employees to share their views, ideas and suggestions
- To ensure robust processes are in place for colleagues to raise concerns
- To develop mechanism for two-way communication to flow throughout the organisation at all levels
- To feedback to colleagues, demonstrating how their contributions have made a difference
- Increase visibility and access to Board members

Deliver Year 1 of our 2018 -2021 People Strategy

- **Retain**- Focus on the annual colleagues survey and the quarterly pulse checks to drive organisation and team improvement, all leaders colleagues engagement as an annual objective, provide a benefits package that supports the needs of colleagues at every stage of their career , support and focus on colleagues wellbeing
- **Develop –** Offer a flexible approach to induction, preceptorship and development to meet the needs of new joiners, build flexible career pathways per occupation to grow and retain colleagues, ensure all colleagues have a meaningful and engaging annual appraisal that supports their personal development, align succession planning with workforce and business planning
- **Attract -** Strengthen the DHCFT brand ensuring that we are seen as a first choice place to work and develop innovative and targeted recruitment campaigns to reach a diverse range of applicants, provide an employment offer that is flexible to meet the needs of colleagues at all stages of their career

What we need to achieve – financial sustainability



- Services will be planned in such a way that they **deliver the vision** for our people using them in 2021 – we will work across boundaries, linking physical and mental health.
- We will review **clinical and operational best practice** to ensure that services meet the needs of service receivers and their carers, who access our services
- Transformation will be have **quality, access and affordability** at the heart of service change.
- We will use sound clinical evidenced based practice and business principles to achieve the transformation of our services – **clinically led and managerially supported changes.**
- We will follow a **clear and transparent process** for any service change
- We will work with our **partners** to deliver joined-up care.

- We will all be **encouraged to contribute ideas** which will help transform services to meet our vision.
- **Thinking differently** - there are no wrong ideas – we will develop a culture of innovation and embracing change.
- We will **continuously review our everyday working practices** to ask if we are doing things in the most efficient and effective way. Is what we are doing enhancing people's care and their experience?
- We will adopt **'lean principles'** – getting things right first time, working with partners to stop duplication, no waste and no wasted time.
- Everything we do will put people first**.**

- **Continuous business improvement** will be fundamental for us to meet our statutory requirements and deliver our financial plans.
- We expect to be able to **achieve a similar level of overall surplus** as in our current financial plan, following NHS guidelines.
- We will continue to work with **operational and clinical teams** to ensure everyone can make financially well-informed decisions.

Achieving our vision

What we need to achieve – operational delivery

- We will develop a new Urgent Care model for Adult Mental health Services across Derbyshire
- Continue to improve the consistency and purposefulness of inpatient care across the Trust by implementing and building on best practice
- Review our current Neighbourhood care model and deliver a revised model of care for Community Mental Health Services
- Fully implement a Dementia Rapid Response Team in North Derbyshire
- Review pathways for other services such as personality disorders
- Develop new models of care for patients who are currently in Locked Door Rehabilitation

- Deliver national waiting time targets for our services
- Review our service specifications with Commissioners so that they meet our patients needs and reflect the work we are doing
- Deliver our contractual targets as set out in our contract with Commissioners
- Delivering the performance requirements associated with the Five Year Forward View

- We will continue to work with our commissioners to deliver the 5 Year Forward View for Mental Health and Children
- We will implement the Transforming Care agenda in Learning Disability Services
- We expect to develop a new Community Forensic Service
- We will enhance our Community Peri-natal service in line with national expectations set in the 5 year forward view
- We will work with Public Health to deliver enhanced joined-up pathways for people who require support from our substance misuse services

How will we measure our achievements?

In delivering our strategy we need to be able to show that we have achieved our priorities. With our focus on people, we want to measure how colleagues and patients will know that things have changed. Below we have added the high level changes that we want to see. Our monthly Board Reports will have more detailed measures to help us monitor progress.

Strategic Objective	What will it mean for colleagues in the Trust?	What will it mean for patients?
Quality		
• Delivering a quality, people focused service through regulatory compliance	• Will understand what is required to deliver services that comply with core standards • Work in an environment that helps deliver core standards	• We will give greater public assurance to the community of Derbyshire that we have received and acted feedback following external assessments of our quality.
• Delivering improvements in physical healthcare	• We will have the knowledge and the knowledge, skills and tools within teams to deliver improved physical healthcare.	• We will implement the evidence, and focus upon the public health concerns that individuals with specific conditions have worse outcomes. • We will contribute to the public health knowledge gap, on the outcomes of smoking, high alcohol consumption, substance misuse, (prescribed and illegal) lack of effective exercise, occupation and diet.

How will we measure our achievements?

Strategic Objective	What will it mean for colleagues in the Trust?	What will it mean for patients?
Engagement		
• Developing empowered, compassionate and inclusive leaders	• Leaders who create an environment where people can experience the values • A positive and engaging work environment for all colleagues making the Trust a place where people choose to work. • Developing inclusive and compassionate leadership • A caring and progressive organisation that promotes equality, values and celebrates diversity and has created an inclusive and compassionate environment for receiving care and for employment	• Less bank and agency colleagues ensuring greater continuity of care • Inclusive services that are delivered with kindness, dignity and respect and meet the needs of service users and patients
• Enhancing colleague voice through action	• A well-developed colleagues engagement programme with a focus on two-way communication. • Vibrant and connected networked colleague to help everyone make a difference	• A happy, motivated and well supported workforce who give good patient care.

How will we measure our achievements?

Strategic Objective	What will it mean for colleagues in the Trust?	What will it mean for patients?
Operational Delivery		
• Transform our services	• Working in more joined-up pathways of care which are easy to understand • Ability to develop new skills and work in ne roles for example Advanced Clinical Practitioners and Nurse Associates	• Easier access to care – 'I tell my story once' • New Pathways developed as part of the Five Year Forward View • Services will be developed using evidence and feedback from a variety of sources to ensure we meet peoples diverse needs and considered impact
• Meet Operational Targets	• Expectations about performance are clearly articulated at all levels of the organisation.	• Access to care in a timely way
Financial Sustainability		
• Create and deliver a recurrent cost improvement plan (CIP)	Recurrent CIP delivery through continuous cost and quality improvement helps us get things right first time which means less waste of resources and time	Continuous cost and quality improvement means CIPs are well planned and effective which help services to become more efficient for patients and better value for money for the public purse
• Achieve agency 'ceiling' through reduced temporary colleague using usage	Less use of temporary colleagues means more substantive colleagues .Reducing the expensive agency costs means better quality of care, better team cohesion and better overall workforce planning. It also reduces the need to find savings from substantive roles	Less use of temporary colleagues means more substantive colleagues and that enables better patient experience through improved consistency of clinical contacts as well as better value for money

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 28 March 2018

Trust Business Plans 2018-19

Purpose of this Report

This paper is to present the Trust Board with the final Business Plans for clinical divisions, clinical support services and corporate areas. The draft plans have been amended with the comments from the January and March TMT meetings and we are seeking final approval of the plans from Trust Board.

Executive Summary

Final plans
At the January TMT meeting, the first draft Business Plans for clinical divisions were presented for comment prior to being finalised. The plans have been amended in line with TMT comments as follows:

- All plans have been restructured to present their milestones in line with the new Trust strategic objectives
- The clinical divisions now have corporate and clinical support services milestones woven into their own plans where appropriate
- Any remaining corporate or clinical support service objectives which are specific to that area have been retained in a Trust wide Business Plan
- The Business Plans have included the objectives of other supporting Trust strategies (for example the Quality Strategy)

Section 1 includes the Trust wide Business Plans.

Section 2 includes the clinical divisions Business Plans.

Please note that the Business Plans have been through several iterations to take on board all of the feedback from TMT and incorporating the wider requirements of the Trust. We will build on the learning from the Deloitte well-led review and this year's planning process to help inform next year's planning cycle. The final plans are presented for approval subject to final branding and formatting.

2018/19 Business Plan Performance Reporting

It is proposed that the reporting for the Business Plans is adjusted slightly for 2018/19, for which a blank reporting template will be included in performance packs at TMT for completion during the performance review. This will allow a more rounded discussion for those areas which support divisional plans, and reduce the reporting burden on Operational Divisions who will need to collate the information for review.

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
A significant amount of time and resource has been devoted to developing the Business Plans to ensure that they are meaningful to services, and reflect the requirements of the wider organisation.

Consultation
The plans have previously been presented at TMT and all comments incorporated. Some plans have been considered at wider divisional COAT meetings.

Governance or Legal Issues
None noted at the time of writing

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:

1) Note the contents of the plans and be assured over the development process
2) Approve the final Trust Business Plans (subject to final design work and branding)

Report presented by: **Lynn Wilmott-Shepherd, Interim Director of Strategic Development**

Report prepared by: **Jenny Sutcliffe, Head of Contracting and Commissioning**

NHS
Derbyshire Healthcare
NHS Foundation Trust

2018/19 Business Plans

Annual Trust Business Plans

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Making a positive difference

FOREWORD - DRAFT

In last years plan I said that research tells us that there is a significant link between staff having a clear understanding of the direction of travel for their service areas, improving staff morale and ultimately ensuring people who use our services get better outcomes. This still holds true. You will be aware that we have recently refreshed our Trust Strategy which identifies the common purpose all of us who work in the Trust share, the way we go about doing business and what outcomes people can expect to see from us over the next few years. The Strategy has been refreshed because as a Board of Directors we have recognised the absolute need to focus on 'people first' and by that we mean colleagues who work in the Trust.

The Strategy identifies four broad strategic objectives or areas for action, we will, together, constantly review what the 2 or 3 key priorities under each area are, if we have made improvements and if we need to change our focus. This is why an Annual Business Plan is important to say how we are going to meet those objectives within the year.

Each 'Plan on a Page' (well several pages now!) has been developed by Divisional and Corporate Teams and clearly identifies who is responsible for delivery. However, it is important to recognise that no one individual can deliver the objectives outlined, they will work with their teams to deliver the plan.

We will build on the significant achievements of 2017/18 and continue to work hard to deliver both quality and service improvements. This year is possibly even more exciting as the Five Year Forward View for Mental Health has clearly stated that money meant for mental health will be used for just that purpose. So for the first time in many years we will see some investment in our services. This does not mean we can be complacent as we need to continually drive for quality and service improvement, but it does mean that areas which have been underfunded can start to see some gains.

I really hope we can use this plan to 'make a difference'. The Trust Management Team will oversee day to day delivery receiving reports on progress from service areas with a twice yearly highlight report going to Trust Board.

I look forward to working together to make our plans a reality and to make a difference for the people of Derbyshire

Ifti Majid
Chief Executive

INTRODUCTION

- This paper provides a consolidated summary of each division and corporate directorate's plan for year three of the refreshed five year Trust Strategy.
- There are a number of published documents that contain implications for clinical and corporate areas across the Trust, including the Sustainability and Transformation Partnership (STP) business cases, Five Year Forward View for Mental Health (FYFVMH), the Trust Strategy, the Trust Operational Plan, and divisional business plans. This paper seeks to consolidate the objectives and milestones from within each of these documents into a single strategic plan.
- The onus has been placed on each corporate directorate and division to produce their own Business Plan with support from the Strategy team, which answers a number of questions:
    - What are the priorities for the year
    - What actions are to be taken to achieve these objectives
    - When are these actions/priorities expected to be completed
    - What will success look like?
    - Links with the wider system
- Section 1 includes the Trust wide Business Plans for corporate areas and clinical support services.
- Section 2 includes all of the clinical divisions Business Plans.

Section 1

- Trust wide Business Plans

Business Plan – Trust Wide

Service	Trust Objective	Milestone	Lead	Time frame
Pharmacy	Operational Delivery	Provide pharmacist and pharmacy technician support to the Dementia Rapid Response Teams to improve access to medication for service users and to support clinical teams in the pharmacological management of complex cases	SJ	Q1
		Provide pharmacist and pharmacy technician support to the Crisis Resolution and Home Treatment teams to improve access to medication for service users and to support clinical teams in the pharmacological management of complex cases	SJ	Q4
		Focus a greater proportion of specialist mental health pharmacist resource towards the Neighbourhoods to support work through clinical advice and contact with service users to reduce frequency of admission to inpatient care	SJ	Q2
		Focus a greater proportion of Pharmacy Technician resource towards the Neighbourhoods to support the development of systems to better manage medicines, particularly depot injections in the first instance, to reduce the risk of treatment breakdown	SJ	Q2
	Quality Improvement	Work with Senior Management to develop an implementation strategy for Electronic Prescribing and Medicines Administration	SJ	Q4
		Continue to work with Derbyshire Community Health Services (DCHS) and East Midlands Ambulance Service (EMAS) to provide high-quality medicines supply services	SJ	Q4
		Continue to work with DCHS to provide clinical services	SJ	Q4
	Colleague Engagement	Introduce a new role of Chief Pharmacy Technician – team Manager to provide management support for and lead development of Pharmacy Technicians and Pharmacy Support Workers in the department	SJ	Q1
		Continue to generate revenue from pharmacy staff developing and / or delivering resourced training	SJ	Q4
		Support pharmacy staff to study for advanced qualifications relevant to their specialist role, to enable them to support Trust teams with this expertise and to facilitate recruitment and retention in a challenging environment	SJ	Q4
	Financial Sustainability	Provide Associate Clinical Director (ACDs) and prescribers with information on prescribing costs, volume and patterns to allow benchmarking between colleagues	SJ	Q4
		Provide information on trends and changes in medicines expenditure to the Drug and Therapeutics Committee and the Trust management Team	SJ	Q4
		Review the current model for purchasing and distributing pharmaceuticals in-line with anticipated publication of Lord Carter's report into productivity of Mental Health and Community Health Services NHS Trusts in England	SJ	Q4

Business Plan – Trust Wide

Service	Trust Objective	Milestone	Lead	When
IM&T	Operational Delivery	Investigate Electronic Prescribing and Medicines Administration (EPMA) system functionality	PC	Q2
		Explore the capabilities of Voice Recognition	PC	Q4
		Continue to enhance integration within the Trust and with other organisations to make the Trust more efficient	PC	Subject to BC
		Ensure patients have appropriate access to their records	PC	Q4
		Development of apps to support clinicians and patients	PC	Subject to BC
		Respond efficiently and affectively to any issues or enhancements raised by the Trust	PC	Q4
	Quality improvement	Enhance Electronic Patient Record to reflect required clinical processes	PC	Q4
		Provide reliable technical environments and support services	PC	Q4
		Maintain appropriate Cyber Security measures to protect the Trust	PC	Q4
		Deliver all NHS England or Clinical Commissioning Group (CCG) mandated information on time and of the required quality	PC	Q4
		Maintain our Information Governance (IG) excellence and implement General Data Protection Regulation (GDPR) by end of May 2018	PC	Q4
		Ensure patients paper records are efficiently processed and stored	PC	Q4
		Provide access to SystmOne or PARIS to ensure clinicians can access records when appropriate	PC	Subject to BC
	Colleague Engagement	Enhance network to support Agile working	PC	Subject to BC
	Financial Sustainability	Deliver required Cost Improvement Plan (CIP)	PC	Q4
Estates and Facilities	Operational Delivery	To ensure completion of annual returns Estates Return Information Collection (ERIC) and Project Assurance Model (PAM)	SD	Q4
		To support through capital and the Trust Estate Strategy, clinical services in redesigning their services	SD	Q4

Business Plan – Trust Wide

Service	Trust Objective	Milestone	Lead	When
Estates and Facilities	Quality Improvement	Ensuring preparedness for the next Care Quality Commission (CQC) visit. Estates to ensure compliance files are current	SD	Q4
	Colleague engagement	To work with the wider Healthcare community in compiling a Derbyshire Wide Estate Strategy and ensuring best use is made of all premises	LW	Q4
		Amplifying colleague voice through action	SD	Q4
	Financial Sustainability	Create and deliver a recurrent cost improvement plan	LB	Q2
		Work within budget constraints make sure break even at year end	SD	Q4
Communications and Involvement	Operational delivery	To develop a comprehensive understanding and record of the Trust's stakeholder engagement activities.	AS	Q3
		To identify key stakeholders and prioritisation in order to deliver the Trust strategy. Undertake a brand audit to asses the Trust's current reputation amongst stakeholders	AS	Q3
		Development of a new extranet, to replace the existing Trust website and intranet.	AS	Q3
	Quality Improvement	Development of a new Trust-wide Communications Strategy and associated policies	AS	Q2
	Colleague Engagement	Develop and implement a new programme of staff engagement. Implement system to capture staff engagement feedback. Identify key themes from staff engagement and ensure appropriate response	AS	Q1
	Financial Sustainability	To determine best value options for graphic design support into the organisation.	AS	Q4
Legal Affairs	Operational Delivery	To ensure that the Accessing Legal Advice Policy is fully embedded in the organisation	AC	Q4
	Quality Improvement	To create a self-sustaining internal system of knowledge to minimalize external legal expenditure.	AC	Q4
	Colleague Engagement	To create a self-sustaining internal system of knowledge to minimalize external legal expenditure.	AC	Q4
	Financial Sustainability	To optimise external legal use to achieve value for money by rationalising legal services to one provider wherever possible [or to rationalise legal services to one framework thus ensuring consistent costs across the various departments that access legal services].	AC	Q4

Business Plan – Trust Wide

Service	Trust Objective	Milestone	Lead	When
Governance	Operational Delivery	To sustain and embed governance improvements in preparation for the next external well-led framework review	SH	Q4
	Quality Improvement	Ensure continued improving effectiveness of Board and Board Committees	SH	Q4
	Colleague Engagement	Ensure that there is good governance practice embedded throughout the organisation	SH	Q4
	Financial Sustainability	Maintain an effective and streamlined governance structure, which releases indirect savings and ensures financial sustainability	SH	Q4
Contracting and Strategic Development	Operational Delivery	Establish permanent second Business Development Manager Post	JS	Q1
		Review the Contract Negotiation Protocol and contractual governance processes	JS	Q1
	Quality Improvement	Establish internal web based contract systems – finalise roll out of online contract database and initiate development of reporting module	JS	Q4
		Options developed for alternative contractual governance frameworks in Sustainability and Transformation Plan (STP) environment	JS	Q2
	Colleague Engagement	Continue development of Business Bytes programme to support organisational development – roll out specific programmes to certain staff groups, expand topics, market internally to improve uptake	JS	Q4
		Develop a suite of best practise guides and templates for the intranet (i.e. business case development)	JS	Q2
	Financial Sustainability	Implement revised governance processes for 2019/20 contract negotiations	LWS	Q3
		Quarterly reconciliation of contracts with invoices and increased rigour of uplift	JS	Q1

