Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Meeting of the Board of Directors

Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital, Derby
1 May 2018 09:30 - 1 May 2018 13:00

INDEX

NHS
Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – TUESDAY 1 MAY 2018
TO COMMENCE AT 9:30 AM IN CONFERENCE ROOMS A&B
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOPMENT, KINGSWAY HOSPITAL

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies for absence and Declarations of Interest including year-end review of Declarations of Interest Register	Caroline Maley
2.	9:35	Service Receiver Story – *Building Better Opportunities*	Carolyn Green
3.	10:00	Minutes of Board of Directors meeting held on 28 March 2018	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.		Questions from governors or members of the public	Caroline Maley
6.	10:10	Chair's Update Update from Remuneration & Appointments Committee held 18 April 2018	Caroline Maley
7.	10:15	Dying to Work Charter	Amanda Rawlings/ Lee Fretwell
8.	10:25	Chief Executive's Update	Ifti Majid
9.	10:35	Quarterly update on Joined Up Care Derbyshire	Vikki Taylor
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY			
10.	10:50	Verbal update from Operational Planning meeting held on 26 April 2018	Claire Wright
11.	10:55	Integrated Performance and Activity Report	Claire Wright/Amanda Rawlings/Carolyn Green/ Mark Powell
12.	11:20	Strategy 2017/18 Dashboard Signoff	Lynn Wilmott-Shepherd
13.	11:30	People & Organisational Effectiveness Function Update	Amanda Rawlings
11:40 B R E A K			
14.	11:50	Equality Delivery System 2 and Workforce Race Equality Standard Update Report	Amanda Rawlings
15.	12:00	Board Committee Assurance Summaries and Escalations from the Quality Committee held 10 April 2018 *(minutes are available upon request)*	Committee Chairs
GOVERNANCE			
16.	12:10	2018/19 Board Assurance Framework Issue 1	Sam Harrison
17.	12:20	2017/18 Data Security Protection Requirements Year End Declaration	Sam Harrison
18.	12:30	NHSI Compliance Returns	Sam Harrison
19.	12:35	Fit and Proper Persons Test Declaration, Revised Fit and Proper Person Policy	Sam Harrison
20.	12:45	2017/18 Year-end review of Trust Sealings	Sam Harrison
21.	12:50	Well-led Review Recommendations	Sam Harrison
CLOSING MATTERS			
22.	12:55	- 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			

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: Sue.Turner2@derbyshcft.nhs.uk

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

The next meeting will be held at 9.30am on 5 June2018 in Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ

Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.

Participation in meetings is at the Chair's discretion

Derbyshire Healthcare
NHS Foundation Trust

Our vision

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

Making a positive difference

Our values

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

Our Trust values are:

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

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 1 May 2018

Corporate Governance
Register of Directors' Interests 2017/18

Purpose of Report

This report provides the Trust Board with an account of directors' interests during 2017/18.

Executive Summary

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

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

Board Assurances

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

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

Governance or Legal issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks – not applicable

Recommendations

The Board of Directors is requested to:

1) Approve and record the declarations of interest as disclosed. These will be recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's annual report and accounts for 2017/18.
2) Record that all Directors have signed as to compliance with the NHS Codes of Conduct and Accountability and Nolan principles; no relevant audit matters have been declared.

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

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

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/Part Owner, Woodhouse May Ltd	(a, b)
Ifti Majid Chief Executive	• Kate Majid (spouse) Chief Executive of the Shaw Mind Foundation which is a global mental health charity	(a, d)
Caroline Maley Acting Trust Chair	• Director – C D Maley Ltd • Trustee – Vocaleyes Ltd. • Governor, Brooksby Melton College	(a, b) (a, d) (a, d)
Mark Powell Chief Operating Officer	• Chair of Governors, Brookfield Primary School, Mickleover, Derby	(e)
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	(a) (d)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients.	(e)
Richard Wright Non-Executive Director	• Executive Director, Sheffield Chamber of Commerce • Chair Sheffield UTC Multi Academy Trust • Board Member, National Centre of Sport and Exercise Medicine Sheffield	(a) (a) (a)
Lynn Wilmott-Shepherd Interim Director of Strategic Development	• Substantive position is 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) Detail any connection with a voluntary or other organisation contracting for National Health Services, or hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or any other body which could be seen to influence decisions you take in your NHS role. (see conflict of interest policy - loyalty interests).

Employment support as unique as you are

LOTTERY FUNDED

European Union
European Social Fund

Building Better Opportunities
SHEFFIELD CITY REGION

What do you need to move forward?

We're all different. We've each got our own strengths, ambitions and ideas.

And the best workplaces are made up of a diverse group of people, who bring their unique experiences, personality and skills to their roles. However, we all have things in our lives that can make getting into or staying in work a bit more difficult. Worries about money, your health, your home, your kids... or maybe it's a combination?

That's why we're offering a personalised package of support that's as unique as you are.

We listened...

We listened to over 400 people who found getting work or keeping a job difficult. They told us their stories about the barriers they had experienced, what they did to overcome them, and the achievements that they're proud of. We used these stories to design your free Building Better Opportunities package.

What can I get in my package?

Building Better Opportunities (BBO) is based on Individual Placement Support, a place then train approach.

First, this means working with you to get a job. We learn about your strengths, skills and interests, and about how you work best. Then, we'll move quickly to find the role that's right for you. We'll start contacting employers and searching for jobs within 30 days of you joining BBO.

And then, in your new role, you'll be able to access extra BBO support, mentoring and courses. We'll work with you to make sure you keep and enjoy your new role. You'll choose where you'd like to develop your skills or learn new things – there are loads of different options available!

Your BBO package includes...

- **Your Health and Wellbeing Coach.** Your strengths and skills are at their best when you're feeling good. Your dedicated Health and Wellbeing Coach will support you emotionally and practically, through coaching and counselling, one-to-one sessions, and recommending useful activities.
- **Your Work and Enterprise Coach.** Your coach will help you look for jobs that match your strengths, ambitions and interests. Once you're in your job, they can work with your employer to make sure you've got everything you need to shine in your new role.
- **Benefits advice.** Don't let worry over losing benefits, or understanding what benefits you might be entitled to, hold you back: your BBO package contains specialist benefits and debt advice. This support and information is available at your home, if you'd prefer.
- **Wellbeing and employment courses.** You can access free courses that develop essential skills – from tips on healthy eating, to managing responsibilities at work. They'll be full of other people who are also accessing support and guidance from BBO, so they're a great chance to meet new people, too.
- **Activities.** There are lots of activities to get involved in, from keeping active to volunteer opportunities.
- **Access fund.** Is paying for transport or childcare a worry? Our access fund may help towards the costs that are preventing you getting to or enjoying work.

BBO is funded by the Big Lottery Fund and the European Social Fund. BBO is led by South Yorkshire Housing Association, alongside delivery partners with expertise in employment and wellbeing.

A bit more about your BBO coaches...

You and your BBO coaches will work as a team to meet your goals. They'll support you to stay happy, thriving and well, both in and outside of work. Your friends and family are always welcome to come along when you meet with your BBO coaches.

Your **Health and Wellbeing Coach** will be a trained professional, like an occupational therapist or a counsellor, and will help you to stay well and to meet your ambitions. They'll work with you to develop the skills to thrive at work, and to decide what other support, courses and training you'd like to access.

Your **Work and Enterprise Coach** will help you to understand your skills and strengths, and the jobs and training that you want to apply for. For up to 13 weeks after you start your job, they'll be on hand to make sure you're flourishing in your new role.

Specialist benefits and debt advice

We know that benefits and debt advice is really important when considering moving into work. It's useful to know about the different options and support you have, so that the decisions you make are right for you. You'll meet a trained Benefits and Debt Adviser – they'll offer you guidance both when you join BBO, and when you start your new job. If you'd like, the Benefits Adviser can also visit your home to offer confidential advice to you and your family.

Meet our Peer Ambassadors...