Business Plan – Trust Wide

Service	Trust Objective	Milestone	Lead	When
Procurement	Quality Improvement	Completing the CQC action plan and the preparedness plan for next year – Partnership section completed and kept up to date as required	RH	Q4
	Engagement	Continued development of Purchasing Team to provide greater support to the organisation	RH	Q4
	Financial Sustainability	Procurement re-org. plan proposed and under consideration 3 year Procurement Work Plan completed and continuous monitoring of cost reduction opportunities through use of Purchase Price Index and Benchmarking (PPIB) and emerging Future Operating Model (FOM)	RH	Q4
Programme Assurance Office	Operational Delivery	Relocate team to Kingsway House base following series of moves to accommodate wider estate strategy. Including Contracts and STP in the plan	JW	Q1
		Review team structure and job descriptions to ensure fit for purpose programme office delivery and assurance function	JW	Q2
	Quality Improvement	Develop Continuous Quality Improvement (CQI) methodology to support financial sustainability	JW	Q3
	Colleague Engagement	Develop co-production approach to continuous improvement process	JW	Q3
		Team development for sustainable capability relating to CQI	JW	Q3
	Financial Sustainability	Work across the Trust to create and deliver a re-current cost-improvement-plan	JW	Q4
		Further development of Programme Assurance process generating leadership and accountability	JW	Q1

Business Plan – Trust Wide

Service	Trust Objective	Milestone	Lead	When
Nursing and Quality	Operational Delivery	Ensure the Trust meets its legal duties around Safeguarding Children & Adults	TN	Q4
		Ensure the Trust meets its legal duties around Infection Prevention & Control	RM	Q4
		Ensure the Trust meets its legal duties around the Mental Health Act and Mental Capacity Act	KB	Q4
		Ensure the Trust meets its legal duties around Health & Safety	CG	Q4
		Report on the Schedule 4 Quality Contract to the CCG	DTh	Q4
		Oversee the reporting process and submit CQUIN evidence to the CCG and NHS Improvement (NHSI)	DTh	Q4
		Oversee the Trust position on Patient Safety and Mortality, submitting committee reports and national data as appropriate	RW	Q4
		Manage, respond and report appropriately to all complaints that come to the Trust	AR	Q4
		Lead on our carer involvement work	WS	Q4
		Oversee and manage the Datix incident reporting system	RK	Q4
		Deliver the annual Quality Report	DTh	Q4
		Oversee the annual Quality Visit programme	DTh	Q4
	Quality Improvement	Deliver the Quality Improvement Strategy for the Trust	DTh	Q4
		Participate in the national patient safety campaign 'Sign up to Safety'	RW	Q4
		Develop a structure to demonstrate our position around NICE Guidelines and promote their use	DTh	Q4
		Improve level of Datix reporting	RK	Q4
		Engage with the NHS Staff Health and Wellbeing agenda for the Nursing & Quality Team	DTh	Q4
		Offer leads for each CQUIN and enable teams to succeed	DTh	Q4
		Revise the Quality Visit programme – to a new model	CG	Q4
		Design a new Quality Improvement strategy and define agreed methodology toolkit that can be used	CG	Q4

Business Plan – Trust Wide

Service	Trust Objective	Milestone	Lead	When
Nursing and Quality	Colleague Engagement	Support Area Service Managers (ASMs) in their understanding of and delivery of Commissioning for Quality and Innovation National Goals (CQUINs)	DTh	Q4
		Engage operational colleagues in the delivery of the Schedule 4 Quality Contract	DTh	Q4
		Provide training on the reporting of incidents, including serious incidents, ensuring they are accurate and promoting a culture of candour	DTh	Q4
	Financial Sustainability	Support the achievement of CQUINs	DTh	Q4
People and Engagement	Operational Delivery	Joined up recruitment processes that reduce time to recruit	CS	Q4
		Dedicated Bank for DHCFT supported by DCHS	CS	Q4
		New structure to provide HR support to divisions e.g. Business partners embedded in services providing strategic advice and support	CS	Q4
	Quality Improvement	Strengthened employee relations team, reducing length of investigations and improving outcomes	CS	Q4
		Developing empowered and compassionate leaders through Leadership Development Programme. Team Derbyshire Healthcare, Talent Management and succession planning	CS	Q4
	Colleague Engagement	Amplifying colleague voice through pulse check feedback and staff survey results	CS	Q4
		Promote Staff Forum and attendance across DHCFT, feedback and outcomes published	CS	Q4
		Promote Equalities Forum	CS	Q4
		Effective Appraisal process	CS	Q4
		Retain and retrain strategy	CS	Q4
		Flexible career pathways	CS	Q4
	Financial Sustainability	Create and deliver a recurrent cost improvement plan	CS	Q4
		Achieve agency ceiling	CS	Q4

Business Plan – Trust Wide

Service	Trust Objective	Milestone	Lead	When
Finance	Operational Delivery	Continue to provide a responsive service to budget holders and senior managers across the Trust to enable them to effectively manage their budgets	RL	Q4
	Quality Improvement	Involvement in the National Costing Transformation Programme groups	KP	ON-GOING
	Colleague Engagement	Provide information and support to managers to support the delivery of the 2018/19 efficiency programme	RL	Q4
	Financial Sustainability	To support the delivery of the short term and long term financial plans	RL	Q4
		Provide information on expenditure and accurate forecast information	RL	Q4
		Contribute and support the Costing Transformation Programme - on-going development of Patient Level Information and Costing Systems (PLICS)	KP	Q4 2019-20

Section 2

- Business Plans for clinical divisions

Business Plan – Campus

Trust Objective	Milestone	Lead	When
Operational Delivery	Urgent care clinical model review	TH	Q3
	Delivery of bed optimisation programme, including repatriation of out of area patients	KL	Q4
	Review of rehab pathway, identifying a pathway to pursue and completing an options appraisal	KL	Q4
	Stepdown – Review current model and address any governance concerns	TH	Q3
	High Intensity Network (HIN) – Develop work programme to address pathway issues for this cohort, establishing exactly who the term applies to and conducting a case review for the last financial year	FW	Q3
	Low secure – Ensure full bed occupancy at Kedleston following refurbishment	TH	Q4
	Effective and timely rostering processes in place to support operational delivery	CS	Q4
Quality Improvement	Plan created for implementation of improved audit of Care Programme Approach (CPA) and discharge summaries, with approval sought at Trust level	TH	Q1
	Complete CQC Action Plan	TH	Q1
	Provide a leadership role and support operational colleagues with regards to improving physical healthcare for people who use our services	RM	Q4
	Support ASMs in their understanding of and delivery of CQUINs	DTh	Q4
	Meeting Physical Healthcare Strategy standards and the CQUIN requirements for health checks	DTh	Q4
	A well rounded health and psychological plan that identifies, relapse signature and prevention reduction of avoidable admission	CG	Q4
	Progress and work on the High Need Support Group (157) offering interventions	DTh	Q4
	For all staff to have access to and undertake autism awareness training	DTh	Q4
	Improve physical healthcare for people who use our services	DTh	Q4
	Improve services for people with mental health needs who present to Accident and Emergency (A&E)	DTh	Q4
	Developing Electronic Patient Records (EPR) and technological solutions to help our teams care plan well	CG	Q4
	Increase staff uptake of flu vaccine in support of the Physical Healthcare CQUIN	CS	Q4

Business Plan – Campus

Trust Objective	Milestone	Lead	When
Colleague Engagement	Reduce vacancies to maximum of 5%	CS	Q4
	Build a sustainable workforce by reviewing skill mix, plans for recruitment and retention and training opportunities	TH	Q3
	Develop empowered and compassionate leaders through the Leadership Development Programme (Team Derbyshire Healthcare), talent management and succession planning	CS	Q4
	Amplify colleague voice through pulse check feedback and staff survey results	CS	Q4
Financial Sustainability	Create and deliver a recurrent Cost Improvement Plan	TH	Q4
	Achieve agency ceiling	TH	Q4
	To support the delivery of the short term and long term financial plans	RL	Q4
	To support in the reduction of the agency expenditure to contain within ceiling - provide information on expenditure and accurate forecast information	RL	Q4
	Contribute and support the Costing Transformation Programme - on-going development of PLICS	KP	Q4 2019-20

Business Plan – Children's and CAMHs

Trust Objective	Milestone	Lead	When
Operational Delivery	• Continued development and evaluation of home treatment and support in Child and Adolescent Mental Health Services (CAMHS) • Scope services along with commissioners around services in CAMHS becoming 0-25 • Continue workforce development of Future in Mind (FiM) – and interdependencies with 'place' based care • 0-19 services – scope alignment to localities and school clusters re future provision • Provision of a clearer service delivery model for specialist paediatric services	HD	Q4
	• Ongoing participation in workstream 7 led by CCG – out of area placement (CAMHS & Special Educational Needs and Disability (SEND)) • Participation in scoping of 'place of safety' discussions in Southern Derbyshire CCG (SDCCG) – and developing our response and role in development • Development of a crisis response in line with FiM	HD	Q4
	• Develop an integrated Neurodevelopment pathway across services within DHcFT and with wider service providers • To work with partners on delivery of a regional Sexual Assault Referral Centre (SARC) service – mobilisation and delivery of specification • Future in mind developments – alignment with 0-19 services – develop shared pathways to increase community resilience	HD	Q4
	• Alignment to trauma based services • Review of all outstanding service specifications, providing clarity on current identified gaps • Focus on future tenders – 0-19 • Lifespan service review – eg eating disorders services	HD	Q4
	• To work with commissioners on clarifying role and subsequent service delivery of Primary mental Health Workers (PMHW) within CAMHs services • Develop an integrated Neurodevelopment pathway across services within DHCFT and with wider service providers • Building stakeholder relationships in a changing education provision around complex health – eg special schools health provision	HD	Q4
	Effective and timely rostering processes in place to support operational delivery	CS	Q4
Quality Improvement	Look for opportunity to reduce duplication of clinical intervention	HD	Q4
	• Further Develop transitions process for Children and Young People (C&YP) from CAMHS – CQUIN • Ongoing dialogue with Commissioners re services aged 16-18 – prescribing agreements, stepdown provision, • Pathways – across providers – underpinnned by SEND, among others – End of Life Care (EOLC) • Transitions between providers – need to review and agree in distinct areas	HD	Q4

Business Plan – Children's and CAMHs

Trust Objective	Milestone	Lead	When
Quality Improvement	Provide a leadership role and support operational colleagues with regards to improving physical healthcare for people who use our services	RM	Q4
	Support ASMs in their understanding of and delivery of CQUINs	DTh	Q4
	Meeting Physical Healthcare Strategy standards and the CQUIN requirements for health checks	DTh	Q4
	In children's services, contribute to one of the following: Achieving Baby Friendly status / A personal health or family support plan / A plan to reduce deterioration which results in avoidable admission	CG	Q4
	A well rounded health and psychological plan that identifies, relapse signature and prevention reduction of avoidable admission	CG	Q4
	Progress and work on the High Need Support Group (157) offering interventions	DTh	Q4
	For all staff to have access to and undertake autism awareness training	DTh	Q4
	Improve physical healthcare for people who use our services	DTh	Q4
	Improve services for people with mental health needs who present to A&E	DTh	Q4
	Developing EPR and technological solutions to help our teams care plan well	CG	Q4
	Increase staff uptake of flu vaccine in support of the Physical Healthcare CQUIN	CS	Q4
Colleague Engagement	Continue workforce development of Future in Mind – and interdependencies with 'place' based care	HD	Q4
	• Develop a framework of development opportunities across Division • Succession and progression plan for Division – including resilience of staff • Ongoing review of skill mix across the services – alignment with workforce strategy • Scoping and alignment of all of the roles across those who interface across age range 0-19 • Explore joint training / development opportunities • Sharing expertise of roles across the care pathway	HD	Q4
	• Review of tools for the 'job' – IT systems, IT infrastructure & equipment • Work to identify flexible working and agile working opportunities and create explicit expectations around this for the service • Develop 'you said we did' feedback mechanism with clinical leads, focussing on staff wellbeing	HD	Q4
	Reduce vacancies to maximum of 5%	CS	Q4

Business Plan – Children's and CAMHs

Trust Objective	Milestone	Lead	When
Colleague Engagement	Build a sustainable workforce by reviewing skill mix, plans for recruitment and retention and training opportunities	HD	Q4
	Develop empowered and compassionate leaders through the Leadership Development Programme (Team Derbyshire Healthcare), talent management and succession planning	CS	Q4
	Amplify colleague voice through pulse check feedback and staff survey results	CS	Q4
Financial Sustainability	Create and deliver a recurrent Cost Improvement Plan	HD	Q4
	Achieve agency ceiling	HD	Q4
	To support the delivery of the short term and long term financial plans	RL	Q4
	To support in the reduction of the agency expenditure to contain within ceiling - provide information on expenditure and accurate forecast information	RL	Q4
	Contribute and support the Costing Transformation Programme - on-going development of PLICS	KP	Q4 2019-20

Success will be	Out of area bed usage may reduce	Waiting times for services may reduce	High-cost placements may reduce	Implementation of commissioned services	The development of a jointly developed plan between CAMHs and Neighbourhoods with a joint lead and joint reporting

Business Plan – Central Services

Trust Objective	Milestone	Lead	When
Operational Delivery	Service Models: Ongoing developments of models within services; review Service Models based on feedback within Perinatal; Learning Disabilities (LD) to complete clinical pathways work; - LD to develop operational model in line with Transforming Care	DH	Q4
	Business Case: Improving Access to Psychological Therapies (IAPT) business case to expand into Serious Mental Illness (SMI) 3+ services; complete to ensure that new models are viable	JW	Q2
	Service Specification: develop Cognitive Behavioural Therapy (CBT) specification for Specialist Psychological Therapies; IAPT to develop treatment options by exploring electronic/remote options	DH	Q2
	Service Evaluation: Substance Misuse service to evaluate new services, new ways of working and lessons learnt after 6 months	HP	Q3
	Linking with other services and teams to develop integrated ways of working; exploration of internal requirements across services;, explore LD and Mental Health (MH) teams working closely together with formal definitions of roles	DH	Q2
	STP - Work with Commissioners and providers to highlight client need after diagnosis; Health Psychology to work with the wider physical healthcare teams and review work undertaken and level of activity Perinatal to undertake 3 methods of working with patients and partners	DH	Q4
	Effective and timely rostering processes in place to support operational delivery	CS	Q4
	Link CBT with improved neighbourhood pathway review and redesign	DH	Q4
Quality Improvement	Completing the CQC action plan and the preparedness plan for next year	DH	Q1
	Eating disorders to agree new outcome tool with clinicians and joint development of Key Performance Indicators (KPIs)	DH	Q3
	Provide a leadership role and support operational colleagues with regards to improving physical healthcare for people who use our services	RM	Q4
	Support ASMs in their understanding of and delivery of CQUINs	DTh	Q4
	Meeting Physical Healthcare Strategy standards and the CQUIN requirements for health checks	DTh	Q4
	Improve services for people with mental health needs who present to A&E	DTh	Q4
	Developing EPR and technological solutions to help our teams care plan well	CG	Q4

Business Plan – Central Services

Trust Objective	Milestone	Lead	When
Quality Improvement	In central services, delivering compliance with Annual Health checks and Lead the Greenlight toolkit	DTh	Q4
	In central services, develop a well-rounded personal health plan that identifies, prevention and reduction of avoidable admission	CG	Q4
	A well rounded health and psychological plan that identifies, relapse signature and prevention reduction of avoidable admission	CG	Q4
	Progress and work on the High Need Support Group (157) offering interventions	DTh	Q4
	For all staff to have access to and undertake autism awareness training	DTh	Q4
	Improve physical healthcare for people who use our services	DTh	Q4
	Increase staff uptake of flu vaccine in support of the Physical Healthcare CQUIN	CS	Q4
Colleague Engagement	LD service to review skill mix as part of service specification and consultation	LR	Q3
	Deliver basic Autism Spectrum Disorder (ASD) training and more advanced skill based training Retraining of substance abuse staff in physical healthcare interventions	DH	Q2
	Reduce vacancies to maximum of 5%	CS	Q4
	Develop empowered and compassionate leaders through the Leadership Development Programme (Team Derbyshire Healthcare), talent management and succession planning	CS	Q4
	Amplify colleague voice through pulse check feedback and staff survey results	CS	Q4
Financial Sustainability	Create and deliver a recurrent cost improvement plan	DH	Q4
	Achieve agency ceiling	DH	Q4
	To support the delivery of the short term and long term financial plans	RL	Q4
	To support in the reduction of the agency expenditure to contain within ceiling - provide information on expenditure and accurate forecast information	RL	Q4
	Contribute and support the Costing Transformation Programme - on-going development of PLICS	KP	Q4 2019-20

Business Plan – Neighbourhood Services

Trust Objective	Milestone	Lead	When
Operational Delivery	To complete Neighbourhood Review	DT	Q4
	To implement recommendations from Neighbourhood Review	DT	Q4
	To recruit and operationalise the North Dementia Rapid Response Services (DRRT)	DT	Q3
	To establish STP plans for the following services: Older Peoples Day Hospital; Community Rehab Services; Community Personality Disorders (PD) Services; Community Forensic Services	TBC	Q4
	To implement STP plans for the following services: Older Peoples Day Hospital; Community Rehab Services; Community PD Services; Community Forensic Services	DT	Q4
	Reduce vacancies to minimum of 5%	CS	Q4
	Effective and timely rostering processes in place to support operational delivery	CS	Q4
Quality Improvement	To benchmark services against NICE Guidelines	PB	Q2
	To complete Comprehensive Case File Audit and implement associated Action Plan	KW	Q1
	To hold bi monthly meetings to embed effective Neighbourhood Dementia Lead network	SW	Q4
	Completing the CQC action plan and the preparedness plan for next year	DT	Q1
	To implement a county wide service monitoring physical health needs of people prescribed anti psychotic medication	DTh	Q1
	Provide a leadership role and support operational colleagues with regards to improving physical healthcare for people who use our services	RM	Q4
	Support ASMs in their understanding of and delivery of CQUINs	DTh	Q4
	Meeting Physical Healthcare Strategy standards and the CQUIN requirements for health checks	DTh	Q4
	A well rounded health and psychological plan that identifies, relapse signature and prevention reduction of avoidable admission	CG	Q4
	Progress and work on the High Need Support Group (157) offering interventions	DTh	Q4

Business Plan – Neighbourhood Services

Trust Objective	Milestone	Lead	When
Quality Improvement	For all staff to have access to and undertake autism awareness training	DTh	Q4
	Improve physical healthcare for people who use our services	DTh	Q4
	Improve services for people with mental health needs who present to A&E	DTh	Q4
	Developing EPR and technological solutions to help our teams care plan well	CG	Q4
	Increase staff uptake of flu vaccine in support of the Physical Healthcare CQUIN	CS	Q4
Colleague Engagement	Reduce vacancies to maximum of 5%	CS	Q4
	Develop empowered and compassionate leaders through the Leadership Development Programme (Team Derbyshire Healthcare), talent management and succession planning	CS	Q4
	Amplify colleague voice through pulse check feedback and staff survey results	CS	Q4
Financial Sustainability	Create and deliver a recurrent cost improvement plan	DT	Q4
	Minimise agency usage to contribute towards the Trust achieving agency ceiling	DT	Q4
	To support the delivery of the short term and long term financial plans	RL	Q4
	To support in the reduction of the agency expenditure to contain within ceiling - provide information on expenditure and accurate forecast information	RL	Q4
	Contribute and support the Costing Transformation Programme - on-going development of PLICS	KP	Q4 2019-20

Derbyshire Healthcare NHS Foundation Trust

Board Committee Summary Report to Trust Board
Quality Committee - meeting held 8 March 2018

Key items discussed

- Discussion re clinical quality indicators the difference between the Quality dashboard for Quality committee and a reduced version for Trust Board.
- Action and decision to move forward on revisions by Carolyn Green

Assurance/lack of assurance obtained

- Board assurance framework- Review and incidents and the potential future horizon risks. This was reviewed and limited assurance.
- Quality dashboard – limited assurance due to remaining CQC actions
- Quality strategy- improvements/ significant assurance. To trust strategy/ QS signed off and framework. 3month implementation and action with direction of travel. June 2018. Thank you to the team for their hard work.
- CQUIN- Significant quality improvement and improved clinical performance. We have some key risks going forward for flu and Physical Healthcare improvements. Limited assurance.
- NICE guidelines- significant improvement. Assurance around the process, indicator Limited assurance. A gap of NICE guidelines and the number completed and a trajectory. A matter arising was the release of a call for evidence on suicide prevention in prisons.
- Quality and Equality impact assessment – Significant assurance. Add a flowchart and escalation. Full scrutiny and improvement. On trajectory for completion for May 2018
- Quality visits- New model and agreed and focus on outcomes. Dates and a shadow day, schedule for the year
- Quality report- Verbal up-date we are on trajectory and it will emailed/ upgrade on board pack/ with an attachment. To Non-Executive Directors to ensure their input and scrutiny.
- Medicines Management Terms of Reference – Change of name, Medicines Management and Optimisation. Agreed and ratified
- Neighbourhood review - developing ideas and new modelling and devolvement. Discussion re pathway development and developing ideas. Limited assurance, significant assurance on methodology.
- Security standards and briefing on Police engagement on drugs dealing and police goes on site as preventative approach. Significant assurance, an additional action on bay protection and security of babies in clinic and in The Beeches.
- Allied Health Professionals- Full complement of all WBOT recruited with a few start dates remaining. There have been some cultural changes. The WBOTS have been trained on the clinical and therapeutic skills. We are increasing meaningful activity and recovery this will lead to increasing effectiveness and increasing bi-psychosocial model, we need to continue. How we measure impact and reduce length of stay and improve clinical outcomes. Significant

assurance and monitoring new SALT risk associate / on the risk register. Potential emerging risk. Monitored through performance monitoring / TMT for Central services and monitoring of CQC actions

- Clinical audit report- Overdue actions and 11% remain outstanding. A continued approach to improving. Improve forward plan to be SMART actions and metrics and targets for overdue actions and 360 feedback from COATS on performance. Agreed significant assurance.

- **Patient experience report:** Improvements in communication of staff. Overall feedback from carers and families will be included, to represent their voice. Team improvements. Due to the spike in self-harm, improvement work on reporting on self-harm, we are completing further analysis. The increase in violence is a concerning trend. We have low up-take on friends and family, this is a known risk. Improvement work on a dashboard level. The patient experience group to give their ideas on improvements and a timescale for this work - for October.

- **Safety needs assessment:** A briefing on the safety plan, an audit of gap and plan, the potential of risks on the use of safety box and the safety plan. The compliance audit of practice.CG challenges the gap in teams who have not completed a safety plan. Limited assurance, action for COATS and gap in safety planning per team and adaptations, and improvement work to implement.

- **Equality and Quality delivery system:** Completed for EDS for clinical and workforce. We have rated ourselves as Amber and some areas progressing. Appreciative enquiry, will be the new model, we have five case studies on NHS England website. NEDS were requested to be involved to assess Board papers./ 30th of March – dip of Board- selection of Board papers and committee and random selection. The April Audit with the Board, NEDS and external members are using it. Significant assurance. Risk re older adults re commissioning older adult letter / outlining discriminatory act and outline letter and specification to CEO

- **Mortality report:** Discussion re family with regards to mortality reviews, a regional meeting will explore this issue and explore the risks. A gap in assurance is the ability to undertake 200 mortality reviews, which recommends family always involve, we will involve John Trevains National lead on other Trusts performing in this area and expected changes in the new policy and guidance. Very positive work and impressive development we still have remaining areas to continually improve. Limited assurance. We are complaint with the main requirements and we are reviewing the outstanding issues re involving families and not reviewing mortality deaths per month.

- **Terms of reference:** We have revised the model and accepted

Key risks identified

- Risks re older adults crisis gaps
- Improvement work on safety planning and auditing
- Improvements and continual improvement in quality and implementation plan

Decisions made

Escalations to Board or other committee

Breach of equalities Act- Safety and Quality 1a, as an equality gap. Letter from CEO to commissioner on gap in access of Older Adults to a Crisis service.

Committee Chair: Julia Tabreham, Deputy Trust Chair	**Executive Lead: Carolyn Green, Director of Nursing and Patient Experience**

Board Committee Summary Report to Trust Board
Audit & Risk Committee – Meeting held 20 March 2018

Key items discussed

- Deep Dive on Board Assurance Framework (BAF) risk 4b – 'Failure to deliver internal transformation at pace' presented by lead director Lynn Wilmott Shepherd. .
- Final BAF report 2017/18 and draft 2018/19 headline BAF risks.
- Update on progress with the Annual Report, Quality Account and Annual Governance Statement.
- Review of outstanding actions arising from internal and external audits.
- Oversight of Deloitte recommendations relating to the remit of the Committee arising from their Phase 3 external Well-Led review.
- Review of year-end report of the Committee.
- Review of External Audit progress report.
- Review of Internal Audit report including the Q3 benchmarking report comparing the Trust to other NHS trusts and FTs in KPMG's portfolio.
- Fraud Risk Assessment update report
- Counter fraud plan and counter fraud self-review
- Audit and Risk Committee Effectiveness self-assessment results
- A confidential meeting was held including further discussion on the Committee Effectiveness Survey results and update on auditor contractual arrangements

Assurance/lack of assurance obtained

- Deep Dive – 4b significant assurance was received on progress with actions, controls and developments. Notably a more robust business planning process is underway. Continuous improvement is a key theme going forwards into 2018/19. Clear governance is in place and wider performance management is undertaken.
- Annual report and accounts – significant assurance on progress to plan. Fully engaged with external audit who gave their assurance.
- Quality account – significant assurance received on progress to date, consultation that is scheduled and that the document will be completed to deadline. Quality Committee to confirm assurance on content and flag any issues.
- Annual governance statement – significant assurance on progress and content to date
- Significant Assurance agreed relating to the governance processes and arrangements set in place to oversee progress of Deloitte recommendations relating to the Committee

- Significant Assurance was received from External Auditors that their work was on track
- Assurances as outlined received in respect of internal audit reports presented (BAF and Risk Management, Expenditure Data Analytics, Payroll Data Analytics).
- Significant assurance was received from the Q3 benchmarking report relating to the Trust's performance and this will be shared with the Chair of Finance and Performance Committee.
- Significant assurance was received relating to the outcome of the counter fraud self-review tool
- Partial assurance was received from the Committee Effectiveness survey results with areas for further clarification and work for the Committee agreed to address going forwards. The majority of responses were level 4 which is an indicator of maturity of the Committee.

Key risks identified

- Deep Dive 4b – risks were outlined and risk rating reviewed.
- Risk to progress annual report and quality account due to wider organisational priorities for staff (including CQC inspection preparation). This is mitigated by close project management and liaison with contributors.

Decisions made

- Deep Dive 4b - It was agreed to reduce the likelihood from 4 to 3 (impact to remain the same at 5) to give a risk score of 15 (formerly 20). This will be incorporated into the BAF paper presented to Board on 28 March.
- Agreed to work up the BAF risks for 2018/19 and arrange a workshop session for members to work through the detail of the 2018/19 BAF on 18 April 2018 prior to presentation to Board on 1 May 2018
- Recommendations arising from internal audit and counter fraud reports presented were agreed and progress will be reported as per established forward plan of the Committee
- Deloitte recommendations: Agreed to assurance reporting as outlined – reporting on training elements to be routed to People & Culture Committee.
- The counter fraud plan was agreed subject to amendments raised at the meeting. It was agreed that self-review tool would be submitted by the 1 April deadline subject to final discussion with relevant Executive Directors and further discuss post-submission with the Executive Team in terms of addressing Amber rated areas going forwards.
- Agreed the draft year-end review of the Committee was accurate and agreed that this should be completed in line with additional information now available from internal audit and counter fraud. This is to include feedback from the Effectiveness survey that has been undertaken.

Escalations to Board or other committee

- To refer assurance reporting to People & Culture Committee on risk management training plans arising from Deloitte recommendations

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

Board Committee Summary Report to Trust Board
People & Culture Committee – Meeting held 22 March 2018

Key items discussed

- Staff Story from a new joiner to DHCT. A registered nurse who relocated from Surrey to Derbyshire – what worked well and the things the Trust can improve
- Board Assurance Framework (BAF) end of year report was presented – highlights that the Trust has made progress in the year on risk 3d – Trust Operating Inclusively
- People and Assurance Committee Year End Report and the activity that the Committee has undertaken during the year
- Well Led review – Action to create a meaningful annual objectives connected to the trusts key priorities
- Review of the draft three year People Strategy
- Year 2 of the workforce plan
- Gender Pay Gap Reporting
- Staff Survey Results
- Workforce Supply and Recruitment Update
- Workforce Performance Report
- Staff Health & Wellbeing Strategy and CQUIN Update
- Staff Health & Wellbeing Communications Plan
- Training Compliance
- Apprenticeship Levy
- Media Handling Policy
- Social Media Handling Policy

Assurance/lack of assurance obtained

- BAF/medical cover on workforce supply
- PCC year-end report of 7 key people priorities and BAF progress through the year
- GIAP – WOD2 to close and move action. RAC system is in place and the risk is being assessed via the internal audit programme for September 2018

- Assurance provided on the draft People Strategy
- Year 2 of the Workforce Plan
- Assurance obtained that the areas identified from staff engagement group are aligned to the People Strategy and are the right things to focus on
- Assurance taken that the recruitment activity is taking the trust in the right direction
- Significant assurance taken on the People Flow and Metrics contained the Workforce Performance Report of the progress being made
- Limited assurance on the Staff Health and Wellbeing CQUIN achievement
- Limited assurance on specific areas of training - positive and safe, resuscitation training, safe guarding and physical health

Key risks identified

- Volume of work completed and planned. PCC identified leadership and management as a key ingredient
- Making changes to the staff appraisal process timing and linking to the new pay deal
- The need to increase the volume of apprentices into Nursing to meet the future workforce supply of the trust
- The need to build our medical workforce supply
- The new pay deal could impact the retention of experienced staff who need to support new joiners
- Retirement profile over the next 5 years - impact on recruitment and retention
- Delivery of CQUIN and the resources available to make the improvements
- Training compliance, some progression in some key areas ie care certificate, but below compliance in a number of areas

Decisions made

- To get all our policies back onto our web site and on an external platform so current and future staff can get access to outside the trust
- To refer back to the Executive Team the timeframe for revising the appraisal process
- To close off GIAP WOD2 and move to internal audit schedule for September 2018
- People Strategy with comments made at PCC to go to Board
- To revisit the workforce plan to identify how we can increase the supply Nursing apprentices
- Staff Wellbeing CQUIN to progress to ELT to discuss the risks
- To review our Apprenticeship Levy focus areas
- To approve the Media Handling and Social Media Policy

Escalations to Board or other committee

- To refer back to the Executive Team the timeframe for revising the appraisal process in light of the national pay deal
- Gender Pay Gap Reporting will be presented at board
- People Strategy will be presented to Trust Board with the feedback from PCC
- Staff Survey Results will be presented to Trust Board
- People Flow and Metrics – the progress that is being made and the risk profile and the focus areas
- Staff Health & Wellbeing Strategy to back to ELT for discussion
- Training compliance on mandatory training across a range of training programmes
- How we use our Apprenticeship Levy to invest in a small scale Apprentice Nurse Training pilot and how we fund the salary costs

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 28 March 2018

Draft People Strategy

Purpose of Report

To provide the Trust Board with a draft three People Strategy to review and provide feedback.

Executive Summary

This People Strategy has been developed to support the revised Trust Strategy and to provide five key aspects of putting our 'People First' and making Derbyshire Healthcare a great place to work.

The strategy focuses on the key priorities that we will focus on over the next three years to retain, develop and attract staff supported and enabled by a focus on management and leadership and inclusion.

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

Assurances

The Trust Board is asked to take assurance that the development of the strategy involved a wide range of staff, including the staff engagement group and has been discussed with the Executive Team and People and Culture Committee.

Consultation

As part of the development of the strategy we have consulted with staff but plan to engage further once the board are supportive of the direction of travel. This document is a corporate document and we will work with staff and our communications team to develop a simple, more visual and engaging version that can be widely communicated and available on our web site and recruitment materials.

Governance or Legal Issues

People and Culture Committee will oversee the delivery of the strategy and the agenda will be themed to focus on the key issues.

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (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 receive, review and comment on the draft People Strategy.

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

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

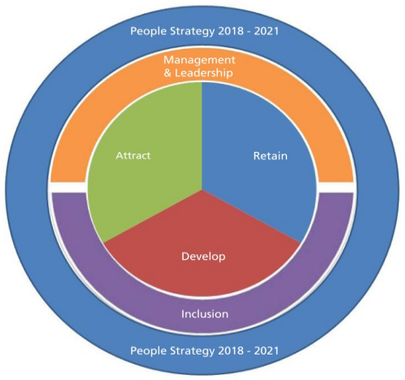
People Strategy 2018 – 2021

Welcome to our 2018 – 2021 People Strategy. This strategy has been developed to support the delivery of the refreshed Trust Strategy and to support our ambition to:

- Put our people first in order to live our values.
- Develop our Managers and Leaders so they can create the environment where people experience our values.
- Ensure the people who access our services are supported to achieve the best possible physical health status, in addition to providing excellent mental health care and support.
- Enable Derbyshire Healthcare to fit within system-wide and partnership working.

Across our trust we employ a multi-generational workforce and recognise that our employment offer needs to be more flexible and adaptable in order to retain, develop and attract colleagues.

Taking these things into account, we developed our 'People Strategy', as we believe that by putting our 'people first' we will create a culture that supports continuous improvement; learning from mistakes and promotes innovation. We believe that by focusing on our people this will enable us to attract colleagues to work for us who we can develop and retain, who will be supported by excellent management and leadership and an empowered, compassionate and inclusive culture that respects diversity. The strategy has five key focus areas:



Retain - We will create a positive and engaging working environment for all our DHCFT colleagues. We will listen to colleague feedback via the annual staff survey and the quarterly pulse checks to drive the improvement across the Trust and individual teams to improve colleague engagement and involvement. We will develop a benefits package that supports the needs of colleagues at every stage of their career. We will create a compassionate culture that nurtures and supports colleagues' physical and mental well-being.

Develop - We will offer a flexible approach to induction, preceptorship and development that meet the needs of new joiners; build a flexible career pathway by profession to grow and retain colleagues and ensure that all colleagues have a meaningful and engaging annual appraisal that supports their personal development. We will align succession planning with workforce and business planning

Attract - We will strengthen our brand ensuring we are seen as the first choice place to work. We will develop innovative and targeted recruitment campaigns to reach a diverse range of applicants and provide an employment offer that is flexible and meets the needs of all colleagues at all stages of their career

To ***Retain, Develop and Attract*** - colleagues in DHCFT, we recognise that there are two golden threads that enable and are key to delivery; to be excellent in Management and Leadership and to provide a positively inclusive culture:

Management and Leadership - In tandem, we will develop our management and leadership skills and capabilities across the Trust, ensuring all people and Service Managers have the skills and knowlesge to do their role well. We will develop visionary, inclusive and engaging leaders that create a high performing and inclusive work environment and great place to work.

Inclusion - We will create a 'positively inclusive' employment offer that supports every colleague to be the best they can be, supported by a compassionate, engaging and enhancing environment that provides inclusive services and employment.