Our Peer Ambassadors have all experienced barriers to getting a job, and are now thriving in work. They're individuals who are in employment, or running their own business, while managing health conditions and/or living with disabilities.

They'll share their thoughts, experiences and triumphs –speaking to other people who have had similar experiences can be helpful and inspirational. You'll choose your Peer Ambassador, and they'll support you in one-to-one meetings.

Our Peer Ambassadors will also visit local employers to promote BBO. They'll talk to them about the different needs people might have when starting work and what they can do to ensure the transition is a success. They'll suggest ways in which employers can work with their staff to help them to flourish in their job, and to stay happy and well.

You may also wish to volunteer as a Peer Ambassador, and support others by sharing your unique experiences and expertise. We'd love to have you on board.

Want to volunteer as a Peer Ambassador?

Contact Caroline Muddimer at c.muddimer@syha.co.uk or call 07393 015276

Guidance, support and training: What we can offer you...

Wellbeing and employment courses

There are many BBO courses available – you simply choose the ones that you'll find most useful. These courses will develop skills that are important both in work and at home. Here are some of the modules we offer:

- Preparing for job interviews
- Communicating effectively with managers and co-workers
- Eating, exercising and sleeping well

You'll take part in the courses alongside other people who have joined BBO – they're a great way to meet others, and to support each other by sharing your experiences. Courses are available at evenings and weekends, and you're welcome to invite friends and family along, too.

Specialist support

At BBO, we work with a number of partners in the Sheffield City Region – each with specialist know-how, talents and resources. You can connect with them to boost specific skills, access useful information, and take part in inspiring experiences. There's lots to choose from, and your Health and Wellbeing Coach can help you decide what support you'd like to access, and when.

Black, Asian, minority ethnic and refugee support

We have a number of brilliant partners that work specifically with people from a Black, Asian, minority ethnic or refugee background. With these organisations, you'll develop skills in:

- Learning or improving English language skills
- Building self-esteem, confidence and aspirations
- Learning about British culture and work environments
- Developing interview techniques and accessing volunteer opportunities

There is also support available for women with learning disabilities, and for those experiencing, or at risk of, domestic violence.

DELIVERED BY

Ashiana
Bassetlaw CVS
Changing Lives
Roshni
Rotherham Ethnic Minority Alliance

Training and skills development

Whether you're eager to boost your creativity, or determined to improve your maths, there's loads of training and skills development options available at BBO! Simply pick the opportunities that most interest or inspire you – here are a few examples of what you can get involved in:

- Budgeting, internet banking and financial planning
- Developing communication skills, confidence and self-esteem
- Improving skills in photography, film, creative writing and IT
- Opportunities to complete accredited courses in maths, English and employability skills
- Learning more about beauty and hairdressing, with the chance to gain recognised qualifications
- Job searching, CV development and interview preparation
- Working in a team, problem-solving, and developing leadership skills
- Increasing confidence in using public transport, and planning travel routes
- Developing self-esteem and confidence through horse-riding

There is women-only and one-to-one support available.

DELIVERED BY

Changing Lives
Heeley Development Trust
Ignite Imaginations
Key Changes
Landmarks College
Manor Training and Resource Centre
Pakistan Advice and Community Association
Places for People
Reach South Sheffield
Richmond Fellowship
Rural Action Derbyshire
The Learning Community
Wiseability
Woodthorpe Development Trust
Workers' Education Association

Money and legal advice

Managing money is an important part of starting or returning to work. We work with partners to offer:

- Information about debt repayment, bankruptcy and write-offs
- Legal advice on rent and mortgage arrears, harassment, homelessness and discrimination

DELIVERED BY

Citizens Advice North East Derbyshire
Chesterfield CAB
Derbyshire Law Centre

Physical activity

Staying active helps you to keep fit, feel good, and maintain a positive balance between work and the rest of your life. To keep active at BBO, you can take part in:

- Fun and accessible activities to improve physical fitness, such as walking football, walking groups, and running
- Fitness sessions that also develop social skills
- Groups that explore green spaces, such as local parks and nature trails

DELIVERED BY

Chesterfield FC Community Trust
Rotherham United FC Community Sports Trust
Sheffield Wednesday FC in the Community

Work experience and volunteering

Our work experience and volunteer placements are welcoming, constructive and supportive. And by trying new experiences, gaining knowledge and building confidence, you'll also have some great additions to your CV. The placements and support you can take part in include:

- Experience and training in food growing, composting, and grounds maintenance at local farms
- Placements in catering, construction, crafts and childcare
- Specific work experience and volunteer opportunities for deaf people
- Assistance in finding the right volunteer role, and continued support throughout your placement

DELIVERED BY

Deafinitions
Heeley City Farm
Pre-School Learning Alliance
Rhubarb Farm
Voluntary Action Rotherham
Voluntary Action Sheffield

Additional support and advocacy

And, last but not least, we also offer mentoring, training and support in these areas:

- Mentoring for ex-offenders, to help to prepare for employment and to adjust to new environments
- Crèche services, and guidance in finding sustainable childcare solutions
- Deaf advocate support and British Sign Language interpretation (available in person or via a mobile phone/tablet)
- Workplace assessments, and support for employers to make reasonable adjustments

DELIVERED BY

Cascade Foundation
Deafinitions
Grow
Key Changes
Pre-School Learning Alliance
Sheffield Occupational Health Advisory Service

An employment journey that's as unique as you are

Getting to know your strengths and the things you enjoy

HEALTH AND WELLBEING COACH:

"I'll help you to identify your strengths to help you on your employment journey. I'll also provide emotional and practical support from day one."

WE'RE HERE FOR YOU WHENEVER YOU NEED US

bb

WORK AND ENTERPRISE COACH:

"I'll help you to find out what type of job you would enjoy and explore how we can get you there."

Helping you with benefits (and debts)

You'll get specialist support to ensure you're better off in work. You can visit one of our BBO partners to get this support – or we'll come to you if you prefer.

Starting your rapid job search

We'll help you to start looking for the job you want within 30 days. We'll be there for you whenever you need us, with lots of practical help and advice.

As well as getting help and advice from your coaches, you can choose to get peer-to-peer support from people who have completed their journey to work. You can talk to these Peer Ambassadors one to one, hear about things first-hand and learn from their experience.

HEALTH AND WELLBEING COACH:

"I'll help you manage your health as you return to work. Together, we'll build your confidence and improve your wellbeing."

WORK AND ENTERPRISE COACH:

"I am an expert at finding the right job for you. I'll help you to prepare and apply for roles and I'll be at your side throughout your job search."

Choose a course to help you with your job search

BUILD YOUR CONFIDENCE AND GAIN NEW SKILLS

Delivered by our expert partners, the courses are a good way to build your confidence and gain new skills. It's also a great opportunity to meet people on the same journey as you, share your thoughts and make new friends.

YOU'VE GOT THE JOB YOU WANT!

When you start your new job we'll still be here for you. We'll make sure you have everything you need to succeed.

IF YOU NEED US...

...we'll continue to help you with benefits and debts

...your coaches continue to support you during the first 13 weeks of your new job

...your peer-to-peer support will continue while you settle in and become happy at work

THINKING ABOUT YOUR FUTURE

Now that you're working (or learning) and achieving your goals, you can become a Peer Ambassador and help other people along their employment journey.

After training to become a Peer Ambassador you'll talk one to one, share your thoughts and help others learn from your experience.

BECOME A PEER-TO-PEER AMBASSADOR

A NEW JOURNEY!

Building Better Opportunities

Employment support as unique as you are

If you'd like to know more:
Call 0114 290 0200
Email bbo@syha.co.uk
Visit us at syha.co.uk/bbo

@bbo_scr
facebook.com/SouthYorksHA

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European Union
European
Social Fund

Building
Better
Opportunities
SHEFFIELD
CITY REGION

LOTTERY FUNDED

European Union
European
Social Fund

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Opportunities
SHEFFIELD
CITY REGION

Recruit great people
Keep them well
Work Better

Free, expert support to keep your business working well
Email bbo@syha.co.uk or call 0114 290 0200

Let's work together

Every year, 1 in 4 of us experiences a mental health problem.

(Source: Mind)

7 million working age people in the UK have a disability or health condition.

(Source: UK Government)

People with disabilities and health conditions are already among your company's best and most resilient employees. You may be one of them.

They're also some of your most important customers, a growing market of 1.43 billion people worldwide (Source: BBC News).

Building Better Opportunities (BBO) is a new employment support programme, financed by the Big Lottery and European Social Fund. We're working with talented people who want to find jobs and who have the potential to thrive in employment.

BBO will help you to recruit and retain these brilliant candidates. We also offer specialist training and advice on workplace health.

Our free service can work with you to...

- Fill vacancies quicker, bringing new talent and diversity to your business.
- Access 13 weeks of on-the-job training and support for these new employees, including expert advice from occupational therapists and counsellors.
- Improve workplace wellbeing for all your staff. This includes free training in mental health awareness and stress reduction.
- Tap into government-backed schemes, like Access to Work, that provide practical and financial support for people with a disability or long-term physical or mental health condition.

Let's get started

Employing a Building Better Opportunities customer

A member of our team will work with you to understand how your business operates, what you expect from your employees, and what you offer in return. We'll then be able to find the most suitable candidate for your vacancies.

If you recruit a Building Better Opportunities customer, we'll offer a range of support to ensure that they contribute to the growth and success of your business.

For up to 13 weeks after they start work with you, BBO customers will access free training, peer support, coaching and counselling so that they flourish in their new role.

Working with you

We'll be on hand to make sure that you're happy, too. We tailor our service to your business, so you get all the information and support you need.

You'll be able to access training courses on topics such as Mental Health First Aid, Managing Stress at Work, and Making Reasonable Adjustments. We also offer free advice from our team of occupational therapists, counsellors and employment specialists.

Investing in your employees' health and wellbeing is proven to reduce sickness absence and to improve productivity. So, we'll help you support your existing employees to feel and perform well.

This includes:

- **Workplace Wellbeing assessment**
  We'll work with you to recognise the positive things you already do to retain your best staff and keep them well. We'll also identify areas for improvement and give you advice on next steps. We use National Institute for Health and Care Excellence (NICE) guidelines on workplace health, so you'll benefit from the latest and best evidence on what keeps staff engaged and performing at their best.

- **Training for line managers**
  Our BBO coaches will equip line managers with the knowledge and confidence to identify signs of ill health among their team members and offer appropriate support. We teach skills and strategies that are proven to increase staff retention and decrease sickness-related absence.

- **Peer Ambassador programme**
  Our volunteer Peer Ambassadors have experienced barriers to getting a job and are now thriving in work. They're all individuals that are in employment, or running their own business, while managing health conditions and/or living with disabilities. They can share their inspiring stories with your staff. They'll also provide mentoring and peer support for your new BBO employees.

Want to volunteer as a Peer Ambassador?

Contact Caroline Muddimer at c.muddimer@syha.co.uk or call 07393 015276

How is Building Better Opportunities different?

- Building Better Opportunities is based on Individual Placement Support, a place-then-train approach that's proven to be twice as effective as traditional methods (source: Centre for Mental Health). It means getting people into competitive employment first, with training, support, and opportunities for development on the job.
- We only work with people who have voluntarily participated in BBO – all of our customers are motivated to find work, and to excel in their new role.
- We support customers to find job roles that interest and inspire them. By tailoring job search around individual preferences, we can find candidates that will thrive in your business.
- We offer expert advice from occupational therapists, counsellors and employment specialists.
- All our support is free: we can show you where to access free online resources to manage employee wellbeing and how to access government-backed funding schemes, such as Access to Work.
- BBO is led by South Yorkshire Housing Association, a not-for-profit social landlord and award-winning provider of health and wellbeing services. Our partnership includes trusted names from the public, private and voluntary sectors within the Sheffield City Region. We aim to create genuine partnerships with business, providing outstanding customer service to firms that share our ethos and values.
- We've co-designed the programme with more than 400 people who have disabilities and health conditions; our support works because it provides what our customers want, when they want it.

What does this mean for your business?

By providing employment to a Building Better Opportunities customer, your business will benefit from:

- Reduced recruitment and adverting costs by filling vacancies with people that have a desire to work, and the skills and ambition to do their role well.
- Increased workforce diversity and resilience. We'll widen your talent pool and provide the staff you need to tap into a growing disability market, estimated at £6.4 trillion worldwide (source: BBC News).
- Free in-work training and support for new and existing employees, to ensure that they're flourishing and realising their full potential.
- A better-engaged workforce who see that you're investing in their health and wellbeing.
- Increased staff retention and productivity: if your employees are happy and engaged, they're more likely to remain committed to your organisation.
- Lower rates of sickness-related absence: we follow NICE guidelines for workplace health. They're evidence-based steps that are proven to reduce sickness-related absence, and mitigate the risk of employee grievances.

"I employed staff with disabilities in a previous job. We thought it was the right thing to do, but expected it to involve a lot of extra work and support. We were wrong. The staff we employed were among our hardest working and most reliable staff. They were a huge asset to our business"

Paul Blomfield, MP for Sheffield Central

BBO
SHEFFIELD CITY REGION

Building Better Opportunities

Free, expert support to keep your business working well

If you'd like to know more:
Call 0114 290 0200
Email bbo@syha.co.uk
Visit us at syha.co.uk/bbo

@bbo_scr
facebook.com/SouthYorksHA

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National Institute for Health Research