People Strategy 2018 – 2021

	Strategic Aim	Over the next three years we will….	By……	Success measures
Retain	To work in partnership with our colleagues to create a positive and engaging work environment for all colleagues making DHCFT a top ten Trust to work for in the NHS as measured by the annual staff survey To provide a safe working environment, ensuring that colleagues are kept free of harm Create a compassionate culture that nurtures and supports both the physical and mental well-being of colleagues To provide a multi-generational employment offer that attracts and retains staff	• Continually engage and listen to colleagues to hear and act on what is going well and what needs to be improved • Actively demonstrate our commitment and focus on the annual staff survey and the quarterly pulse checks to drive the organisation and team improvements • Organisational and team engagement improvement plans owned and monitored. All Leaders have improving staff engagement as an annual objective • Implement the Staff Well-being Strategy; focusing on Mental Health support, Prevention, Resilience and support staff when things go wrong • Provide comprehensive support through organisational change • Develop a culture where colleagues view their safety as a top priority • Continually engage and listen to colleagues ensuring our employment model meets their needs • Provide a benefits and support package that meets the needs of colleagues at each stage of their life and personal circumstances • Enhance our approach to colleague recognition achievements and successes through a range of recognition mechanisms • Develop an effective process to talent management and succession planning	• Enhancing and enriching the Staff Forum as the route to hear what organisational wide improvements are needed • Regular and proactive 'You said we did" • Develop a real time interactive tool that enable colleagues to make suggestions and provide feedback • Ensure all Leaders have an annual objective to improve their colleague engagement, wellbeing and retention • Cascade team brief across the Trust, ensuring all colleagues are kept up to date on Trust issues • Focus on physical and mental well-being of colleagues • Provide rapid access to support services, Occupational Health, Resolve, Physiotherapy and supporting policies and processes • Focus on prevention – stress risk assessments, health training/coaching, self-guided well-being resources • Developing a zero tolerance approach to bullying and harassment • Provide support and interventions to the teams whose staff engagement scores are below the Trust's average • Ensuring all Leaders have staff engagement and retention as a key performance metric as measured by their annual appraisal • Provide resilience training for all Leaders and staff • Actively promote the current NHS benefits package and enhance by listening to what colleagues need including support services • Enhance our annual recognition awards	• Tracking and closing Staff Forum actions • Upper quartile staff survey participation rates • Upper quartile staff engagement scores – the Trust as a place to work and receive treatment • Improvements in the quarterly pulse check participation rate and engagement score • Retention rates tracked by team and profession <8% per annum • Attendance <4.5% per annum • Annual appraisal rate of available staff of 95% • Reduction in stress and anxiety absence • Annual RIDDORs tracked for improvement • Increased near miss reporting and findings acted upon • Staff survey results • Exit interviews – findings to be reviewed, monitored and tracked with lessons learnt put into place

	Strategic Aim	Over the next three years we will….	By…….	Success measures
Develop	To provide the experience, skills and competencies that colleagues need in order to provide a high quality service and experience to our patient and service users	• Offer a flexible and engaging induction process for all new joiners ensuring a positive start with the Trust • Provide a flexible and enriching preceptorship scheme that meets the needs of new joiners • Develop a flexible and targeted mandatory training programme	• Refreshing our induction offer so that it is tailored in length and approach and matches the contract requirements of colleagues • Ensure all preceptors have a programme that meets their needs and is supported with a quality mentorship • Review the mandatory training programme so that it is simplified and aligned to the needs of each role and each person's contract • Build a hub and spoke model of training provision built on a flexible platform of face to face and technology-based delivery	• % of staff completing induction process in xx days • % of staff reporting a successful induction 3 months post joining the trust • % of staff completing their preceptorship programme • % of staff who stay with the Trust > 2 years • % of available staff completing their annual mandatory training requirements • % of staff receiving an annual appraisal • Xx number of colleagues accessing the apprenticeship levy every year • 5% per annum improvement in the staff survey Q XX on annual appraisals of staff reporting a meaningful appraisal • Annual appraisal rate of available staff of 95%
	To offer career pathways and development opportunities so DHCFT is recognised as the place to work and to enhance your career. Development that is tailored to an individual's needs and learning preferences at each stage of their career and to enable them to reach their full potential	• Build flexible career pathways by occupation to grow and retain our workforce • Ensure all colleagues have a meaningful and engaging annual appraisal that supports their personal development • Align succession planning with the workforce and business planning process • To work with colleagues across DHCT and Derbyshire to provide development via rotational routes	• Ensure that all colleagues have a meaningful annual appraisal that links their objectives to the trusts objectives and identifies their development and career aspirations • Work with services to develop a succession plan supported by a development plan • Design and develop rotational development opportunities for key professions to support career aspirations and retention • Exploring salary sacrifice as an opportunity not to force staff to access an increased range of development opportunities	

People Strategy 2018 – 2021

	Strategic Aim	Over the next three years we will….	By…..	Success Measures
		• Strengthen the DHCFT brand so that current and future colleagues see DHCFT as their first-choice place to work	• Strengthening our working relationships with Schools, Colleges, Universities and professional bodies so they actively and positively promote DHCFT as the place to work	• XX students chose DHCFT for their placement • XX students after a placement return to DHCFT in a permanent position • XX external colleagues join DHCFT annually on an apprenticeship • XX number of clinical colleagues decide to return to practice with DHCFT
Attract	We aspire to be recognised as the number one employer to work for in Mental Health, Learning Disabilities, Children's and Substance Misuse Services in the NHS	• Develop innovative and targeted recruitment campaigns that reach and attract a diverse range of potential applicants who hold the values and behaviours we require • Create a positive 'end to end' recruitment experience that is streamlined, personalised and engaging	• Develop and launch a recruitment portal that positively positions the range of career opportunities available, the current vacancies and why choose DHCFT as a place to work • Increase our social media presence to ensure we reach a wide and diverse audience • Appointing Managers and the recruitment team work in partnership on each vacancy to ensure we provide a safe, efficient and personalised approach for each applicant	• Portal hits per month • XX colleagues join DHCFT per annum • XX 90% of vacancies filled first time • < 4% vacancy rate across all professions (with exception of Medical vacancies) • Social media reach and hits per month/annum • XX recruitment satisfaction rating from new joiner surveys
	We want to be an employer that offers a positive and engaging work environment and a flexible employment offer that meets the needs of a colleague at each stage of their career	• Effective workforce planning for today and the future to meet the needs of the services • Provide an employment offer that is flexible to meet the needs of colleagues at all stages of their career • Offer a range of career routes to attract and retain colleagues in DHCFT • Build a robust range of staffing solutions to enable DHCFT to meet its short term and long term workforce requirement	• Annual workforce plan aligned to the business plan, reviewed and tracked quarterly • Offer a range of contracts and employment solutions that meets the needs of colleagues; full time, part time, term time, annualised hours etc • Increase the range of career routes for colleagues across all professions • Build and grow our bank and responsive workforce team • Revitalise our benefits package so that it meets the needs of colleagues at each stage of their career and their personal circumstances	• Approved and funded workforce plan • Agency and bank cost target met annually • Bank fill rates per month • Turnover rate of xx • XX of staff who choice to continue to work for DHCFT post retirement

People Strategy 2018 – 2021

	Strategic Aim	Over the next three years we will….	By…….	Success measures
Management and Leadership	To develop and deliver consistent and capable people and service management capabilities across the Trust To develop empowered, compassionate and inclusive leaders. Leaders who create an environment where colleagues can live the values To develop visionary and engaging leaders that create a high performing and inclusive work environment and great place to work To enable leadership to flourish at every level across the Trust	• Develop a robust and thorough management development offer that builds knowledge and capability across the Trust ensuring all service and people managers are equipped to do their role • Support our Managers to build their leadership capabilities focusing on contextual, personal, technical and relationship skills and insight • Develop clear leadership expectations that are embedded into recruitment, induction, appraisal • Develop reflective practice so Leaders can receive feedback on their leadership style and the climate they create for their colleagues • Develop a support package of coaching, mentoring and shadowing. • Provide all Leaders with knowledge of improvement methods and how to use them at all levels • To embed talent management and succession planning to identify risks and potential to fulfil future leadership pipelines with the right numbers of diverse, appropriately developed people	• Building a comprehensive management development programme that covers all the people management and service management knowledge and skills required • Providing a leadership development programme that builds Leaders at all levels of the Trust. Development that supports Leaders to build their personal, technical, relationship and contextual insight • Offering reflective development via 360 appraisal, coaching and mentoring • Developing a clear set of leadership expectations and align recruitment, induction, appraisal and through a range of development programmes • Roll out talent management and succession planning aligned to the appraisal process	• Supply of Leaders for each post • Staff engagement and satisfaction as measured by staff survey leadership questions • Delivery of people metrics by Leader • Retention of Leaders • Retention rates by team • Reduction of employee relation cases

	Strategic Aim	Over the next three years we will….	By……	Success Measures
Inclusion	To be a 'positively inclusive' and fair employer so everyone can be the best they can To be recognised as a caring and progressive organisation that promotes equality, values and celebrates diversity and has created an inclusive and compassionate environment for receiving care and for employment. To provide inclusive services that are delivered with kindness, dignity and respect and meet the needs of service users and patients	• Develop Equality Champions and Allies across the Trust who actively promote inclusion • Expand our colleague network groups for each protected characteristic • Build Reverse Mentoring across the Trust and share learning through action research in partnership with the University of Nottingham • Develop a calendar of diversity events to celebrate key dates • Focus on the findings from the staff survey identifying where colleagues from protective characteristics receive lesser positive experience at work and drive improvement • Focus on the annual EDS2 work programme and grading by workforce as a barometer for inclusion culture and environment by assessing fair systems, processes, treatment, career development and progression. • Focus on the actions arising from Workforce Race Equality Standard (WRES) and Gender Pay Gap (GPG) reporting • Ensure compliance with statutory public sector equality duties e.g. Equality Act 2010	• Expanding the number of Equality Champions across the Trust ensuring each protective characteristic is covered • Roll out Reverse Mentoring and evaluation in partnership with the University of Nottingham • Develop an annual diversity calendar and programme of agreed key events • Carry out Annual Equality Delivery System self-assessment and grading for workforce and inclusion leadership outcomes. • Annual submission of WRES and GPG and action plans to address gaps • Provide a range of equality, inclusion and compassionate workshops to build cultural knowledge and competence • Deep analysis of the staff survey findings to identify where we need to focus on improving colleagues experience at work • Use data collection of colleague and service user profiles to identify focus areas	• Increase the number of Equality Champions across the Trust for all nine protected characteristics • Number of diversity key events promoted and supported • Increase the number of new colleague networks – LGBT+ And Long-Term conditions And Disability • Year on year improvement in EDS2 rating for workforce and inclusive leadership outcomes to achieving by 2021 • Year on year improvements in the differences/gaps across core WRES and GPG between protected characteristics • Improvement in staff engagement by protected characteristic as measured in the staff survey • 95% of colleagues complete their annual Equality and Diversity mandatory training requirements • % of Leaders completed inclusive and compassionate leadership training • Annual workforce Diversity analysis and WRES and GPG reported in March each year

Derbyshire Healthcare NHS Foundation Trust
Report to the Board Committee – 28 March 2018

Staff Survey Results

Purpose of Report

The purpose of this report is to update Trust Board on the initial NHS Staff Survey results, which show our current position based on the 2017 all staff survey.

Executive Summary

Response Rate:

- 1,020 DHCFT staff completed the survey giving a 44.8% response rate (5.8% up on last year). The average score for similar trusts is 45% (the highest being 63% and lowest 32%).

The engagement score is up from 3.69 to 3.74, from 2016 the National average is 3.79 for similar trusts.

There are two areas where staff experience has improved:

- KF6 - percentage of staff reporting good communication between senior management and staff up 6% to 30%

- KF1 - staff recommendation of the organisation as a place to work or receive treatment up 1.1% to 5.58%

Comparison with the 2016 staff survey:

- A total of 88 questions were used in both the 2016 and 2017 surveys and compared to 2016 survey the organisation is better on 8 questions, is significantly worse on 2 questions and shows no significant difference on 78 questions

- In NSS17 a comparison can be drawn between your organisation and the Picker average on the 88 questions. The organisation did significantly better on 2 questions, significantly worse on 36 questions and average on 50 questions

- On the two promoter scores the trust did better:

    - I would recommend DHCFT as a place to work up 8.6%
    - If a friend or relative or friend needed treatment, I would be happy with the standard of care provided by this organisation up by 3.7%.

- For those areas of improvement eight questions improved, two were reduced.

Recommendations:

The areas proposed for improvement (by the Staff Forum and the Engagement Group are:

- Recruitment, selection and retention
- Staff wellbeing
- Leadership and management
- Bullying and harassment
- Opportunities for development (including succession planning).

The People strategy for 2018 will address all of these issues under the guidance of the PCC.

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

Assurances

The Trust Board is asked to take assurance that the staff survey is starting to move forward in a positive direction.

Consultation

As part of the development of the priorities for staff survey action plan we have engaged with the Staff Engagement Group and Staff Forum.

Governance or Legal Issues

The Staff Survey is an NHS England requirement.

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:

1) Receive and review the 2017 NHS Staff Survey results
2) Discuss the recommendations for initial focus areas from the 2017 results and agree the priorities for 2018.

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

Report prepared by: **Ian Shepherd**
Management Trainer

2017 NHS Staff Survey Results

This paper covers the 2017 Staff Survey conducted 4 October to 1 December 2017. 1,020 DHCFT staff completed the survey giving a 44.8% response rate (5.8% up on last year). The average score for similar trusts was 45% (the highest being 63% the lowest 32%).

1. Response rates

Locality	Eligible Sample	Respondents	Response Rate
Finance (	22	21	95.50%
Workforce OD	12	11	91.70%
Corporate+ Legal Affairs	18	16	88.90%
Clinical Services Management	32	28	87.50%
Estates	19	16	84.20%
Human Resources	22	18	81.80%
IT, Information Management & Patient Records	41	32	78.00%
Pharmacy	35	26	74.30%
OTHER	40	28	70.00%
Governance	24	16	66.70%
Centre for Research + Development	13	8	61.50%
Central Services	378	220	58.20%
Facilities Group	113	57	50.40%
Medical	25	12	48.00%
Neighbourhood	517	199	38.50%
Campus	604	195	32.30%
Children's Services	364	117	32.10%

2. Staff engagement score

2017 3.74
2016 3.69
Similar trusts 3.79

The possible scores range from 1-5, with 1 indicating staff are poorly engaged and 5 indicating staff are highly engaged. This score is calculated based upon staff members:

- Perceived ability to contribute to improvements at work
- Willingness to recommend the trust as a place to work or receive treatment
- The extent to which they feel motivated and engaged in their work.

How our Staff Engagement Score compares to similar Trusts

The following is a selection of similar trusts to Derbyshire Healthcare NHS Foundation Trust

Organisation	Response rate		Engagement score	
	2016	2017	2016	2017
Dudley and Walsall Mental Health Partnership NHS Trust	51%	52%	3.82	3.94
Northamptonshire Healthcare NHS Foundation Trust	43%	48%	3.85	3.91
Northumbria Healthcare NHS Foundation Trust	77%	73%	3.96	3.91
2Gether NHS Foundation Trust	40%	45%	3.89	3.88
Lincolnshire Partnership NHS Foundation Trust	59%	59%	3.77	3.85
Barnet, Enfield and Haringey Mental Health NHS Trust	53%	46%	3.81	3.81
Pennine Care NHS Foundation Trust	36%	32%	3.84	3.8
Norfolk Community Health And Care NHS Trust	48%	55%	3.71	3.77
Essex Partnership University NHS Foundation Trust		42%		3.76
North Staffordshire Combined Healthcare NHS Trust	51%	52%	3.73	3.76
Sussex Partnership NHS Foundation Trust	53%	55%	3.77	3.76
Mersey Care NHS Foundation Trust	60%	60%	3.74	3.75
Derbyshire Healthcare NHS Foundation Trust	39%	45%	3.69	3.74

Organisation	Response rate		Engagement score	
Nottinghamshire Healthcare NHS Foundation Trust	48%	47%	3.79	3.72
Leicestershire Partnership NHS Trust	42%	43%	3.74	3.71
Avon And Wiltshire Mental Health Partnership NHS Trust	51%	52%	3.7	3.67
Medway NHS Foundation Trust	49%	40%	3.76	3.66
Sheffield Health & Social Care NHS Foundation Trust	40%	35%	3.74	3.64
Lancashire Care NHS Foundation Trust	35%	41%	3.81	3.63

3. How our results compare to the 2016 staff survey

Please see **figure 1** *for a pie chart to show how we compare to our results in the 2016 staff survey and how we compare to other 'Picker' organisations this year*.

Figure 1

Have you improved from 2016?

A total of 88 questions were used in both the 2016 and 2017 surveys. Compared to the 2016 survey, your organisation is:

- Significantly BETTER on 8 question(s)
- Significantly WORSE on 2 question(s)
- The scores show no significant difference on 78 question(s)

How do you appear to others?

In NSS17 a comparison can be drawn between your organisation and the Picker average on a total of 88 questions. Your organisation is:

- Significantly BETTER than average on 2 question(s)
- Significantly WORSE than average on 36 question(s)
- The scores were average on 50 question(s)

88 questions were used in both the 2016 and 2017 staff survey and compared to the 2016 survey we are:

- Significantly better on 8 questions
- Significantly worse on 2 questions
- No significant difference on 78 questions.

4. Our top five ranking scores

Key finding:	DHCFT 2017 score	Other trust scores
KF 15 Percentage of staff satisfied with the opportunities for flexible working patterns	63%	58%
KF23 Percentage of staff experiencing physical violence from staff in the last 12 months	1%	2%
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	22%	23%
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	26%	26%
KF16. Percentage of staff working extra hours	71%	71%

Our bottom five ranking scores

Key finding	DCHFT 2017 score	Other trust scores
KF32. Effective use of patient / service user feedback	3.44	3.69
KF13. Quality of non-mandatory training, learning or development	3.99	4.06
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	78%	86%
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.58	3.76
KF31. Staff confidence and security in reporting unsafe clinical practice	3.56	3.72

Two areas where staff experience has improved:

- KF6. Percentage of staff reporting good communication between senior management and staff up 6% to 30%.
- KF1. Staff recommendation of the organisation as a place to work or receive treatment up 1.1 to 5.58.

5. Staff Recommending the Trust as a Place to work

Q21C - Percentage of staff who would recommend DHCFT as a place to work

2017 – 52%
2016 – 43%
Similar trusts 2017 58%

	'I would recommend my organisation as a place to work'	
	2017	**2016**
Strongly disagree	9.0%	10.7%
Disagree	11.2%	15.6%
Neither agree or disagree	28.1%	30.7%
Agree	37.4%	32.5%
Strongly agree	14.2%	10.5%

Q21D - Percentage of staff who would be happy to recommend the standard of care provided by DHCFT if a friend or relative needed treatment

2017 – 60%
2016 – 56%
Similar trusts 2017 67%

	'If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation'	
	2017	**2016**
Strongly disagree	4.6%	5.6%
Disagree	8.6%	10.3%
Neither agree or disagree	27.2%	28.2%
Agree	44.6%	42.8%
Strongly agree	15.0%	13.1%

6. How did we do against our 2016 action plan for improvement?

We had five focus areas that we have worked on over the past year and the progress on these is outlined below:

- Safe to raise concerns about unsafe clinical practice
- That career progression is fair
- The quality of appraisals is good
- The Trust is interested in the well-being of staff
- Valued by managers.