NIHR Dissemination Centre

THEMED REVIEW

FORWARD THINKING

NIHR research on support for people with severe mental illness

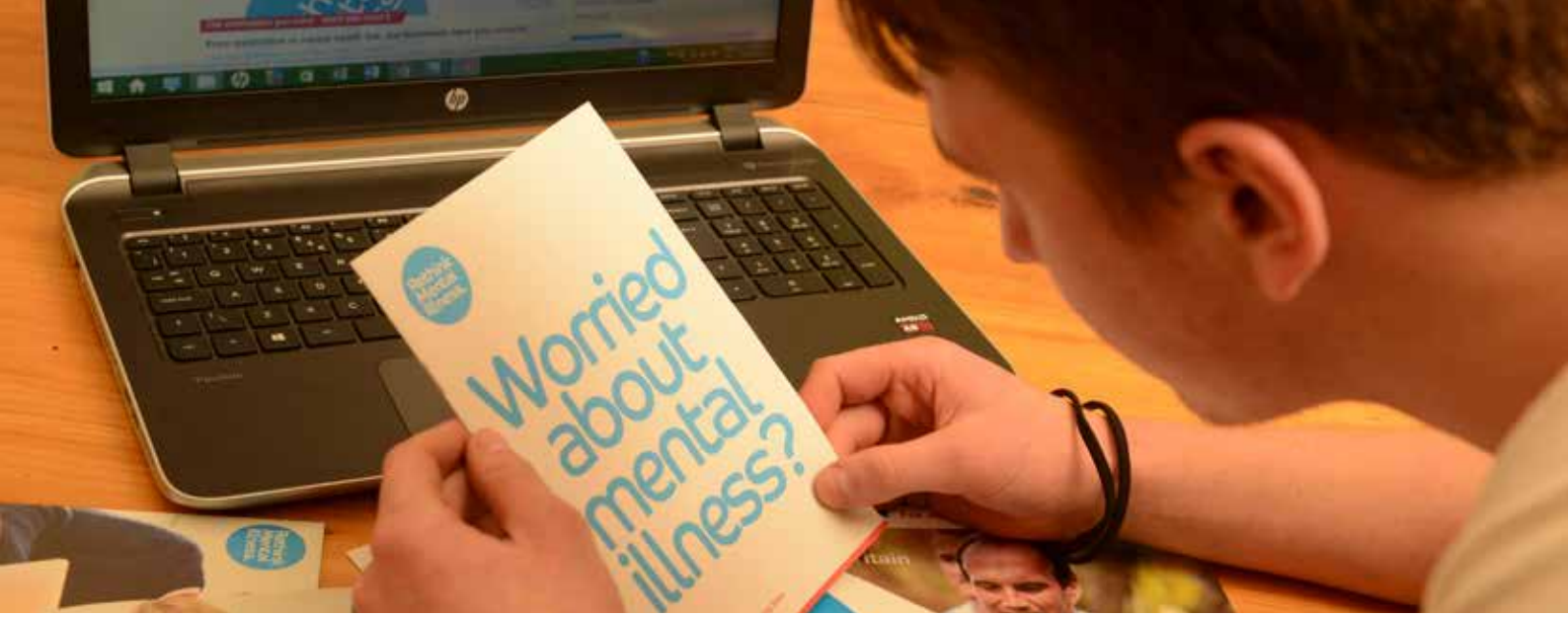
FOREWORD

This report reminds us of the significant disadvantages faced by many people with severe mental illnesses (SMI) – with difficulties in gaining and keeping employment, in maintaining stable relationships and receiving a decent income. They also face distinct inequalities when it comes to their mental and physical health, both in terms of having timely access to evidence-based mental health treatment and a experiencing a greater likelihood of poor nutrition, obesity and smoking-related diseases – all of which can and do contribute to premature mortality. Our intention is to change this as we implement the Five Year Forward View for Mental Health. With significantly increased investment in both the mental and physical health of people with SMI, we aim to not only help people with SMI quickly access evidence-based, NICE-concordant mental health care; we also want them to access NICE-concordant physical health care, to secure gainful and meaningful employment and for services across a range of sectors to work together to help improve their clinical and social outcomes in such a way that they have the same opportunities to live healthy, full and fulfilling lives like anyone else. In our view, we can no longer accept women and men with SMI struggling to access the high-quality care and support they ought to receive during their lifetime and dying 15 to 20 years before they should.

The findings set out in this useful research review will support this drive to improve care – and, indeed, lives – and we commend the report to you.

Karen Turner
Director of Mental Health, NHS England
NHS England

Professor Tim Kendall
National Clinical Director for Mental Health
NHS England



CONTENTS

EVIDENCE HIGHLIGHTS AND QUESTIONS TO ASK ABOUT YOUR SERVICES

People with severe mental illness (SMI), like schizophrenia, often experience poorer health and die sooner than others. Access to services may be patchy and care is not always well coordinated. But with the right care and treatment, and knowing what kind of support is needed, people can live well with these conditions. Mental health is now a recognised priority for policy and service, with research playing an important part in delivering best care. This review features 30 published studies funded by the National Institute of Health Research (NIHR) and additional examples of ongoing research. These should be read alongside published clinical guidelines for services and treatments.

SUPPORTING EARLY DETECTION AND INTERVENTION

Finding who to treat

Identifying people with psychosis and starting the right treatment without delay leads to better outcomes. A large trial of over 50 GP practices showed the impact of an educational intervention for GPs in improving identification and referral rates for young people at risk of developing psychosis. However another trial of a community awareness programme showed no effect in improving early referral rates.

Avoiding delay

A small trial comparing a public health campaign to raise awareness of psychosis in the local community and improve knowledge of early warning signs showed a significant reduction in delay in untreated psychosis compared to areas without this intervention. A study in Birmingham found that a third of individuals waited more than six months to start treatment despite long standing availability of early intervention services; the major delay identified was within the mental health service itself, suggesting the current configuration is a barrier to early intervention.

QUESTIONS

- Do we know how many people here might benefit from early intervention services?
- Can we use a research- informed prediction tool like Psymaptic (www.psymaptic.org) to help us understand the burden of mental illness in our community?
- Do we know how many people with early signs of psychosis are waiting more than 6 months for treatment in our community?
- What are we doing to improve awareness and detection of psychosis in young people in our community? Any tailored approaches for particular populations or groups?
- What early intervention services are available for our community?

CRISIS CARE: LOCATION, SETTINGS AND PRACTICES

Developing alternatives to hospitals

People experiencing mental health crises need expert and prompt support. A recent review found a lack of high quality evidence overall for models of mental health crisis care. What research there is suggests that crisis resolution teams in the community are more effective than inpatient care for many outcomes. Alternatives to hospital stays for mental health crises include crisis houses and acute day hospitals which appear as clinically effective as inpatient treatment and are largely preferred by those using crisis services. Research has explored the nature of therapeutic relations in crisis houses and why users tend to be more satisfied with these services.

Improving care on inpatient wards

For people needing hospital care, research has looked at different approaches to managing disturbed behaviour, from seclusion to transfer to specialist units. One study found variation in practice, and supported prioritising therapeutic over coercive interventions. To test this further, a large-scale trial

in nine hospitals evaluated a package of evidence-based interventions (Safewards) to help staff manage flashpoints and improve safety in acute psychiatric wards. This was shown to be effective in reducing conflict and containment, such as the need to sedate patients. A study looking at the acceptability of locked ward doors to staff and service users found that the evidence was inconclusive in terms of locked doors reducing absconding and self-harm.

Caring for young people

Other studies have looked at services for children and young people, important given that most severe mental illnesses start before adulthood, although SMI is very rare in children and young people. Should children and young people be admitted, one review stressed the importance of young people being allowed to lead as normal a life as possible, to make it easier to adjust to leaving hospital.

QUESTIONS

- What crisis houses and other alternatives to inpatient crisis care are available in our area?
- Are we evaluating any new approaches we are testing, such as placing adults with SMI within foster families?
- Do our hospital wards use Safewards interventions?

STABILISING, MANAGING PHYSICAL & MENTAL HEALTH

Staying well

We know that preventing relapse and recurring psychotic episodes is important to long-term health. A programme of research explored different approaches to keeping well in the first few years of illness, from therapeutic efforts to lifestyle change, but none of the interventions showed any significant effect. Another important aspect of keeping well is having regular medication, including injectable antipsychotics, but adherence can be poor. A trial showed that financial incentives improved attendance and outcomes, although the effect did not last after the payment stopped.

Planning future care

Family involvement in care planning can lead to better outcomes for people with mental illness such as fewer inpatient admissions but this is often not implemented in mental health organisations. One study concluded that involving families in care plans may require a cultural and organisational shift towards working with families.

QUESTIONS

- What training do we give new patients in spotting early warning signs of relapse?
- What is the rate of non-attendance at outpatients for injections? Could we consider financial incentives or other approaches to improve adherence?
- Are patients and families given opportunities to be involved in care planning?

SUPPORTING RECOVERY, SELF-MANAGEMENT AND ENGAGEMENT

Recovering better health

New approaches to mental health care focus on recovery, with individuals taking control and setting goals for themselves that are meaningful to them. A study of NHS rehabilitation services showed that quality of care was positively associated with service users' autonomy, experiences and perceptions of therapeutic care. Vocational rehabilitation has been shown to be effective but has been poorly implemented; one study found that employment outcomes were improved by addressing staff ambivalence about service users returning to work. A study of recovery focused care planning found evidence of widespread commitment to safe, respectful, compassionate care, but the majority of service users and carers did not feel that they had been genuinely involved in the recovery process. A large trial showed clinical benefits of using social recovery therapy as part of early intervention services after first episodes of psychosis. One study to understand and promote recovery from psychosis was done in collaboration with service users and the

research team included two service user researchers. The research provided significant advances in the understanding and facilitation of recovery in both psychosis and bipolar disorder.

Using technology

Digital technology is changing the way people with SMI seek information about their illness. One trial found that web-based interventions may prove an important, inexpensive, feasible, and acceptable step forward in creating a choice of evidence-based interventions at different stages of recovery. An evaluation of interventions to train people with schizophrenia to recognise early warning signs of psychosis showed some positive benefits.