Q13b Percentage of staff who feel secure in raising concerns about unsafe clinical practice

2017 – 67% (improved – more staff felt secure raising concerns about unsafe clinical practice)

2016 – 64% Similar trust 2017 73%	**'I would feel secure raising concerns about unsafe clinical practice'**	
	2017	**2016**
Strongly disagree	3.8%	3.2%
Disagree	6.9%	8.6%
Neither agree or disagree	22.5%	24.3%
Agree	48.4%	46.3%
Strongly agree	18.3%	17.5%

Q16+ Percentage of staff who feel the organisation acts fairly with regard to career progression/promotion

2017 – 77% (improved – more staff felt the organisation acts fairly with regards to career progression/promotion)

2016 – 75% Similar trusts 2017 86%	**'Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?'**	
	2017	**2016**
Yes	77.3%	74.9%
No	22.7%	25.1%

Q20b The percentage of staff who felt their appraisal/review helped them to improve how they did their job

2017 – 19% (Improved – more staff who felt their appraisal/review helped them to improve how they did their job)

2016 – 17% Similar trusts 2017 21%	**'The appraisal/review helped me to improve how I did my job'**	
	2017	**2016**
Yes, definitely	19.5%	16.7%
Yes to some extent	50.8%	50.4%
No	29.7%	32.9%

Q20.c The percentage of staff who felt their appraisal helped them agree clear objectives for their work

2017 – 30% (Reduced – Less staff felt their appraisal helped them agree clear objectives for their work).

2016 – 27% Similar trusts 2017 34%	**'The appraisal/review helped me agree clear objectives for my work'**	
	2017	**2016**
Yes, definitely	19.5	27
Yes to some extent	50.8	55.2
No	29.7	17.8

Q20.d The percentage of staff who felt their appraisal/review left them with a feeling that their work is valued by the organisation

2017 – 26% (Improved - staff who felt their appraisal/review left them with a feeling that their work is valued by the organisation)

2016 – 24% Similar trusts 2017 28%	**'The appraisal/review left me feeling my work is valued by my organisation'**	
	2017	**2016**
Yes, definitely	26.2%	23.5
Yes to some extent	46.7%	46.3
No	27.1%	30.2

Q20.e The percentage of staff who said the organisation values were discussed as part of the appraisal

2017 – 31% (Improved – more staff said the organisation values were discussed as part of the appraisal)

2016 – 36% Similar trusts 2017 33%	**'The values of my organisation were discussed as part of the appraisal'**	
	2017	**2016**
Yes, definitely	30.8%	35.6%
Yes to some extent	47.6%	48.1
No	21.5%	16.3%

Q20. The percentage of staff who felt training, learning or development needs were identified

2017 – 68% (Improved - staff who felt training, learning or development needs were identified)

2016 – 65% Similar trusts 2017 67%	**'Were any training, learning or development needs identified?**	
	2017	**2016**
Yes, definitely	68.9%	67.4
No	31.1%	32.6

Q9.a The percentage of staff who felt the organisation takes positive action on health and well-being

2017 – 25% (Improved - staff who felt the organisation takes positive action on health and well-being)

2016 – 24% Similar trusts 2017 32%	**'Does your organisation take positive action on health and well-being'**	
	2017	**2016**
Yes, definitely	25.3%	24.4%
Yes to some extent	62.0%	63.3%
No	12.7%	12.3%

Q5. The percentage of staff who felt the organisation values their work

2017 – 41% (Improved – more staff who felt the organisation values their work)

2016 – 36%

Similar trusts 2017 44%	**'How satisfied am I with the extent ro which my organisation values my work'**	
	2017	**2016**
Very dissatisfied	12.0%	13.3%
Dissatisfied	19.6%	22.8%
Neither satisfied not dissatisfied	27.2%	28.2%
Satisfied	32.9%	26.9%
Very satisfied	8.3%	8.9%

Q7.g The percentage of staff who believe their immediate manager values their work

2017 – 75% (No Change).
2016 - 75%
Similar trusts 2017 76%

	'My immediate manager values my work'	
	2017	**2016**
Strongly disagree	3.2%	3.7%
Disagree	5.3%	5.4%
Neither agree or disagree	16.9%	15.4%
Agree	39.1%	43.2%
Strongly agree	35.5%	32.3%

7. Historical Comparisons

This section shows our reported Positive Scores for 2017 and the previous 2 years (as available) so we can track our results year on year. The historical comparisons are grouped under the reported headings as highlighted in the figures below. **Please note higher scores indicate better performance in this positive score section.**

Figure 3 – Your Job

		2013	2014	2015	2016	2017	
Q2a	Often/always look forward to going to work	-%	-%	52%	53%	58%	+
Q2b	Often/always enthusiastic about my job	-%	-%	72%	70%	73%	
Q2c	Time often/always passes quickly when I am working	-%	-%	78%	77%	79%	
Q3a	Always know what work responsibilities are	-%	-%	83%	82%	83%	
Q3b	Feel trusted to do my job	-%	-%	92%	91%	92%	
Q3c	Able to do my job to a standard I am pleased with	-%	-%	77%	75%	75%	
Q4a	Opportunities to show initiative frequent in my role	-%	-%	76%	74%	73%	
Q4b	Able to make suggestions to improve the work of my team/dept	-%	-%	76%	74%	75%	
Q4c	Involved in deciding changes that affect work	-%	-%	51%	51%	54%	
Q4d	Able to make improvements happen in my area of work	-%	-%	58%	55%	56%	
Q4e	Able to meet conflicting demands on my time at work	-%	-%	41%	38%	42%	
Q4f	Have adequate materials, supplies and equipment to do my work	-%	-%	56%	55%	56%	
Q4g	Enough staff at organisation to do my job properly	-%	-%	29%	26%	31%	+
Q4h	Team members have a set of shared objectives	-%	-%	74%	72%	72%	
Q4i	Team members often meet to discuss the team's effectiveness	-%	-%	69%	64%	64%	
Q4j	Team members have to communicate closely with each other to achieve the team's objectives	-%	-%	82%	76%	77%	

Your Job (continued)

		2013	2014	2015	2016	2017	
Q5a	Satisfied with recognition for good work	-%	-%	58%	51%	55%	
Q5b	Satisfied with support from immediate manager	-%	-%	73%	69%	71%	
Q5c	Satisfied with support from colleagues	-%	-%	85%	82%	83%	
Q5d	Satisfied with amount of responsibility given	-%	-%	77%	72%	74%	
Q5e	Satisfied with opportunities to use skills	-%	-%	75%	67%	67%	
Q5f	Satisfied with extent organisation values my work	-%	-%	40%	36%	41%	+
Q5g	Satisfied with level of pay	-%	-%	41%	42%	35%	-
Q5h	Satisfied with opportunities for flexible working patterns	-%	-%	60%	61%	62%	
Q6a+	Satisfied with quality of care I give to patients/service users	-%	-%	80%	80%	79%	
Q6b+	Feel my role makes a difference to patients/service users	-%	-%	87%	88%	86%	
Q6c+	Able to provide the care I aspire to	-%	-%	60%	60%	61%	

Figure 4 – Your managers

		2013	2014	2015	2016	2017	
Q7a	Immediate manager encourages team working	-%	-%	76%	75%	75%	
Q7b	Immediate manager can be counted upon to help with difficult tasks	-%	-%	74%	71%	73%	
Q7c	Immediate manager gives clear feedback on my work	-%	-%	65%	63%	66%	
Q7d	Immediate manager asks for my opinion before making decisions that affect my work	-%	-%	57%	61%	62%	
Q7e	Immediate manager supportive in personal crisis	-%	-%	76%	78%	78%	
Q7f	Immediate manager takes a positive interest in my health & well-being	-%	-%	71%	73%	73%	
Q7g	Immediate manager values my work	-%	-%	74%	75%	75%	
Q8a	I know who senior managers are	-%	-%	83%	76%	79%	
Q8b	Communication between senior management and staff is effective	-%	-%	31%	29%	36%	+
Q8c	Senior managers try to involve staff in important decisions	-%	-%	30%	26%	32%	+
Q8d	Senior managers act on staff feedback	-%	-%	23%	22%	30%	+

Figure 5 – Your health, well-being and safety at work

		2013	2014	2015	2016	2017
Q9a	Organisation definitely takes positive action on health and well-being	-%	-%	35%	24%	25%
Q9b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	-%	-%	83%	82%	80%
Q9c	Not felt unwell due to work related stress in last 12 months	-%	-%	58%	57%	59%
Q9d	In last 3 months, have not come to work when not feeling well enough to perform duties	-%	-%	31%	42%	40%
Q9e	Not felt pressure from manager to come to work when not feeling well enough	-%	-%	82%	84%	83%
Q9f	Not felt pressure from colleagues to come to work when not feeling well enough	-%	-%	82%	84%	83%
Q9g	Not put myself under pressure to come to work when not feeling well enough	-%	-%	6%	6%	7%
Q10b	Don't work any additional paid hours per week for this organisation, over and above contracted hours	-%	-%	79%	77%	78%
Q10c	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	-%	-%	40%	37%	38%
Q11a	In last month, have not seen errors/near misses/incidents that could hurt staff	-%	-%	85%	84%	84%
Q11b	In last month, have not seen errors/near misses/incidents that could hurt patients	-%	-%	82%	81%	82%
Q11c+	Last error/near miss/incident seen that could hurt staff and/or patients/service users reported	-%	-%	97%	97%	93%
Q12a+	Organisation treats staff involved in errors fairly	-%	-%	41%	38%	39%
Q12b+	Organisation encourages reporting of errors	-%	-%	84%	83%	84%
Q12c+	Organisation takes action to ensure errors are not repeated	-%	-%	64%	57%	61%
Q12d+	Staff given feedback about changes made in response to reported errors	-%	-%	57%	50%	54%

Figure 5 – Your health, well-being and safety at work (continued)

		2013	2014	2015	2016	2017	
Q13a+	Know how to report unsafe clinical practice	-%	-%	98%	97%	96%	
Q13b	Would feel secure raising concerns about unsafe clinical practice	-%	-%	67%	64%	67%	
Q13c	Would feel confident that organisation would address concerns about unsafe clinical practice	-%	-%	52%	43%	51%	+
Q14a	Not experienced physical violence from patients/service users, their relatives or other members of the public	-%	-%	82%	86%	86%	
Q14b	Not experienced physical violence from managers	-%	-%	100%	100%	99%	
Q14c	Not experienced physical violence from other colleagues	-%	-%	97%	99%	99%	
Q14d+	Last experience of physical violence reported	-%	-%	82%	86%	87%	
Q15a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	-%	-%	67%	73%	75%	
Q15b	Not experienced harassment, bullying or abuse from managers	-%	-%	91%	88%	90%	
Q15c	Not experienced harassment, bullying or abuse from other colleagues	-%	-%	83%	83%	83%	
Q15d+	Last experience of harassment/bullying/abuse reported	-%	-%	65%	60%	55%	
Q16+	Organisation acts fairly: career progression	-%	-%	83%	75%	77%	
Q17a	Not experienced discrimination from patients/service users, their relatives or other members of the public	-%	-%	94%	95%	95%	
Q17b	Not experienced discrimination from manager/team leader or other colleagues	-%	-%	93%	93%	93%	

Figure 6 – Your personal development

		2013	2014	2015	2016	2017	
Q18a+	Had training, learning or development in the last 12 months	-%	-%	76%	72%	75%	
Q18b+	Training helped me do my job more effectively	-%	-%	79%	82%	80%	
Q18c+	Training helped me stay up-to-date with prof. requirements	-%	-%	85%	86%	85%	
Q18d+	Training helped me deliver a better patient / service user experience	-%	-%	80%	79%	79%	
Q19+	Had mandatory training in the last 12 months	-%	-%	98%	97%	97%	
Q20a+	Had appraisal/KSF review in last 12 months	-%	-%	83%	86%	89%	
Q20b	Appraisal/review definitely helped me improve how I do my job	-%	-%	14%	17%	19%	
Q20c	Clear work objectives definitely agreed during appraisal	-%	-%	25%	27%	30%	
Q20d	Appraisal/performance review: definitely left feeling work is valued	-%	-%	25%	24%	26%	
Q20e	Appraisal/performance review: organisational values definitely discussed	-%	-%	40%	36%	31%	-
Q20f	Appraisal/performance review: training, learning or development needs identified	-%	-%	70%	67%	69%	
Q20g	Supported by manager to receive training, learning or development definitely identified in appraisal	-%	-%	56%	51%	53%	

Figure 7 – Your organisation

		2013	2014	2015	2016	2017
Q21a	Care of patients/service users is organisation's top priority	-%	-%	68%	68%	69%
Q21b	Organisation acts on concerns raised by patients/service users	-%	-%	70%	68%	71%
Q21c	Would recommend organisation as place to work	-%	-%	46%	43%	52% +
Q21d	If friend/relative needed treatment would be happy with standard of care provided by organisation	-%	-%	63%	56%	60%
Q22a+	Patient/service user feedback collected within directorate/department	-%	-%	93%	89%	90%
Q22b+	Receive regular updates on patient/service user feedback in my directorate/department	-%	-%	37%	40%	41%
Q22c+	Feedback from patients/service users is used to make informed decisions within directorate/department	-%	-%	38%	42%	46%

Figure 8 – Background information

		2013	2014	2015	2016	2017
Q27b+	Disability: organisation made adequate adjustment(s) to enable me to carry out work	-%	-%	87%	83%	81%

8. Improvement areas of focus over the next year

We have worked with our Staff Engagement Group and consulted with our Staff Forum members about what they see as the key priorities are for the trust to focus on over the next few months and the following has been identified:

- Recruitment, selection and retention
- Staff wellbeing
- Leadership and management
- Bullying and harassment
- Opportunities for development (including succession planning).

We have developed a two year People Strategy 2018-2020 which has these focus areas covered but we will have a dedicated action plan to ensure we have sufficient attention at ELT, People and Culture Committee, Staff Forum and the Engagement Group and can be clearly communicated to staff.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 28 March 2018

Gender Pay Gap 2018

Purpose of Report

This paper looks at the requirements under the new GPG reporting and sets out the results of GPG in DCHS. Following government consultation, it became mandatory on 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap (GPG). This data has to be reported by 30 March 2018 and is part of the Public Sector Equality Duty under the Equality Act 2010.

Appendix 1: Gender Pay Gap Report 2018 (extracted 31/3/2017)

The Board is asked approve the attached and discuss communication plan prior to publishing on our external website and Government Equalities Office by 30 March, 2018.

Executive Summary

The new requirements

Employers with 250 employees and over will need to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This will include those under Agenda for Change terms and conditions, medical staff and very senior managers. All calculations should be made relating to the pay period in which the snapshot day falls. For the first year, this will be the pay period including 31 March 2017.

Employers will need to:

- calculate the hourly rate of ordinary pay relating to the pay period in which the snapshot day falls
- calculate the difference between the mean hourly rate of ordinary pay of male and female employees, and the difference between the median hourly rate of ordinary pay of male and female employees
- calculate the difference between the mean (and median) bonus pay paid to male and female employees
- calculate the proportions of male and female employees who were paid bonus pay
- Calculate the proportions of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands by number of employees rather than rate of pay.

<u>What employers need to publish</u>

- The information outlined above will need to be published within one year of the date for the 2017 snapshot (publishing deadline of 30 March 2018 for data as at

31 March 2017)

- The information must be published on a website that is accessible to employees and the public free of charge. The information should remain on the website for a period of at least three years beginning with the date of publication.
- In addition employers have the option to provide narrative that will help people to understand why a gender pay gap is present and what the organisation intends to do to close it.
- Employers will also need to register with the Government online reporting service and submit their GPG results (as at 31 March 2017) by 30 March 2018.

Data used

The data and calculations for GPG reporting are complex and potentially resource intensive therefore Electronic Staff Record (ESR) have developed a tool that will help NHS organisations nationally to calculate their GPG data.

It should be noted that, whilst a standard report has been produced by ESR and the GPG is automatically calculated, the pay elements used in the calculations can be determined locally by individual Trusts therefore it is possible that disparities can occur due to interpretation by different organisations.

Our Results

Derbyshire Healthcare NHS FT Gender Pay Gap (GPG) results as at 31 March 2017:

Trust Workforce Profile by Gender	Female	Male
(As at 31 March 2017)	79%	21%

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	19.4423	16.6437
Female	15.7468	14.5556
Difference	3.6955	2.0881
Pay Gap %	19.0073	12.5460

Our data shows that we employ a high proportion of female staff in Agenda for Change bands 2 – 5 with a lower proportion of female staff in band 8a and above including senior medical staff. Whilst our senior medical staff is approximately 50/50 female to male this still presents an under representation compared to the overall female to male ratio in the Trust.

We are also required to present our data in quartiles calculated by determining the hourly rate of pay and then ranking the relevant employees in order from the lowest to the highest. The calculation requires an employer to show the proportions of male and female full-pay in four quartile pay bands, which is done by dividing the workforce into four equal parts; lower, middle, upper middle and upper quartile pay bands as outlined below.

Quartile	Female	Male	Female %	Male %
1	480.00	90.00	84.21	15.79
2	475.00	110.00	81.20	18.80
3	463.00	120.00	79.42	20.58
4	409.00	174.00	70.15	29.85

GPG Bonus

For this calculation we have followed the national guidance and included Clinical Excellence Awards paid to Medical staff and Long Service Awards available to all staff.

Gender	Avg. Pay	Median Pay
Male	7,602.72	2,562.01
Female	1,137.52	300.00
Difference	6,465.20	2,262.01
Pay Gap %	85.04	88.29

Gender	Employees Paid Bonus	Total Relevant Employees	%
Male	38	521	7.29
Female	82	1,970	4.16

Benchmarking

As the reporting deadline is not until 30th March 2018 the benchmarking information currently available is limited as many organisations are waiting to publish their results. This could be due to various reasons including - timescale for completing the complex payroll calculations, wanting to see the results of other organisations in their sector or concern about a reputational risk of publishing a significant pay gap.

The below tables show some benchmarking results so far -

NHS Organisations	Gender Pay Gap (female hourly rates lower by):	
	Average	Median
Derbyshire Healthcare NHS Foundation Trust	19%	13%
Derbyshire Community Health Services NHS Foundation Trust	13%	9%
Lincolnshire Partnership NHS Foundation Trust	19%	15%
Department of Health	14%	13%

NON NHS Organisations(as published by	Gender Pay Gap (female

CIPD People Management)	hourly rates lower by):
Average across the first 570 organisations to report	11%
Cambridgeshire Police	-12.9% (positive)
Unilever	-8.8% (positive)
Department for Work and Pensions	5.3%
Rolls Royce	6.3%
Department for Transport	16.9%
TSB	31%
PwC	33.1%
EasyJet	51.7%
Phase Eight Fashion	64.8%

Next Steps

The Trust is committed to ensuring a representative workforce and addressing the imbalance in our workforce. We recognise that the Gender Pay Gap involves using a national measure across the sector, which is a useful statistical tool to help inform us of gaps and variations between the genders. However, we will be going beyond this to support our decisions and demonstrate our intention to equalise the balance by developing our own robust methods in helping us to identify where the actual gaps are and reasons within the context of our specific organisational composition and practice.