Getting support from peers

The use of peer workers is an interesting new development, with benefits and some challenges for organisations. Research highlights the importance of keeping this as a distinct role and contribution. Another study suggested that more effort should be directed to support people with severe mental illness to build and maintain their personal networks.

QUESTIONS

- What approaches do we have to support recovery in our area, from recovery colleges to therapies adopted by early intervention services and others?
- How many service users in our patch have personalised care plans with recovery goals?
- Do we use validated measures of recovery here?
- Do we use peer workers at our organisations? How are they recruited and supported?
- What kind of input do our provider organisations have from service users? How are they supported?
- How are strategic decisions about services shared with patient groups?

ABOUT THIS REVIEW

The National Institute of Health Research (NIHR) was set up in 2006 as a health and care research system that focuses on the needs of patients and the public. It aims to produce an evidence base that is translatable into policy and practice.

This themed review provides an overview of recent research funded by the NIHR on the support for people living with severe mental illness. Unless otherwise stated, most of the research projects featured in this report are funded entirely or substantively by the NIHR through its project, programme or infrastructure support.

This report is not a systematic review of all the research conducted on the topic of severe mental illness. It highlights a selection of NIHR-funded research on aspects of severe mental illness that has been undertaken in health and social services since 2005. These studies were commissioned to address particular uncertainties and evidence gaps identified by those working in and using these services. We have included reference to some non-NIHR studies which we believe are important to demonstrate the overall context in which the NIHR research was undertaken.

We identified the 30 studies included in this review by searching online databases and websites where NIHR research is registered or published. We have chosen to particularly highlight research studies that are relevant to commissioners, provider organisations (in the NHS and voluntary sector), specialist mental health and general health and care professionals, people living with severe mental illness and their family and carers, educators and others inducting and training staff in this area. Not all research in this review have findings for immediate action. Some will add insights and weight to a growing evidence base. We hope that this report will help those delivering and using services to be aware of and consider the implications of some relevant published and emerging research in this field.

We have not included a range of clinical trials and other studies on treatment effectiveness funded by NIHR. Many of these have supported clinical guidelines for the management of schizophrenia and other conditions. Treatment decisions are best made through the careful deliberations of guideline committees, so we have not featured NIHR-funded trials which could give a partial or misleading view on best practice. These can be found at www.journalslibrary.nihr.ac.uk. For the same reason, we have not featured all relevant systematic reviews. Important resources are available from the NIHR-supported Cochrane review group (http://schizophrenia.cochrane.org). We have also not included relevant research in prison settings. This review focuses on general evidence to inform the support, care and services for people with severe mental illness.

INTRODUCTION

UNDERSTANDING SEVERE MENTAL ILLNESS

WHAT IS SEVERE MENTAL ILLNESS?

Psychotic illnesses – such as schizophrenia and affective psychosis – affect somewhere between one in one hundred and one in two hundred adults.[1] Psychotic illnesses can have a profound effect on people and their families, and appropriate and effective interventions are needed. Schizophrenia is the most common psychotic illness. In England alone, it is estimated to cost over £7 billion a year, which is equivalent to about £36,000 a year for each affected person.[2]

Severe mental illness (SMI) is not always a long-term condition. A significant number of people with SMI can experience a reduction of both symptoms and associated impairments over time and make a full recovery. Research suggests that remission and recovery rates in first episode psychosis may be more favourable than previously thought, suggesting that a progressive deteriorating course of illness is not typical[3, 4]. Indeed, for those who continue to live with the symptoms of psychosis, recovery in terms of personal, social and occupational aspirations is a realistic goal and sets the context for the recovery approach.

Severe mental illness is generally accepted to have the following attributes:

1. Mental illness with a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder. During a psychotic disorder, people may experience hallucinations such as hearing voices or seeing, tasting, smelling or feeling things that other people do not. People with psychosis may hold strong beliefs that others do not, for example, someone is controlling their thoughts, or someone wants to do them harm (paranoid or persecutory delusions). Other experiences can include difficulties in thinking and concentrating, thought disorder, lacking emotional expression, and being withdrawn and unmotivated.[5]

2. Mental illness that results in significant disability in terms of day-to-day functioning.
3. Mental illness that has lasted for a significant duration, usually at least 2 years.[6]

In this review, we use the term 'mental illness' to denote the group of conditions also called 'mental health problems', 'disorders', 'ill health' and 'conditions'. In line with the definition of SMI above which we have adopted for this review, we have not included NIHR research on personality disorders and other conditions. The terms 'serious' and 'severe' are both used interchangeably in the literature in the context of SMI; for consistency, we will use severe mental illness (SMI) throughout this review. Similarly 'early intervention services' and 'early intervention services for psychosis' are terms used to describe the same services, the latter being used in the more recent literature. We have left the terms as they were used by the researchers in their papers rather than using one term in preference to the other.

WHY IS SEVERE MENTAL ILLNESS IMPORTANT?

Currently the life-expectancy of people with severe mental illness is 15-20 years shorter than that of the general population, mostly due to preventable causes[7]. This excess mortality is one of the worst health inequalities in England and Wales.[8]

Physical health problems are exacerbated by uneven access to health care for people with SMI, and a lack of coordination between mental health and medical care providers.[9] Because of this, people with SMI use emergency services more, and preventative services less, than the general population; are three times more likely to attend A&E; and almost five times more likely to be admitted to hospital as an emergency.

People with SMI are also more vulnerable to higher rates of homelessness, victimisation, domestic violence, trauma, poverty, incarceration and social isolation.[10, 11] The unemployment rate for people with severe mental illness is 6 to 7 times that of the general population.[12] Most would like to work but only a few actually do, and this can be due to issues of stigma and discrimination as well as health. Employment rates for people with schizophrenia in the UK are about 8%, compared with a national employment average of 71%. [13] This low rate of employment just for people with schizophrenia is estimated to cost the economy around £3.4 billion.[14]

The causes of shortened life expectancy are many; suicide and injury account for about 40% of excess mortality; people with severe mental illness tend to have high rates of alcohol consumption, poor nutrition, obesity (anti-psychotic medications can lead to weight gain) and are twice as likely to smoke than the general population. About 60% of excess mortality can be attributed to preventable medical conditions such as diabetes, heart, lung and infectious diseases. Premature mortality due to schizophrenia alone is estimated to cost the UK economy about £1.4 billion a year.[15]

Further inequalities can be found in ethnic differences in prevalence of psychosis. The 2014 Psychiatric Morbidity Survey found that the estimated prevalence of psychotic disorder was higher among black men (3.2%) than men from other ethnic groups (0.3% of white men, 1.3% in the Asian group), with no significant variation by ethnic group among women.[16] A study part-funded by NIHR, the SEPEA Study, investigated if the incidence of psychosis varied by ethnicity, generation status, and age-at-immigration in a diverse, mixed rural, and urban setting. The study found that people of black African, black Caribbean and Pakistani origins were at the greatest risk of first episode psychosis compared with the white British population. These patterns were observed across rural and urban areas.[17]

TREATMENT AND INTERVENTIONS FOR SEVERE MENTAL ILLNESS

We now know much more about what can be done to improve health and wellbeing for people with severe mental illness. This includes early detection and intervention, and promoting choice and

SECURITY AND THE RIGHT MEDICATION – KEYS TO A BETTER FUTURE

"I have experienced paranoid schizophrenia since 1994. From 1994-2004 I failed to find an antipsychotic I was happy with because of severe side effects and so kept relapsing on a yearly cycle of forced hospitalisation, treatment, release, stopping treatment and relapse. In the autumn of 1997, I became fearful that the police would come and get me again so I took flight to Newquay where I was able to rent a holiday flat that was part of the landlord's house. Newquay is lovely in the winter and being near a family, even though not being 'looked after' by them, I felt peaceful and secure there. In fact, I felt better from the moment I arrived. I stayed happily there until the spring without the police or psychiatric team finding me and without getting into any kind of trouble. But in the spring, seaside rental costs shoot up for the summer season and my calm and peaceful life there was disrupted. I was forced to move back to cities I had known before, firstly living on the street and then back into hospital with all the problems of medication and its side effects.

I did eventually find an antipsychotic medication that suits me and have lived on it since 2004, enjoying my life without further hospitalisation. But I look back on that winter in Newquay and wonder how much of the anguish and expense of treating people like me could be avoided by providing comfortable accommodation that makes people feel calm and secure."

Clive Travis, service user

autonomy. Important interventions aimed at tackling inequalities, especially physical health inequalities, are now recommended, such as health screening, health education, and steps taken to improve access to physical and mental health treatment in primary and secondary care.

Most people with severe mental illness who experience recurring episodes of psychosis receive their care from both primary and specialist mental health care (other settings not included in this review are education and the criminal justice system). About 30% of adults with severe mental illness are able to be cared for in primary care alone, but the majority of people with severe mental illness are supported by community services.[18] Anti-psychotic drugs are the primary treatment for psychosis and schizophrenia in the acute and maintenance phases, in both hospital and community settings. Many people with SMI are able to find an antipsychotic drug that suits them, enabling a return to a productive life.[19]

Other modes of treatment that have been shown to be effective in improving symptoms, include psychological and psychosocial interventions. These focus on a person's functioning in society and wellbeing and include cognitive therapy and behavioural therapy.[20]

With the growth of the internet and smartphone apps, healthcare services are beginning to use e-technologies as a way to monitor health.[21] Digital support for mental health is increasingly being developed including the use of online resources, social media and smartphone applications and is associated with improving access to services, online self-help and reducing stigma.[22]

POLICY CONTEXT

ENGLAND

Improving access to mental health services by 2020

In October 2014, NHS England and the Department of Health jointly published Improving Access to Mental Health Services by 2020, which was aimed at ensuring "parity of esteem", where mental and physical health services are given equal priority in terms of access time, service quality and allocation of resources.[23]

The Five Year Forward View for Mental Health

The Five Year Forward View for Mental Health[24] was published by an Independent Mental Health Taskforce in February 2016 and set out a series of recommendations for the NHS to prioritise services for people living with SMI by 2020/21. In July 2016 NHS England published Implementing the *Five Year Forward View for Mental Health*.[25] This recommended that primary care services focus on the physical healthcare of people with SMI by increasing access to physical health assessments and appropriate interventions. The aim was for Primary Care to develop new models of care where GPs and practice nurses would deliver screening, outreach, and carer training, in order to meet the physical health needs of people with SMI. Another aim was for community-based services to be developed, so that people living with SMI are not held in restrictive settings for longer than needed; are supported by community-based services in residential rehabilitation; or supported by assertive outreach teams as close to home as possible. Another important aim was to help people with SMI achieve employment through the introduction of the Individual Placement and Support (IPS) programme. A new standard for waiting time was introduced requiring at least 50% of people with a suspected first episode of psychosis to start treatment with a NICE-recommended package of care within two weeks of referral.

In 2017, the *Five Year Forward View for Mental Health One Year On*[26] reported that since its inception, the waiting time element had been exceeded every month; with data at December 2016 showing 74% of people starting treatment within two weeks. Looking to the future, *Five Year Forward View for Mental Health One Year On* notes that the Sustainability and Transformation Plans (STPs) are tasked with facilitating collaboration across the health and care systems at the local level and are expected to be a powerful medium to deliver the Five Year Forward View for Mental Health.

Stigma and discrimination

The reduction of stigma and discrimination was one of the core objectives in the 2011 mental health strategy. Following this, the Department of Health provided funding for the Time to Change initiative, a national programme to reduce mental health stigma and discrimination, led by Mind and Rethink Mental Illness.[27] Currently the national *Time to Change* anti-stigma campaign is funded up to 2020/21.[28] Anti-stigma programmes have also been implemented in Scotland (See Me), Wales (Time to Change) and Northern Ireland (Change Your Mind).

Thriving at Work

Thriving at Work: a review of mental health and employers,[29] published in October 2017, sets out what employers can do to better support their workforce,

including those with mental health problems, to do well at work. The authors started from the position that the correct way to view mental health is that "we all have it and we fluctuate between thriving, struggling and being ill and possibly off work". People with poor mental health including common mental health problems and severe mental illness can be at any of these stages, and a person with SMI can, with the right support, still be thriving at work.

Children and young people's mental health

Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing, was published in 2015 by NHS England. The report made a number of proposals to improve mental health services for young people by 2020 and set out how to achieve this through better partnership working between the NHS, local authorities, voluntary and community services, schools and other local services.[30] In December 2017, the government published a green paper, *Transforming children and young people's mental health provision*, which set out ways the government can support local areas to adopt a new collaborative approach to tackle the early signs of mental health issues and improve mental health support for children and young people in England.[31]

Women's mental health

The Women's Mental Health Taskforce was set up in early 2017 in response to the findings of the Adult Psychiatric Morbidity Survey (APMS) 2014. This had shown a significant rise in mental ill health among women, particularly between 16-24 years old. The Taskforce is due to report in 2018.

WALES

In 2012, the Welsh Government published the *Together for Mental Health Strategy*,[32] and in 2016 the *Together for Mental Health Delivery Plan*[33]. This strategy echoes many of the aims in *Five Year Forward View for Mental Health*, particularly around physical health and early intervention. It is a 10-year strategy for improving the lives of people using mental health services, their carers and their families.

Primary legislation essential for the organisation of mental health services was passed by the Welsh Government in 2010, called the *Mental Health (Wales) Measure 2010*. This places legal duties on health boards and local authorities to improve support for people with mental ill-health and is aimed at helping people with mental health problems in four different ways:

1. Local Primary Mental Health Support Services

2. Care Coordination and Care and Treatment Planning
3. Assessment of people who have previously used specialist mental health services
4. Independent Mental Health Advocacy[34]

SCOTLAND

The *Mental Health Strategy 2017-2027*[35] was published by Scottish Government in March 2017. It describes a 10-year vision "of a Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma". It emphasises the challenge of achieving parity of esteem and tackling inequalities for people with mental ill-health and recognises the need for work to improve mental health across policy areas affecting poverty, education, justice, social security and employment. The strategy also reflects the critical role of new Integrated Health and Social Care Partnerships in delivering community mental health services with local authorities and geographical Health Boards providing more specialist aspects of care and treatment. The guiding ambition of this strategy is "to prevent and treat mental health problems with the same commitment, passion and drive as we do with physical health problems".

The Strategy defines 40 actions and 20 ambitions which sit under 5 themes:

» Prevention and early intervention
» Access to treatment and joined-up, accessible services
» The physical wellbeing of people with mental health problems
» Rights, information use, and planning
» Data and measurement

Suicide prevention will be published under a separate action plan in Spring 2018. Separate strategies exist for dementia, substance misuse, learning disability and autism. The Scottish Government published "What Research Matters for Mental Health Policy in Scotland 2015" to better align National Mental Health strategy and policy with research to improve both the impact of research and the evidence base for strategy.[36]

NORTHERN IRELAND

In October 2011, the Health Minister of Northern Ireland published *the Service Framework for Mental Health and Wellbeing* which sets standards for the prevention, assessment, diagnosis, treatment, care and rehabilitation of people who have a mental illness. *The Regional Mental Health Care Pathway: You in Mind*, launched in October 2014, commits health and social care services to deliver care which is more personalised and improves the experience of people with mental health problems. There have been calls for a new ten-year mental health strategy for Northern Ireland and a mental health champion to promote, lead and co-ordinate work across government departments, by adopting a more evidence based/recovery-oriented approach to care across the system.[37]

ACADEMY OF MEDICAL ROYAL COLLEGES

The Academy of Medical Royal Colleges and other professional bodies published an important policy document in October 2016: *Improving the Physical Health of Adults with Severe Mental Illness: Essential Actions.*[6] This report recommends that a new national steering group should be formed to lead and link key stakeholders with experts from the healthcare professions to enable key areas of physical health to be addressed and monitored at a national level. Amongst its many recommendations is that national organisations regulating healthcare professionals should review training requirements to ensure training standards and curricula prepare their trainees to recognise poor physical health in people with severe mental illness, to utilise health promotion and screening in disease prevention, and to manage long term conditions.