There are a number of pieces of further analysis that need to be carried out to understand the issues fully and so that we can address these.

We intend to :

- Explain and communicate with our staff colleagues – it is essential that we provide a clear explanation of gender pay gap reporting and what it means (before the results are published nationally). This is likely to generate questions which will need addressing.
- Publish our results nationally – by 30 March 2018 including explaining the steps we intend to take to close the gaps.
- Publish results on our intranet – by 30 March 2018 as above.
- Undertake further detailed analysis through a task group – there will be an ongoing need for further analysis by the Workforce Team, Workforce & OD colleagues and the Equality, Diversity & Inclusion Team We will analyse the gender pay gap across various areas e.g. staff group, bands, service, protected characteristics and recruitment processes etc. Identify any areas of over or under representation which ultimately impacts the results in the same manner that is used in relation to the Workforce Race Equality Standard (WRES).
- Continue to promote opportunities for flexible working, shared parental leave, career progression, promotion and leadership development opportunities.

Strategic Considerations	
1) We will deliver **quality** in everything we do providing safe, effective and service user centred care	
2) We will develop strong, effective, credible and sustainable **partnerships** with key stakeholders to deliver care in the right place at the right time	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

- Registered Government Equality Office.
- Meets PSED reporting in line with Equality 2010 and 30 March deadline.

Consultation

- GPG paper initially presented at Trust Equality Forum
- Communication plan internal and external to explain to our colleagues – it is essential that we provide a clear explanation of gender pay gap reporting and what it means (before the results are published nationally). This is likely to generate questions which will need addressing

Governance or Legal Issues

Since the Equality Act 2010 (Specific Duties) Regulations 2011 (SDR) came into force on 10 September 2011, there has been a duty for public bodies with 150 or more employees to publish information on the diversity of their workforce. Although the SDR did not require mandatory GPG reporting, the Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) provided guidance that made it clear that employers should consider including GPG information in the data they already publish. It was evident that not all employers did this, so the government made GPG reporting mandatory by amending the SDR so that all public sector employers with more than 250 employees have to measure and publish their gender pay gaps.

Showing “due regard” in using the GPG in helping to improve workplace experiences and representation at all level. Equality Act 2010 - the legal duty to comply with the Public Sector Equality Duty (PSED). Under the Equality Act, public sector bodies have a duty to publish evidence on how they have: eliminated discrimination against protected groups, advanced equal opportunities for protected groups, and fostered good relations between those in protected groups and those outside of them. There is also a duty to set equality objectives every 4 years. The data and analyses for the GPG indicators will assist organisations when implementing EDS2, in particular, with the outcomes under EDS2 Goals 3 and 4, as shown below

- EDS2 Goal 3: Empowered, engaged and well supported staff and Workforce

Race Equality Standard *(Is the Trust a good and fair employer for all REGARDS groups)*

- EDS2 Goal 4: Inclusive leadership *(leaders, showing strong and sustained commitment to promoting equality within and beyond organisation. Engaging and responding to the needs of the diverse REGARDS groups).*
- EDS2 Outcome 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.

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 – Gender pay gap analysis shows that there is an imbalance in equal pay between male and female.

Recommendations

The Board of Directors is requested to:

1. Note the statistical analysis and gaps between the genders.

2. Approve the data analysis and the narrative; including the steps we are going to take to equalise the imbalance in pay.

3. Note the requirement to publish on Trust website and Government Equalities Office by 30th March, 2018.

4. Note the communication plan to explain to staff colleagues so there is a clear explanation of the variations and steps we are taking to equalise gaps.

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

Report prepared by: **Liam Carrier**
Workforce Information Manager and
Harinder Dhaliwal, Head of Equality, Diversity & Inclusion.

Appendix 1: Gender Pay Gap Report 2018 (extracted 31/3/2017)

NHS
Derbyshire Healthcare
NHS Foundation Trust

Gender Pay Gap Report

March 2018 (data extract as at 31 March 2017)

Background

Since the Equality Act 2010 (Specific Duties) Regulations 2011 (SDR) came into force on 10 September 2011, there has been a duty for public bodies with 150 or more employees to publish information on the diversity of their workforce. Although the SDR did not require mandatory GPG reporting, the Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) provided guidance that made it clear that employers should consider including GPG information in the data they already publish. It was evident that not all employers did this, so the government made GPG reporting mandatory by amending the SDR so that all public sector employers with more than 250 employees have to measure and publish their gender pay gaps.

The new requirements

Employers with 250 employees and over will need to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This will include those under Agenda for Change terms and conditions, medical staff and very senior managers. All calculations should be made relating to the pay period in which the snapshot day falls. For the first year, this will be the pay period including 31 March 2017.

Employers will need to:

- calculate the hourly rate of ordinary pay relating to the pay period in which the snapshot day falls
- calculate the difference between the mean hourly rate of ordinary pay of male and female employees, and the difference between the median hourly rate of ordinary pay of male and female employees
- calculate the difference between the mean (and median) bonus pay paid to male and female employees
- calculate the proportions of male and female employees who were paid bonus pay
- Calculate the proportions of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands by number of employees rather than rate of pay.

Ordinary pay includes:

- basic pay
- paid leave, including annual, sick, maternity, paternity, adoption or parental leave (except where an employee is paid less than usual or nothing because of being on leave)
- area and other allowances

- shift premium pay, defined as the difference between basic pay and any higher rate paid for work during different times of the day or night
- Pay for piecework.

It does not include:

- remuneration referable to overtime.
- remuneration referable to redundancy or termination of employment
- remuneration in lieu of leave
- remuneration provided otherwise than in money.

The relevant pay period means the pay period within which the snapshot date falls, which for monthly-paid staff would be the month in which the date is included.

Bonus pay relates to performance, productivity, incentive, commission or profit-sharing, but excludes:

- remuneration referable to overtime
- remuneration referable to redundancy
- remuneration referable to termination of employment.

Doctors' clinical distinction/excellence awards will be regarded as bonus pay, as well as any other payments above the level of ordinary for performance or expertise such as performance related pay for very senior managers, long service awards and others. The relevant period means the period of 12 months ending with the snapshot date.

Calculating the quartiles

Determine the hourly rate of pay and then rank the relevant employees in rank order from the lowest to the highest.

Divide those employees into four sections, each comprising an equal number of employees to determine the lower, lower middle, upper middle and upper quartile pay bands.

Show the proportion of male and female employees in each band as a percentage of the total employees in each band.

What employers need to publish

The information outlined above will need to be published within one year of the date for the 2017 snapshot (publishing deadline of 30 March 2018 for data as at 31 March 2017)

The information must be published on a website that is accessible to employees and the public free of charge. The information should remain on the website for a period of at least three years beginning with the date of publication.

In addition employers have the option to provide narrative that will help people to understand why a gender pay gap is present and what the organisation intends to do to close it.

Employers will also need to register with the Government online reporting service and submit their GPG results (as at 31 March 2017) by 30 March 2018.

Colleagues from the Electronic Staff Record (ESR) have developed a tool that will help organisations nationally to calculate their GPG data, results of which are tabled below.

Derbyshire Healthcare NHS FT Gender Pay Gap (GPG) results as at 31 March 2017:

Trust Workforce Profile by Gender	Female	Male
(As at 31 March 2017)	79%	21%

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	19.4423	16.6437
Female	15.7468	14.5556
Difference	3.6955	2.0881
Pay Gap %	19.0073	12.5460

Our data shows that we employ a high proportion of female staff in Agenda for Change bands 2 – 5 with a lower proportion of female staff in band 8a and above including senior medical staff. Whilst our senior medical staff is approximately 50/50 female to male this still presents an under representation compared to the overall female to male ratio in the trust.

Quartile	Female	Male	Female %	Male %
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2	475.00	110.00	81.20	18.80
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We are also required to present our data in quartiles calculated by determining the hourly rate of pay and then ranking the relevant employees in order from the lowest to the highest. The calculation requires an employer to show the proportions of male and female full-pay in four quartile pay bands, which is done by dividing the workforce into four equal parts; lower, lower middle, upper middle and upper quartile pay bands as outlined below.

GPG Bonus

For this calculation we have followed the national guidance and included Clinical Excellence Awards paid to Medical staff and Long Service Awards available to all staff.

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Pay Gap %	85.04	88.29

Gender	Employees Paid Bonus	Total Relevant Employees	%
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Benchmarking data available so far:

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	Average	**Median**
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TSB	31%
PwC	33.1%
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Next Steps

The Trust is committed to ensuring a representative workforce and addressing the imbalance in our workforce. We recognise that the Gender Pay Gap involves using a national measure across the sector, which is a useful statistical tool to help inform us of gaps and variations between the genders. However, we will be going beyond this to support our decisions and demonstrate our intention to equalise the balance by developing our own robust methods in helping us to identify where the actual gaps are and reasons within the context of our specific organisational composition and practice.

There are a number of pieces of further analysis that need to be carried out to understand the issues fully and so that we can address these. We intend to:

- Explain and communicate with our staff colleagues – it is essential that we provide a clear explanation of gender pay gap reporting and what it means (before the results are published nationally). This is likely to generate questions which will need addressing.
- Publish our results nationally – by 30 March 2018 including explaining the steps we intend to take to close the gaps.
- Publish results on our intranet – by 30 March 2018 as above.
- Undertake further detailed analysis through a task group – there will be an ongoing need for further analysis by the Workforce Information Team, Workforce & OD Managers and the Equality, Diversity & Inclusion Team. We will analyse the gender pay gap across various areas e.g. staff group, bands, service, protected characteristics and recruitment processes etc. Identify any areas of over or under representation which ultimately impacts the results in the same manner that is used in relation to the Workforce Race Equality Standard (WRES).
- Continue to promote opportunities for flexible working, shared parental leave, career progression, promotion and leadership development opportunities.

Liam Carrier – Workforce Systems & Information Manager
Harinder Dhaliwal, Head of Equality, Diversity & Inclusion

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board 28 March 2018

GIAP Actions Embeddedness Update 28 March 2018

Purpose of Report

To update on the embeddedness of actions undertaken as part of the Trust's Governance Improvement Action Plan (GIAP).

Executive Summary

All actions within the Governance Improvement Action Plan were completed and signed off by the Trust Board in May 2017. A key focus of the GIAP was to ensure ongoing implementation of the actions and embeddedness in business as usual for the Trust. A six month update presented to the 1 November 2017 Trust Board provided evidence and updates on work relating to actions that fall under the remit of the Board and its Committees. Assurance was received from relevant oversight Committees which had scrutinised and challenged the embeddedness of actions in ongoing business as usual of the Trust.

Narrative was outlined against each action on the GIAP and a RAG rating system was assigned as follows to reflect the following:

GREEN: Recommendation fully implemented and Executive Director/Committee confidence that these are now part of business as usual (either forming part of policy or annual cycle of business for example).

AMBER: The recommendation has been implemented either in part, or for a limited time only such that further period of evidence gathering is required to demonstrate impact or that the action is fully embedded.

RED: Work has not been completed or embedded to deadline and revised plan of action is required.

GIAP Governance: The GIAP itself had a total of 53 recommendations which were assigned across Board Committees as follows:

Core	Committee	Lead Director
Core 1 - HR and associated Functions (5)	People and Culture	Director of People and Organisational Effectiveness
Core 2 - People and Culture (6)	People and Culture	Director of People and Organisational Effectiveness
Core 3 - Clinical Governance (3)	Quality	Director of Nursing

Core 4 - Corporate Governance (13)	Audit & Risk	Director of Corporate Affairs
Core 5 - Council of Governors (3)	Council of Governors	Director of Corporate Affairs
Core 6 - Roles and Responsibilities of Board Members (5)	Remuneration and Appointments	Director of Corporate Affairs
Core 7 - HR and OD (8)	People and Culture	Director of People and Organisational Effectiveness
Core 8 - Raising concerns at work (1)	People and Culture	Director of People and Organisational Effectiveness
Core 9 - Fit and Proper (1)	Remuneration and Appointments	Director of Corporate Affairs
Core 10 – CQC (2)	People and Culture	Chief Operating Officer
Core 11 - NHS improvement undertakings (6)	Board of Directors	Chief Operating Officer

44 of the recommendations were designated as Green and agreed at the 1 November Board meeting. This reports updates on further review of the Amber rated actions which has since taken place at the Executive Leadership Team and relevant Board Committees.

In summary all actions relating to the remit of the **Audit & Risk Committee** (13 recommendations), **Council of Governors** (3), **Remuneration and Appointments Committee** (6) and **Board of Directors** (6) were identified to be Green. Outstanding evidence was identified to be required for the following actions:

People and Culture Committee:
There were seven Amber actions (out of a total 21). These were reviewed by the Committee in January 2018 to scrutinise the additional evidence of sustained action and embeddedness and identify whether additional assurance was required before a Green rating could be applied. Those relates to similar topics are considered together as outlined below:

HR3: ***Define a new structure for HR and its related functions with a priority on operational efficiency and strategic impact taking into account the refreshed People Strategy and revised model for HR and related functions, AND***

HR4: ***Undertake an exercise to update the model for HR. Utilising the model as a guide, expertise and best practice across the LHE, and beyond. As a priority the Trust should focus on establishing clear foundations, utilising key building blocks to create sustainability in the long term*****:**

These recommendations relate to *updating the model* for HR and *defining a new structure*. These exercises have both been undertaken and thus both recommendations have been designated as Green. Delivery of the new model through the HR shared service is a priority for the Trust and progress is reported regularly to the Board.

PC3: ***Supplement the current mechanisms to engage with staff through the inclusion of more informal activities across both clinical and corporate areas AND***

WOD8: ***The Trust should continue to make improvements in staff engagement and communication***

Both these recommendations focus on developing engagement opportunities across the Trust and having clear engagement plans. As part of the Trust's strategy refresh we have identified 'People First' as a priority and invested in and rolled out a range of formal and informal engagement routes over the past year. People and Culture Committee will continue to seek assurance on engagement activity as part of its work plan and engagement activity is now embedded across the organisation and thus it is proposed the recommendation is rated Green. We will continue to ensure we respond to and analyse staff feedback as a key part of our day to day work.

WOD2: ***The Trust should ensure that recruitment processes for all staff are transparent, open & adhere to relevant trust policies***

Significant work relating to ensuring recruitment process are followed has been undertaken and on scrutiny, these have been shown to be open and transparent. Further audit activity planned through internal audit will help to provide assurance on ongoing adherence to policies. It is proposed that this recommendation is designated Green.

WOD7: ***The Trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded***

The Executive Leadership Team monitor outstanding cases and ensure that appropriate external legal advice is obtained where required. The backlog of cases as outlined in the recommendation have been concluded, such that this recommendation can be considered Green. The Trust will continue to monitor complex HR cases as part of business as usual. Internal audit will be used to review adherence to policies as part of the 2018/19 programme.

CQC2 – ***The Trust should continue to proactively recruit staff to fill operational vacancies***

There has been significant focus on this area over the last two years. This work continues on an ongoing basis and is thus rated Green. It remains a priority and key risk for the Trust and details of wide ranging work to recruit are outlined in the appended report.

Quality:

Two recommendations out of a total of three were designated Amber in 1 November 2017:

ClinG1: ***Refresh the role of Quality Leadership Teams (now Clinical and Operational Assurance Team meetings) to increase their effectiveness as core quality governance forums***

ClinG3: ***Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated***

objectives, and ensuring a clear focus on seeking assurance

These actions relate to ongoing work on embeddedness of the accountability framework (ClinG1) and to overall developing maturity of the Committee (ClinG3). A target date of January 2018 was set to achieve a Green rating and following discussion at the February 2018 Quality Committee evidence and assurance was presented such that the Committee agreed that the required actions had been sustained effectively and ongoing review and development of the accountability framework and the Quality Committee itself were embedded in business as usual of the Trust. Both recommendations were agreed to be rated 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	
3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	X
4) We will **transform** services to achieve long-term financial sustainability.	

Assurances
Actions were signed off by the Committees/the Board during early 2017 with detail outlined how ongoing embeddedness would be evidenced. Further assurance has been presented to Board Committees in September/October 2017 and January-March 2018.

Consultation
Board Committees reviewed prior to collation of all embeddedness information for submission to 1 November Trust Board. Executive Leadership Team reviewed outstanding Amber rated actions in January and there has been further assurance presented to Board Committees in January-March.

Governance or Legal Issues
The second external review by Deloitte was a key part of providing assurance to NHSI and the CQC that we had made identified governance improvements to fulfil our foundation trust licence conditions. The review was used by NHSI to consider our licence breach and a certificate of compliance was subsequently issued on 24 May 2017.

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:

1. Receive assurance from the evidence as outlined and assurance received from Board Committees on the embeddedness of the actions taken to address the GIAP recommendations identified.

2. Agree that this assurance report completes the review of sustained implementation of actions to address all GIAP recommendations.

3. Note that work to ensure ongoing embeddedness is now incorporated into business as usual with the Trust's work and that this will be scrutinised through the work of Board Committees and ongoing work programmes to ensure continued compliance with NHS Improvement's well-led framework.