FRAMEWORK FOR MENTAL HEALTH RESEARCH

In December 2017, a national *Framework for Mental Health Research*[38] was published by the Department of Health, stating a commitment to support high quality research in mental health across the main funding agencies.[39] The NIHR in December 2017 issued a call with opportunities for new research on mental health across its programmes.[40] At a national and local level, investment in mental health services and research is now recognised as a top priority.

SUPPORTING EARLY DETECTION AND INTERVENTION

The *Five Year Forward View for Mental Health* set out a series of recommendations for the NHS in England, one of which is to increase early detection of psychosis so that early intervention can take place.

EARLY INTERVENTION SERVICES

Early intervention services (EIS) are specialised services for people who have an episode of psychosis that has not previously been treated (first episode psychosis). The early intervention service is targeted

at people aged 14-65 years (although professionals can use their clinical judgement when considering referral of people outside this age group).[41] People can be referred to early intervention services from primary care, from a Community Mental Health Team (CMHT), or Child & Adolescent Mental Health Services (CAMHS). Early intervention services offer a multidisciplinary, multi-agency approach to assessment, treatment and care. There is strong evidence that early intervention services lead to reductions in the number of admissions and overall inpatient bed days, contact with services at the end of the intervention, risk of relapse and risk of suicide. Early intervention services are associated with improved employment and education outcomes, better service engagement and higher levels of patient satisfaction.[42]

The time period between the onset of psychosis and starting anti-psychotic medication is called the 'duration of untreated psychosis' (DUP). The DUP is a treatment delay that has been the focus of much research because of its importance as a predictor of outcome.[43] If the DUP is long, then this appears to predict a poorer outcome for first episode psychosis. Reducing the DUP has become an important part of the detection and early intervention of severe mental illness. A national waiting time standard has been introduced in England[44] and Wales.[45] It is important to understand the barriers that people face when seeking, or failing to seek, help for psychosis.

An NIHR funded research programme (Study 1) produced a number of studies focused on first episode psychotic disorders and at-risk mental states. One of the studies in the programme (LEGS)[46] was a cluster randomised controlled trial (RCT), educating GPs to identify and refer young people at high risk of developing psychosis. The study explored the beliefs that influence GPs when they see young people with psychosis in primary care. The researchers used those beliefs to develop an educational intervention for GPs. After attending the educational workshop, GPs were found to have doubled the identification and referral of young people with high-risk mental states, first episode psychosis and other mental health problems.[47] This educational approach was found to be cost-effective largely by reducing the costs of unrecognised mental illness in primary care.

Study (2) was part of a wider research programme called the National EDEN Project[48], which was an evaluation of differently configured early intervention services sites across England. Study (2) was conducted in the lead site in Birmingham and documented the care-pathway components of the DUP of patients and their link to delays in accessing specialised early intervention services in Birmingham. The duration of the various components making up the care pathway of people with first episode psychosis period was measured over 47 months. The study found that, in spite of the long-standing availability of early intervention services in Birmingham, a third of the 343 people in the study had a DUP greater than 6 months. The biggest contribution to the length of the DUP was found to come from delays within mental health services, followed by delays in people seeking help. The study showed that the impact of early intervention services on reducing DUP appeared to be failing due to structural barriers specifically by non-crisis generic mental health teams. The findings suggest that mental health services as currently configured are a barrier to early intervention and that a 'psychosis pathway' is needed to improve recognition, engagement and treatment delivery.

Study (3) examined the feasibility and impact of an intervention to reduce DUP involving two components of the care pathway. The first was the introduction of a youth mental health care pathway for young people aged 16-25 providing a seamless transfer to specialist care without the need for further assessment. The second component was a public health campaign to raise awareness of psychosis in the local community and improve

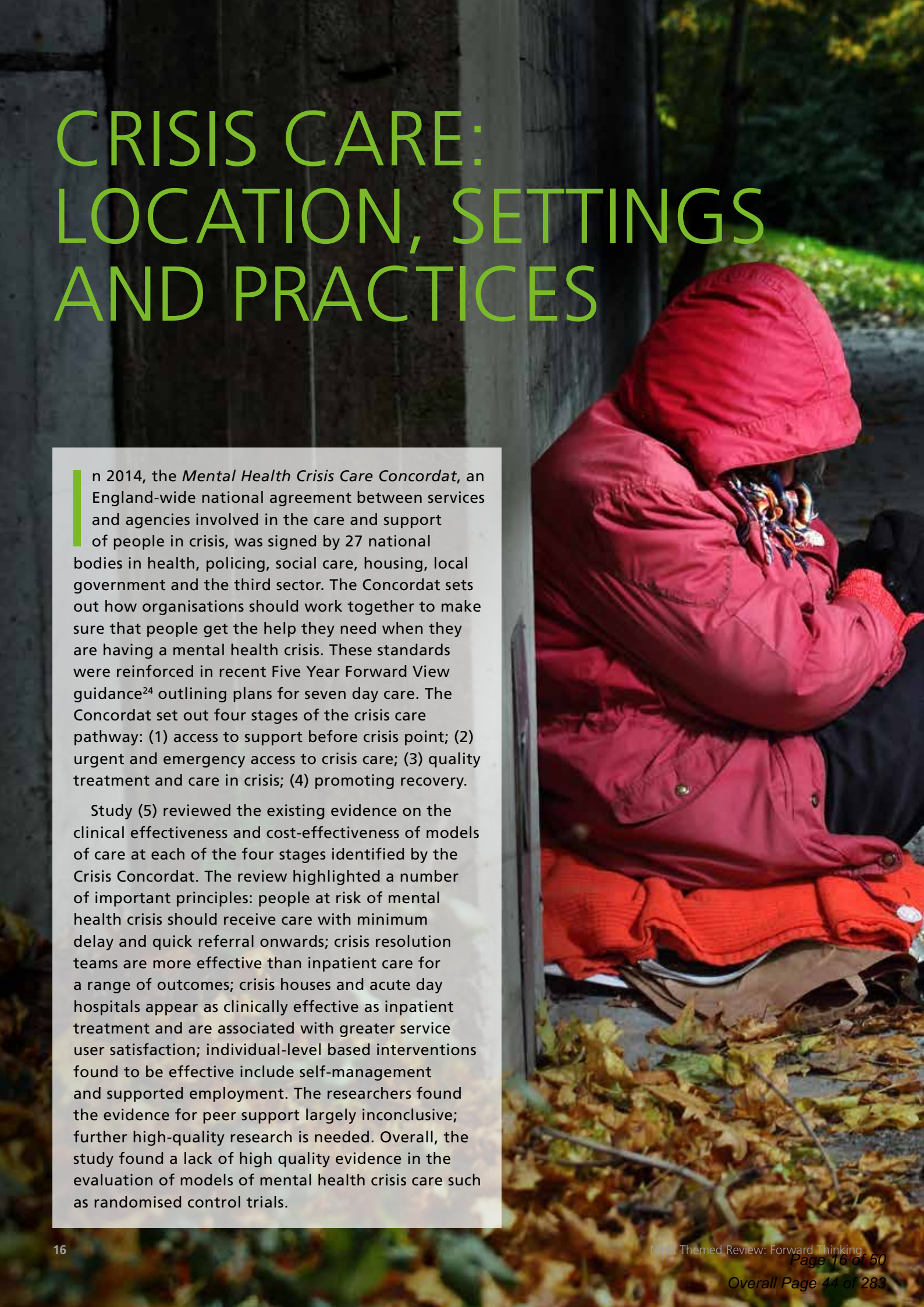
knowledge of early warning signs, and when and where to seek help. The results showed a reduction in median DUP in the intervention area of the study. However, there were limitations to the study; it was a small, pragmatic, quasi-experimental trial targeting only two components of the care pathway, and of limited duration, so a full evaluation could not be done. The researchers suggest that the proof of principle study, with an experimental intervention that focused on the community and use of youth friendly digital media, provides a generalisable methodology that could be used in further research into DUP.