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

People and Culture Committee

Core Area	Issue Raised / Action	Key Tasks	Director	On-going Monitoring Arrangements	Update on Embededness - March 2018	RAG Rating
CORE 1 - REUNIFICATION OF THE HR AND ASSOCIATED FUNCTIONS						
HR3	Undertake an exercise to update the model for HR. Utilising the model as a guide, expertise and best practice across the LHE, and beyond. As a priority the Trust should focus on establishing clear foundations, utilising key building blocks to create sustainability in the long term	1) In consultation with the team develop and deliver the new model for HR	P&OE	As part of the new shared function each team has a detailed service specification and a set of KPI's that will be reviewed and monitored as part of the ongoing back office governance arrangements A business case been developed and is open to consultation and approval for implementation October/November.	Business case overseen and agreed. This is now being taken forward as business as usual with oversight by ELT, P&CC and Trust Board.	**Green**
HR4	Define a new structure for HR and its related functions with a priority on operational efficiency and strategic impact taking into account the refreshed People Strategy and revised model for HR and related functions	1) Develop and implement a new structure for HR and its related functions with a priority on operational efficiency and strategic impact	P&OE	The Trust People Performance report is presented to P&CC each month (part of annual Committee workplan) The recruitment progress report is presented to P&CC each month (part of annual Committee workplan) People Plan progress reports and deep dives are provided to P&CC each month and quarterly progress reports are submitted (part of annual Committee workplan). The service specifications for each team in the new HR structure and KPIs was agreed at ELT on 03.04.17, to be monitored through the back office governance	Implementation of the new HR shared service is progressing This is in the final stages of implementation and will be taken forward as business as usual, with oversight by ELT, P&CC and Trust Board. Service will underpin and further enhance the delivery of the people plan and the Trust priorities.	**Green**

Core Area	Issue Raised / Action	Key Tasks	Director	On-going Monitoring Arrangements	Update on Embededness - March 2018	RAG Rating
CORE 2 - PEOPLE AND CULTURE						
PC3	Supplement the current mechanisms to engage with staff through the inclusion of more informal activities across both clinical and corporate areas. Develop clearer reporting of information and trends from these activities in order to triangulate with other information, for example, through the CEO report and Quality Position Statement	1) Develop a comprehensive internal Comms plan, which clearly articulates engagement approaches both formal and informal 2) Develop a clear system to record feedback received from staff	CA/POE	Engagement Group monthly meeting People and Culture Committee: Bi-monthly reporting	The Engagement Group and P&CC track the progress in staff engagement. There are formal and informal ranges of communication now fully operating across the Trust. The Trust is implementing a staff forum to further enhance the employer voice and engagement and to help focus on the key things that matter to staff. Staff forum has now been implemented and a Team brief commenced in February 2018. Pulse checks and staff survey indicate Trust is heading in the right direction. Ongoing oversight in remit of P&CC.	**Green**
CORE 7 - HR AND OD						
WOD2	The Trust should ensure that recruitment processes for all staff are transparent, open & adhere to relevant trust policies	1) Review and ensure that Trust recruitment and acting up policies are fit for purpose 2) Agree a plan and deliver recruitment training to all appointing officers 3) Deliver a peer audit of recruitment policies compliance to demonstrate improvement	P&OE	The audit will be repeated to assess compliance, and will be included in the 2018/19 internal audit plan	The acting up policy is now embedded across the Trust and arrangements have been reviewed and refreshed in the policy. A review will be completed as part of the future audit process. TRAC system has reinforced good practice. Recruitment that has been challenged has been fully investigated. Review of compliance will be part of audit programme in 2018/19.	**Green**

Core Area	Issue Raised / Action	Key Tasks	Director	On-going Monitoring Arrangements	Update on Embededness - March 2018	RAG Rating
WOD7	The Trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded	1) Implement a proactive system which monitors adherence to the grievance, disciplinary, whistle-blowing policies, including a robust case tracking system 2) Internal audit compliance against named policies and the defined timescales against cases identified on the tracker	P&OE	In order to monitor and ensure adherence to the ER Policies and Procedures the ER Case Tracker is the subject of a two weekly review meeting between Principal Workforce & OD Managers and the Director of People & Organisational Effectiveness. This meeting identifies any pinch points and discusses ways of taking complex cases forward. There is also regular review meeting between Principal Workforce & OD Managers and staff side colleagues. The meeting with Staff Side is paramount in ensuring policies are followed as Staff Side are often privy to information around this, therefore this acts as a monitoring process from both sides. A Principal Workforce & OD Manager attends ELT on a monthly basis to provide an overview of current and new cases and resolved cases. At the meeting any complex, overrunning cases and non-compliance are escalated upwards to the relevant Director. HR&OD will continue to work with Staff Side to review all employee related policies, and information will inform the review of grievance, dignity at work and disciplinary policies. In January 2017 work commenced with IT on a project to improve the mechanism for reporting Employee Relations cases. This system will be an enhancement on the current ER Tracker and will track the process of each stage in all ER cases. There will be access not only for Workforce & OD staff but also restricted access to track each stage of their relevant investigations. They will also be able to populate their investigations also. Therefore at any one time information on what stage the case is at, any complexities and whether process is being followed will be known. A Workforce & OD Working Group is set up to	The complex HR cases are overseen by the Director of People & OE and reviewed regularly with the Executive Leadership Team. Independent support has been brought into identify ways to unblock and move things forward where appropriate. A Spotlight on Leaders event was held in September focussing on Employee Relations including case review and lessons learned. The backlog of cases referred to in the original GIAP action are all now concluded. This will form part of internal audit review on adherence to HR recruitment policies. Regular reviews and deep dives have taken place. Complex cases are reviewed by Director of People and Organisational Effectiveness with support of Executive Leadership Team and nominated legal practice.	**Green**

Core Area	Issue Raised / Action	Key Tasks	Director	On-going Monitoring Arrangements	Update on Embededness - March 2018	RAG Rating
		3) Ensure the backlog of cases made known to the CQC at the time of the inspection are concluded		ensure the system covers everything that is necessary and it is anticipated that this will be complete by end of April 2017. At the end of each month a progress report will be produced and where timescales in accordance with the policy haven't been met; the manager be reminded than an exception report will need to be included. Another internal audit will be undertaken to review the benefits and adherence to policies will be undertaken		
WOD8	The Trust should continue to make improvements in staff engagement and communication	1) Develop a clear staff engagement plan that takes account of listen, learn and lead, wider open staff forums and enhances existing good practice 2) Publish and implement agreed engagement plan 3) Monitor delivery of the plan at P&C Committee using feedback mechanisms such as pulse checks and staff survey	P&OE	People and Culture Committee bi-monthly reporting on progress with Engagement Plan. Engagement group monthly meetings. We will continuously improve staff engagement energy and well-being increasing the positive pulse check year on year. A new quarterly pulse check starts at the end of February 2017 and the findings will be reported quarterly from April 2017 to People and Culture Committee meeting. NHS Staff survey action plans are being developed through teams. Once in place they will also be monitored through the Trust Management Team meeting	The Engagement Group and PCC track the progress in staff engagement. There are formal and informal ranges of communication now fully operating across the Trust. The Trust is implementing a staff forum to further enhance employer voice and engagement and to help focus on the key things that matter to staff (see (PC3) Staff engagement forum is up and running. Board approved staff engagement paper is now implemented. Mechanisms put in place with increased engagement with staff including team brief. Assurance can be found by reviewing quarterly pulse check findings (3 times a year) and annual staff survey results. Staff engagement is a priority in March 2018 Strategy refresh.	**Green**
CORE 10 - CQC						

Core Area	Issue Raised / Action	Key Tasks	Director	On-going Monitoring Arrangements	Update on Embededness - March 2018	RAG Rating
CQC2	The Trust should continue to proactively recruit staff to fill operational vacancies	1) Develop and agree a proactive operational recruitment plan, including in reach to the local University and wider health community	P&OE	• Monthly Board reporting in the performance report • Monthly updates to P&CC • Trajectory monitoring of vacancy fill and retention rates	Recruitment process has been reviewed and is more streamlined. Appointment to posts arising from India/local recruitment is progressing. Included in Integrated Performance Report, which is presented monthly to the Trust Board. Updates to P&CC at each meeting. Effective implementation of TRAC (on-line recruitment software) This remains a key focus for Trust Board. This is an extreme risk on Board Assurance Framework. .	**Green**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board Development Session – 28 March 2018

Board Effectiveness Survey Feedback November 2017

Purpose of Report

This report provides the Board with the results of the Board Effectiveness Survey conducted in November 2017.

Executive Summary

Board Effectiveness Survey

As part of the Deloitte review of Trust governance arrangements in January 2016, a Board Effectiveness Survey was undertaken and the results of that survey were used to inform some of the Deloitte recommendations. After Board discussion it was agreed that the Board would continue to use the survey in order to assess improvements and also gauge how effective the Board believes it is and to triangulate other information on Board effectiveness. Results of the second survey, undertaken in September 2016 were presented to the Board in October 2016. A third survey was undertaken in March 2017 and subsequently presented to the Trust Board.

A fourth survey was undertaken in November 2017. This survey was developed to include opportunity for free comments from respondents. The survey was completed by 12 of the 14 current Board members (83%). Responders were not able to skip any questions. Comments have been incorporated into the summary presented for each question.

The survey with full analysis of results over the two year period was discussed at the Board Development Session on 20 December 2017. It was agreed that results reflected positively on the effectiveness of the Board from the perspective of Board members. The results are summarised below:

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

There was unanimous agreement with this statement with 100% of respondents stating they either strongly agree or agree. This is an increase from 93% in the last survey.

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

There has been a continued increase in positive response with successive surveys. When first surveyed in January 2016 the majority of Board members, 83%, neither agreed nor disagreed and the remaining 17% disagreed. Now, there is 100% agreement (either strongly or agree) that this is under consideration and either in place or taking place.

Q3 We operate as a Unitary Board

100% of respondents felt that the Trust Board operated as a Unitary Board - where all directors are collectively and corporately accountable for organisational performance. This is an increase in 10% from the last survey.

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

There was 100% positive response to Q4 and an increase to a 93% positive response to Q5. However, two respondents considered that senior managers could be further supported to ensure effective role modelling.

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

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

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

Increasing levels of confirmation of this are seen in the survey, with an overall positive response of 91%. The comments reflect the increased levels of engagement the Board has undertaken in this area. This question was slightly amended and the word 'any' removed before 'concerns' to reflect that some concerns, ie of a regulatory nature, may have to go to an external party.

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

There was a slight dip in the positive response, down to 92% from 100% for the Board. When compared with the results of the Council of Governors' (CoG) most recent survey, reported to CoG in January 2018, it is notable that 84.7% of governors 'agree' or 'strongly agree' that there is sufficient opportunity for engagement with NEDs.

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

There has been a slight downward shift from a 100% positive response in March to 92% in November. On responder was in the 'neither agree nor disagree' category here. Comments on this issue are positive.

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

There has been a significant positive swing in relation to this question. 91% of the Board agrees with this statement and comments reflect the work undertaken to make improvements in this area. As a reminder, this question links to the GIAP recommendation *Review the operation of all committees seeking to minimise duplication*.

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

100% of respondents agreed or strongly agreed with this statement. However, comments reflect the desire to see a broader range of stakeholders invited to the Board meetings.

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

There was a mixed response to this question. While there is a positive response of 75%, there are still 25% who neither agree nor disagree. Comments acknowledge the work that has been undertaken but also suggest there is still work to do and that further time and cycles need to pass to ensure embeddedness.

Summary

It was highlighted that work undertaken on Board Effectiveness, including individual and whole Board training and development and implementation of good governance practice, had contributed to the positive responses. At the Board Development Session it was agreed to continue to carry out the review six monthly to benchmark responses. Work will be sustained to ensure the good practice reflected in responses is maintained and the Board's Development Programme for 2018/19 would be developed to support this.

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

Assurances

This paper should be considered in relation to key risks contained in the Board Assurance Framework and core elements of the GIAP.

Consultation

The Board Effectiveness Survey results reflect the input from 12 out of 14 Board members requested to complete the survey.

Governance or Legal Issues

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

Equality Impact Risk Analysis The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics – Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation (REGARDS).	
There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential gaps/inequalities are outlined below, with the appropriate action to mitigate or minimise those risks.	
Actions to Mitigate/Minimise Identified Risks - Not applicable.	

Recommendations

The Board is requested to:

1. Note the outcome of the Board Effectiveness Survey November 2017.
2. Agree that effective Board practices would be sustained and supported through the Board Development programme 2018/19.
3. Agree that the survey should be completed again in April 2018.

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 28 March 2018

Board Assurance Framework (BAF)
Fifth and final issue 2017/18
Initial draft of headline risks for 2018/19

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the fifth and final issue of the BAF for 2017/18 and the initial draft headline risks for the BAF for 2018/19.

Executive Summary

2017/18 BAF

- There remain eleven risks identified on the BAF for 2017/18. The risk rating for one risk *4b Failure to deliver internal transformational change at pace* has been reduced due to strong ongoing progress with the mental health workstream. The reduction of risk *4a Failure to deliver financial plans* was described in the previous (fourth) issue of the BAF to the Board

- Two risks remain identified as extreme, five as high, three as moderate and one as low risk

- Risk ratings at each quarter are shown, together with risks which have been removed from the BAF in year.

- The Deep Dive programme for review of risks by board committees has remained on track throughout the year and completed to agreed timescales.

- The BAF risks for the responsible committee continue to be 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.

- The Board Assurance Framework and Risk Management audit completed by KPMG in Feb 2018, concluded an assurance rating of *significant assurance with minor improvement opportunities*, and identified 1 medium and 1 low risk action

2018/19 BAF

- A Board Development session, facilitated by auditors KPMG, tool place on 14 February 2018. The session considered:

- Findings and draft recommendations from the 2018 BAF and Risk Register internal audit
- BAF benchmarking data with other Trusts
- Considerations for BAF risks for 2018/19

- Following the Board Development, Executive Directors proposed the headlines risks for the 2018/19 BAF

- These were considered and amended following review by ELT on 12 March, and Audit and Risk Committee on 20 March. A fully developed first issue of the BAF is planned for consideration by Audit and Risk Committee members at the Board Development session on 18 April, and by the Board of Directors on 1 May.

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 February/March 2018
Executive Leadership Team - 12 March 2018
Audit and Risk Committee - 20 March 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:

1. Approve this fifth and final 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

2. Approve the initial headline risks for the 2018/19 BAF and the proposal for the BAF to be fully worked up and agreed by Audit and Risk Committee members on 18 April and the Board of Directors on 1 May 2018.

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

Report prepared by: **Samantha Harrison**
Director of Corporate Affairs and Trust Secretary and
Rachel Kempster, Risk and Assurance Manager

Board Assurance Framework
Fifth and final issue 2017/18
Initial draft of headline risks for 2018/19

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

This is the fifth and final formal presentation of the Board Assurance Framework to the Audit & Risk Committee for 2017/18. Changes to the BAF since Issue 4 to the Board, are highlighted in blue text in the detailed word document attached

1) Overview and movement of risks 2017/18

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	Risk rating Q4	Movement Q4
1a	Failure to achieve clinical quality safety standards required by our regulators	Director of Nursing and Patient Experience	HIGH (4x4)	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	Director of Nursing and Patient Experience	HIGH (4x4)	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)	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)	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)	EXTREME (4x5)	⟷

BAF ID	Risk title	Director Lead	Risk rating Q1	Risk rating Q2	Risk rating Q3	Risk rating Q4	Movement Q4
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)	EXTREME (4x5)	⟷
3b	There is a risk to staff engagement and wellbeing by the Trust not having supportive and engaging leaders	Director of People and Organisational Effectiveness	HIGH (4x4)	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	Director of People and Organisational Effectiveness	MOD (4x2)	MOD (4x2)	MOD (4x2)	MOD (4x2)	⟷
3e	Board turnover	Director of Corporate Affairs and Trust Secretary	NEW	MOD (3x4)	LOW (2x2)	LOW (2x2)	⟷
4a	Failure to deliver financial plans	Director of Finance	EXTREME (4x5)	EXTREME (4x5)	EXTREME (4x5)	MOD (4x2)	↓
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	EXTREME (4x5)	EXTREME (4x5)	EXTREME (4x5)	HIGH (3x5)	↓

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 2017/18

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

The plan and completion of all Deep Dives for 2017/18 is shown below, in line with the 2017/18 year end position

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
4a	Financial plan	Claire Wright	Audit and Risk Committee: Dec 2017. Completed
4b	Internal transformation	Lynn Wilmott-Shepherd	Audit and Risk Committee Mar 2018. Completed

*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

3) Initial draft of headline risks for 2018/19

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)
Strategic Objective 1. Quality Improvement			
18_19 1a	There is a risk that the Trust will fail to provide standards for safety and quality required by our Board, and as set out in the Health and Social Care Act 2009 and measured through the CQC's regulatory process	Executive Director of Nursing and Patient Experience	HIGH (4x4)
18_19 1b	There is a risk that the Trust will fail to provide full compliance with the Mental Health Act (1983) and Mental Capacity Act (2005)	Medical Director	HIGH (4x4)
18_19 1c	There is a risk that the Trust will fail to develop systems and processes to deliver safe and effective physical health care for patients	Medical Director	HIGH (4x4)
18_18 1d	There is a risk that the Trust will fail to redesign the Care Programme Approach processes, which may impact upon the quality of care provided to service users and their carers	Executive Director of Nursing and Patient Experience	HIGH (4x4)
Strategic Objective 2. Engagement			
18_19 2a	There is a risk that if the Trust doesn't engage our workforce and create an environment where they experience the aims and values of the Trust, there will be a negative impact on the morale and health & wellbeing of staff which may affect the safety and quality of patient care	Director of People and Organisational Effectiveness	HIGH (4x4)
Strategic Objective 3. Financial Sustainability			
18_19 3a	There is a risk that the Trust fails to deliver its financial plans	Executive Director of Finance	EXTREME (4x5)
18_19 3b	There is a risk that the Trust fails to influence Joined Up Care Derbyshire (the 'system') to effectively engage in enhancing service models for children, and people with mental health problems, learning disabilities, or issues with substance misuse	Director of Strategic Development	HIGH (4x4)
Strategic Objective 4.Operational Delivery			
18_19 4a	There is a risk that the Trust will not be able to recruit and retain enough staff in specific teams to deliver high quality care	Director of People and Organisational Effectiveness	EXTREME (4x5)
18_19 4b	There is a risk that the Trust will fail to gain the confidence of staff to maintain a modern and effective electronic patient record system	Chief Operating Officer	HIGH (4x4)
18_19 4c	There is a risk that the Trust will be unable to meet the needs of service users by not introducing new workforce models and provide sufficient training to reskill staff.	Director of People and Organisational Effectiveness	HIGH (4x4)
18_19 4d	There is a risk that the Trust will not deliver quality improvement (QI) to improve the flow of patients through our services and increase quality and efficiency	Chief Operating Officer	HIGH (4x4)

Summary of Board Assurance Framework Risks 2017/18 - Issue 5.2

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	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	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	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 and Deputy Chief Executive	MODERATE (2x5)
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	HIGH (3x5)

Board Assurance Framework 2017/18 Issue 5.2

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. New Quality Improvement Strategy (March 2018)

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 and 2017/18 BAF and Risk Register Reviews - 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]	31/03/2018	Successful recruitment campaign, nurse vacancy rate now 5.5% (as of March 18). Improved position, with some hotspots remaining. Alternative solutions being explored	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	Improvement plan with commissioners in place	31/03/2018	PICU provision remains an improved situation with no known	Medium

Derbyshire based PICU beds and a secure and effective forensic pathway, and CAMHS Tier 4 beds	[ACTION OWNER DON]		concerns or incidents re access. CAMHS Tier 3.5, partial commissioning in design and development	
Stable clinical workforce in neighbourhood, children's services, crisis services, psychology and forensic services and eating disorders	Clinical and operational leadership to develop an improvement plan [ACTION OWNER DPOE/DON]	31/03/2018	Improvement work on CPA, EPR, Mental Capacity Act in progress. Head of Nursing and lead professional now in place. Tentative financial support for a community forensic team confirmed. . Business model proposed to Commissioners for revised eating disorder services	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]	31/03/2018	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]	31/03/2018	Improvements in patient/ medicines safety and D&T continue. The action plan is progressing, improvements continue. A medicines optimisation strategy is in final design	Medium
Fully integrated Clinical and Operational Assurance Teams and escalation to Quality Committee	Deputy Director of Nursing and Quality Governance to provide coaching and support to COAT's. Undertake team performance reviews	Completed	Deputy Director of Nursing and Quality Governance providing coaching and support to COATs, successful. Undertaking team performance reviews, will continue through TMT performance management	Achieved
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 March 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]	31/03/2018	Most CQUINS are achieving. Two are not achieving full outcomes in relation to physical healthcare and alcohol and smoking. Additional resources have been reallocated to alcohol and smoking. Report provided to Quality Committee March 2018.	Medium ⇩
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	Learning reviews by DHCFT. Elevating	31/03/2018	External investigators assigned for all homicide investigations.	High

related homicides (2017) and inpatient deaths (Q4 2018)	commissioning risk for forensic pathway with commissioners [ACTION OWNER DON]		Peer review commissioned with Medical Director for Lincolnshire trust and external consultant nurse, commenced. Medical review completed, awaiting completion of final peer review. Local benchmarking undertaken by NHSE. Elevated risk but Trust not outlier in region. Awaiting national homicide benchmarking results. Inpatient suicide investigations underway	
Gap in governance and system processes to meet revised essential CQC standards to meet 110 changes of PIR	Develop automated process to meet requirements of revised CQC PIR	Completed	Current solution in place for PIR. On trajectory to submit PIR as per required deadline	Achieved
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. Ratified and is being disseminated and implemented. Only partial achievement of physical healthcare CQUIN	High
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]	31/03/2018	Report to Safeguarding Committee Oct 2017 included 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 in Oct 2017 to support staff competency re victim support strategies. Multiagency strategy agreed for survivors of non-recent abuse, ratified by all Derby City and Derbyshire Boards	Medium
Gap in knowledge and competence in relation to treatment of autism and support in complex cases	Redevelop CPD and training plan to mitigate risk	31/03/2018 and into 2018/19	Develop CPD and training plan by 31/03/2018, with implementation plan into 2018/19. Implement clinical quality improvements in autism treatment during 2018/19	Red

Related operational high/extreme risks:

Organisational level	ID	Directorate	Risk Subtype	Title
Team Risk Assessment	21189	Psychological Therapies, Perinatal & Performance/Training/Admin	Commissioning Risk	Admission criteria to Eating Disorders Service
Team Risk Assessment	2944	Neighbourhood Services - City	H&S - Workplace Health, Safety and Welfare	H&S - Workplace Health, Safety and Welfare
Team Risk Assessment	21204	Campus - Radbourne Unit	Clinical - Points of Ligature	Ligature risk assessment
Team Risk Assessment	21171	Children's Therapies & Complex Needs	Environmental risk - Other	medicines fridge in a room too hot/cold
Trust wide Risk Assessment (Clinical)	21068	Pharmacy	Clinical - Medication/ Pharmaceutical	Medicines Management - providing effective care for patients

Trust wide Risk Assessment (Clinical)	21106	Children's Therapies & Complex Needs	Commissioning Risk	Sexual Abuse Referrals
Divisional Risk Assessment (Clinical)	21002		Commissioning Risk	Withdrawal of police support for inter-facility transport of patients

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

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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]	31/03/2018	The NICE Steering Group is in place and leading improvement work. Quality Priorities are being reviewed this year to include diffusion which will include implementing best practice and NICE guidelines	Medium ⬇
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]	Completed	Organisation development has commenced with external workshops on shared governance and well led. Developmental sessions undertaken at TMT and Spotlight on Leadership event	Achieved
Embedded personalised care planning, physical health checks and clinical standards	Implement CQC action plan around care planning [ACTION OWNER DON]	30/03/2018	Clinical skills tutors continue to develop practice and compliance/ improvement reports continue to be reviewed. Significant improvements in practice achieved through this model	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]	30/03/2018	Preliminary offer of £1.2 million has been made for investment in community forensic mental health service, this would reduce some pressure and demand issues in the city and county	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	Issues have been escalated to commissioners and to the Derby Safeguarding Children Board. Exploration of skill mix and roles, to be further explored.	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]	30/03/2018	The PAM and REQUOL measures are available. Some roll out is happening, further refinement and improved spread and coverage is required over 2018	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]	31/03/2018	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	Fully implement CQC actions plan, with subsequent plan to raise all services identified as	31/03/2018	Significant improvement reported. Warning notice lifted. Remaining actions monitored monthly and reported to the	High

improvement for effectiveness	requires improvement to a rating of good [ACTION OWNER DON]		Quality Committee. Progress not at anticipated pace due to staffing pressures. Residual actions now off trajectory, escalating through operational lines	⬆
'Transforming Care' (learning disability services) red rated across Derbyshire County against required strategic plan	Participate in learning disability services review re effectiveness of service pathways.	31/03/2018	Workshops with staff underway, along with negotiations with Commissioners. Autism strategy reviewed. Continuing to work to implement strategy and meet statutory duty. 'Transforming Care' rating now reduced to routine monitoring, however our county does not have a autism treatment service hence medium risk to achievement	Medium
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: **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	CQC note improvement with compliance with MCA with gaps remaining to close

programme	

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. Chairing monthly new medical management meeting to monitor and improve performance, including aspects of compliance with MHA and MCA requirements, practice improvement being achieved.	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, reported to MHA Committee at each meeting; however compliance is dependent on local authority rather than Trust resources. Position is defensible by the Trust. Reporting has identified low conversion to DoLs following referral from wards. Working with staff to ensure processes are compliant	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]	31/03/2018	One action from 2016 review remains in relation to advance directives. MHA operational group instigated work to rationalise operational response to the action. MD to establish a timescale to scope this work	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. Sustained improvement is required on S17 leave forms	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 31/03/2018	Re-audit of CTO quality improvement commencing Dec 2017. Re-audit in process. Deputy MD undertaking case review as part of peer review of 2 recent mental health homicides. Completed and shared with peer review team as part of overall homicide review. S41 register to be developed supported by MHA Manager. Forensic consultant to review as to how S41's are managed. Re-audit underway	Low Achieved
Current compliance with MCA training below 50%	Increase compliance with MCA training	31/03/2018	Training package reduced to single module (from 3 separate modules). Combined with face to face training, expectation that compliance trajectory will improve. On track to achieve 75% compliance by end March 2018	Low
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	31/03/2018	Audits undertaken in in-patient areas give a high level of assurance in assessing and recording capacity. Community audit results provide partial assurance, an action plan has been developed to support compliance	Medium
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 HIGH	Likelihood 3	Impact 5	Rating MOD	Likelihood 3	Impact 3	Direction ⟷	Rating MOD	Likelihood 3	Impact 3	Accepted	Tolerated	Not accepted

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)	31/03/2018 31/03/2018	Action plan developed following cyber attach. Agreed by Board and overseen by EPRR Steering Group, reported to Quality Committee. The 4 actions still outstanding are being followed through by the Trust Management Team. Actions being embedded as business as usual Business continuity plans underway in highest risk areas. Final plans to be completed by end of March and presented to EPRR mtg April 2018 for approval.	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: None specifically identified				

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

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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]	31/03/2018	Further refinement of STP Governance underway to help decision making process. Designated SRO (Senior Responsible Officer) in place who is working to fully establish the governance processes which will aid decision making	High
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	31/03/2018	On-going issue. However, STP Board are reviewing and organisations have been asked to nominate staff. Programme lead escalating to SRO re lack of dedicated project resource	High
Lack of clarity around collaboration and competition	Continue working with NHSI to gain clarity [ACTION OWNER DSD]	31/03/2018	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]	31/03/2018	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]	31/03/2018	Draft workforce plan for whole of MH STP was submitted on 15th Dec 17 to HEE (Health Education England). Final plan due to be submitted to HEE 15th March 18 included all partner organisations.	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]	Completed	Number of positive clinical meetings have taken place, although pace of change impacted on by lack of capacity	Achieved
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	Further workshop planned for 8/3/2018 to engage regarding rehabilitation and forensic services, and a further part of the workshop will be focused on finalising the workforce plan prior to sign off by the STP Board.	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	Completed	On-going attendance at system wide meetings by	Achieved

	relevant groups [ACTION OWNER CO/DSD]		key people	
The provision of reliable system wide information	Maintenance of relationships and involvement in relevant groups [ACTION OWNER CO/DSD]	31/03/2018	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, 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 updates provided to the People and Culture Committee and Board - Recruitment tracker reporting to People and Culture Committee and Board - Success reporting to from specific recruitment campaigns	- 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

- Financial impact tracking on agency spend through Board - Quarterly staff 'pulse checks'. 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:
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]	31/03/2018	- Workforce plan was approved at the July Board meeting with investment as required for the next 12 months. This was refreshed in Feb 2018, to pick up Year 2 plan ready for business planning for 2018/19. Year 1 implemented. Year 2 in draft. STP Mental Health Plan has been developed. - 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	31/03/2018	- 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]	31/03/2018	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:				

Organisational level	ID	Directorate	Risk Subtype	Title
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
Team Risk Assessment	21124	Neighbourhood Services - South	Clinical - Staffing levels	No long term Consultant psychiatrist cover after 28th January 2018
Divisional Risk Assessment (Clinical)	3386	Campus - Radbourne Unit	Clinical - Staffing levels	Radbourne Unit - Staffing risk assessment
Team Risk Assessment	20993	Children's Therapies & Complex Needs	Clinical - Staffing levels	Staff shortage Children and Therapies
Divisional Risk Assessment (Clinical)	3385		Clinical - Staffing levels	Waiting Times for Psychological Assessment and Intervention

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, 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 HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⟷	Rating MODERATE	Likelihood 3	Impact 4	Accepted	Tolerated	Not accepted

Key controls:

Preventative – Team Derbyshire: 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 during 2018	

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	31/03/2018	12 month plan underway	Low

	Development Plan linked to training needs requirements			
- Staff engagement plan developed linked to embedding the values	Implementation plan during 2018 to embed expectations amongst staff and leaders [ACTION OWNER DPOE]	31/03/2018	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]	31/03/2018	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]	31/03/2018	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. 2017 results are now out and we are working with the staff engagement group and staff forum to develop an action plan	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				

Derbyshire Healthcare NHS Foundation Trust

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, 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]	Completed	- 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. Action plan being monitored by Children's COAT	Achieved

			- Children's services 'you said:we did' action plan considered by Quality Committee 8/3/18	
Evidence of managers supporting staff to work in culturally ways	Delivering equality training. Undertake EDS assessment of services. [ACTION OWNER: DPOE]	31/03/2018	- EDS2 2018 part 2: Workforce and Inclusive leadership grading - partly completed with BME Network on (3/11/2017) and wider workforce planned 13/2/2018. - Reaching out visits by Chief Executive and Deputy Chief Executive to LGBT+ Derbyshire and British Red Cross - E&D e-learning compliance 77.64% 4/1/2018. Monthly Induction now includes 'Why ED & I matters to us' session delivered by Trust ED&I lead. -Inclusive leadership development for Executives – Reverse Mentoring Action Research implementation has commenced. -BME Network launch event 3/11/2017 supported by senior managers. -Inclusive and compassionate leadership – spotlight on leaders planned for May 2018.	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]	31/03/2018	Meeting with IT and equality lead took place Oct 2017 to align PARIS fields to national equality. Quarterly monitoring to TMT to monitor progress. General Managers training undertook 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]	Completed	Paper to Quality Committee March 2018 outlined plan to be completed by task and finish group and reported through Quality Committee	Achieved
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 workforce event 13/02/2018 EDS2 Service grading focused on Children Services. EDS2 Corporate grading - Better health outcomes and experience Workforce Goals - 3 & 4 taking place 13/2/2018.	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	Achieved

			forward plans	
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	Completed	Chief Operating Office now substantively recruited to. Director of Strategy post appointed to.	Achieved
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				

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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 and Deputy Chief Executive	**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

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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.	- 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 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 – CEO] 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. CIP task force meetings set up. PAB to be re-instated. Both chaired by CEO 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

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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 generate 'use of resources' agency score of 4.	Weekly agency meetings to reduce costs. 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]	Completed	Control measures have reduced spend level to <50% with no trigger	Achieved
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 9 cash is £17m	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 confirm governance is no longer in scope for VFM. Issue closed.	Achieved
Related operational high/extreme risks: None specifically identified				

Board Assurance Framework 2017/18 Issue 5.2

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	HIGH	3	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	- Reporting to NHSI - Updates to CMDG/CMB - Pipeline of CQI projects

together with 'barriers' to change - 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]	Completed	MH Workstream ahead of other areas. Some clear deliverables. Links made to other areas particularly urgent and primary care. Strong ongoing progress.	Achieved
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]	31/03/2018	Generally on-track - performance reporting being formalised. Further work with regard to performance reporting underway with further emphasis on achievement of efficiency targets. .	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]	31/03/2018	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]	31/03/2018	Projects set-up and Project Vision realigned. Developing Dashboard reports for all Programmes to be reviewed at Mental Health System Delivery Board (MHSDB). Escalating lack of project resource to system SRO	Medium

Board Assurance Framework 2017/18 Issue 5.2

Related operational high/extreme risks:

Organisational level	ID	Directorate	Risk Subtype	Title
Divisional Risk Assessment (Clinical)	21209	Children's Services - Management Team	Financial risk - other	Contracting and financial risk

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

2017-18 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	1 May 18	5 Jun 18	3 Jul 18	4 Sep 18	2 Oct 18	6 Nov 18	4 Dec 18	5 Feb 19	5 Mar 19
		Deadline for papers	**23 Apr**	**25 May**	**25 Jun**	**24 Aug**	**24 Sep**	**29 Oct**	**26 Nov**	**28 Jan**	**26 Feb**
CM	Apologies given		X	X	X	X	X	X	X	X	X
SH	Declaration of Interests	FT Constitution	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
CG	Actions and learnings from patient stories		X		X		X		X		X
CM	Board Forward Plan (for information)	Licence Condition FT4	X	X	X	X	X	X	X	X	X
CM	Board review of effectiveness of meeting	Statutory Outcome 3	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
IM	Chief Executive's report including JUCD STP Update	Licence Condition FT4	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	Strategic Outcome 3 and 4	AR		X						
AR	Pulse Check Results and Staff Survey Plan					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	1 May 18	5 Jun 18	3 Jul 18	4 Sep 18	2 Oct 18	6 Nov 18	4 Dec 18	5 Feb 19	5 Mar 19
SH	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
SH	Governance Improvement Action Plan Embeddedness (timeline to be advised)	Licence Condition FT4									
SH	Fit and Proper Person Declaration	Licence Condition FT4	X								X
SH	Freedom to speak up guardian update				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	
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											

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	1 May 18	5 Jun 18	3 Jul 18	4 Sep 18	2 Oct 18	6 Nov 18	4 Dec 18	5 Feb 19	5 Mar 19
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
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
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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 28 March 2018

Report from the Council of Governors
21 March 2018

The Council of Governors met on Wednesday 22 March at the Ashbourne Centre, Kingsway, Derby. The meeting was attended 14 governors.

Chief Executive's Report
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. The Chief Executive also presented the proposed refresh of the Trust's Strategy and invited governor input and comment. Details on how it had been developed and what it is hoped to achieve were outlined. Included in the Chief Executive's update was a copy of NHS England's Mental Health Delivery Plan for 2018-19 which provides clarity of intent for investment in services.

Non-Executive Director Deep Dive
Margaret Gildea, Senior Independent Director, Non-Executive Director and Chair of the People & Culture Committee gave an update on the work of the Committee highlighting her role in holding Executive Directors to account. An update was also provided on the 2017 Staff Survey Results. Margaret Gildea highlighted that she was the lead Non-Executive Director for Freedom to Speak Up issues and Kully Hans, the Trust's Freedom to Speak Up Guardian gave an update on her work.

Submitted Questions from Members of the Public
Richard Wright, Non-Executive Director, responded to a question submitted from a Trust member regarding the reporting of percentages in excess of 100% in the Trust's published integrated performance report. Clarity was provided and will be reported in full in the public minutes of the meeting.

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

Option 5
The percentage of admissions to acute wards/inpatient services for which the Crisis Resolution/Home Treatment Team acted as a gatekeeper during the reporting period.

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

Escalation Items to the Council of Governors
Two items were escalated to the Council of Governors from the Governance Committee. Julia Tabreham, Chair of the Quality Committee, responded to a question relating to the provision of personal health budgets. Ifti Majid, Chief Executive, responded to a request for information on how Joined Up Care Derbyshire, formerly the Sustainability Transformation Partnership, engages with the public. Each will be reported in full in the public minutes.

Results of the Annual Council of Governors Effectiveness Survey
The Council of Governors noted the outcomes of its second annual effectiveness survey. Actions undertaken as a result of survey outcomes were noted and welcomed. Proposed additional actions to further enhance the next survey, scheduled for September 2018, were approved.

Nominations & Remuneration Committee – Verbal Update
Caroline Maley briefly outlined the items covered in the meeting, held on 20 March. A full report will be presented to the May Council of Governors Meeting.

NHS Providers – Elections to the Governor Advisory Committee
Carole Riley, Deputy Lead Governor, reported that governors had voted to agree that candidate John Morrissey, the Trust's Lead Governor, would receive the Trust's vote for election to the Governor Advisory Committee.

Governance Committee Report
Carole Riley, Deputy Lead Governor, presented an update on the meeting of the Governance Committee held on 27 February 2018. The Committee had received a Quality Presentation outlining the Quality Visits Programme, the requirement for governors to prepare a statement as part of the formal consultation of the Quality Account and they were also provided with information to support them in the forthcoming selection of Quality Indicators.

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