Study (4) evaluated a one-year community awareness programme that targeted staff working in early intervention services in non-health service community organisations. The programme comprised 41 psycho-educational workshops delivered by 36 organisations to community staff working with young people vulnerable to experiencing early psychosis, and offering direct referral routes to early intervention services. The impact on DUP was evaluated. The researchers found that the workshops with community organisations were well received and engaged large numbers of community staff working with young people vulnerable to experiencing early psychosis. However, the intervention led to very few new referrals through non-health pathways and there was no significant difference in mean or median duration of untreated psychosis for new referrals to the service in the year of the intervention, compared to the year before.

ONGOING RESEARCH

Researchers are also using routine data to see if there are associations between markers of quality in primary care for people with severe mental illness, and health outcomes and hospital admissions (Study A). Other ongoing research in primary care is testing a collaborative care model with experienced mental health workers in GP surgeries (Study B).

CRISIS CARE: LOCATION, SETTINGS AND PRACTICES



In 2014, the *Mental Health Crisis Care Concordat*, an England-wide national agreement between services and agencies involved in the care and support of people in crisis, was signed by 27 national bodies in health, policing, social care, housing, local government and the third sector. The Concordat sets out how organisations should work together to make sure that people get the help they need when they are having a mental health crisis. These standards were reinforced in recent Five Year Forward View guidance[24] outlining plans for seven day care. The Concordat set out four stages of the crisis care pathway: (1) access to support before crisis point; (2) urgent and emergency access to crisis care; (3) quality treatment and care in crisis; (4) promoting recovery.

Study (5) reviewed the existing evidence on the clinical effectiveness and cost-effectiveness of models of care at each of the four stages identified by the Crisis Concordat. The review highlighted a number of important principles: people at risk of mental health crisis should receive care with minimum delay and quick referral onwards; crisis resolution teams are more effective than inpatient care for a range of outcomes; crisis houses and acute day hospitals appear as clinically effective as inpatient treatment and are associated with greater service user satisfaction; individual-level based interventions found to be effective include self-management and supported employment. The researchers found the evidence for peer support largely inconclusive; further high-quality research is needed. Overall, the study found a lack of high quality evidence in the evaluation of models of mental health crisis care such as randomised control trials.

LOCKED DOORS IN ACUTE INPATIENT PSYCHIATRY

Acute inpatient care involves the short-term care and treatment of people with severe psychiatric symptoms within accommodation that is secure and supervised 24 hours per day.[49] Acute inpatient care can be on a voluntary basis or a compulsory basis, for example when people are detained through the Mental Health Act for England and Wales. In 2015/16, a total of 25,577 people were subject to the Mental Health Act, of whom 20,151 were detained in hospitals.[50, 51] The treatment of people with psychosis costs the NHS around £2 billion a year, over half of which is associated with psychiatric inpatient care.[52]

A key issue facing acute psychiatric services is whether to have a system of permanent locking ward doors or a system of open wards. Increasing numbers of wards have a locked ward policy even though the policy contravenes legal guidance in the Mental Health Act. Patients who abscond are more likely to be associated with risk of self-harm and such an event is more likely to take place immediately following absconding. Clearly the safety of inpatients is paramount, but there is a lack of evidence that locking wards increases the safety of patients.

Study (6) was a literature review that investigated if rates of absconding from acute psychiatric wards were related to exit security, and also looked at the acceptability of locked doors to staff, patients and visitors. They found that the evidence was inconclusive regarding the effects of a locked door in that it can reduce absconding but does not eliminate it. Although staff believed that a locked door could prevent patients from leaving, the study showed that patients abscond even with a locked door. A locked door has no impact on inpatient suicide rates, and while it can make staff and patients feel protected, it can also make them feel confined. Patients can particularly feel under the control and power of staff, with feelings of being trapped like a prisoner rather than a patient. On the other hand, an open-door policy can lead to anxious vigilance by the staff. The study recommended that acute admission wards have a single main exit that is unlocked during the day but within the visibility of staff on duty. Patients judged to be at particular high risk of harming themselves should be managed through special observations or temporary transfer to a Psychiatric Intensive Care Unit (PICU). Further research on this topic was recommended by the researchers. A 15 year observational study in Germany reporting in 2016 found that locked doors might not be able to prevent suicide and absconding.[53]

SECLUSION AND PSYCHIATRIC INTENSIVE CARE: 'COERCIVE PRACTICES'

Patients admitted to acute psychiatric wards may be at risk of harming themselves or the people around them, so staff may on occasion have to act to contain a person safely. Seclusion or transferring a patient to a PICU are two methods of containment or coercive interventions that are used in psychiatric wards. Previous research suggests that typical PICU patients in the UK are male, younger, single, unemployed, suffering from schizophrenia or mania, from a black Caribbean or African background, legally detained, and have a forensic history. The most common reason for seclusion or transfer to PICU is the management of aggressive behaviour. There is a need to reduce the use of coercive interventions which are supported by little or no evidence.

Study (7), the Safewards trial, was a large-scale cluster randomised controlled trial conducted in 31 acute psychiatric wards in 15 hospitals around London. The study aimed to evaluate a complex intervention targeted at nursing staff to reduce conflict and containment. Psychiatric wards that were in the experimental condition implemented a package of ten 'Safewards' interventions.[54] While there were limitations to the study, it had many strengths, and a demonstrable impact on conflict and containment rates. Decreased conflict means fewer injuries from violence, suicide and self-harm. In the absence of comparable quality of evidence, the researchers recommended that the Safewards interventions be implemented on adult acute mental health wards.[55]

Study (8), the SPICES trial, assessed the factors associated with the use of seclusion and PICU. The researchers used patient records in one NHS trust to compare patients who did and did not receive seclusion or PICU care. They found that it was not possible to state that seclusion or a PICU reduce aggression, and some evidence suggests that coercion may serve to increase aggression. In hospitals without access to seclusion, nurses were slower to manually restrain patients, but were more likely to use sedating drugs by injection. The researchers recommended that therapeutic rather than coercive interventions be prioritised in the management of disturbed behaviour, and the development of conflict and containment reduction strategies. Further research using randomised designs was recommended.

The rates of compulsory admissions to psychiatric inpatient beds have been rising in recent decades. If the number of Community Treatment Orders are included, then the numbers of people subject to the Mental Health Act has increased by about 5% per annum since 2007.[56] This is despite the development of a range of community-based psychiatric services. Study (9) investigated the increasing rates of compulsory admissions in England to see if this could be explained by variations in people and places. The anonymised records of over 1.2 million people for 2010/11 were analysed. The researchers demonstrated a statistically significant and largely unexplained variance in compulsory admission between local areas and mental health provider trusts. There is a need for in-depth qualitative research to explore factors that might explain the local variation in compulsory admission.

CRISIS INTERVENTION

This Cochrane review[57] looked in 2015 at the effects of crisis intervention models in the home or community for anyone with severe mental illness experiencing an acute episode, compared to standard care. The reviewers included eight randomised controlled trials, involving 1144 individuals. Crisis care was found by this review to provide a package of support that avoided repeat admission to hospital and was worthwhile, acceptable and less expensive than standard care. Although this review drew on small trials subject to bias and some older studies which did not reflect current standards of care, this evidence has informed guidance, including endorsement of crisis resolution and home treatment teams.[24]

ACUTE PSYCHIATRIC WARDS, THERAPEUTIC RELATIONSHIPS AND SERVICE USER SATISFACTION

Service user dissatisfaction with acute psychiatric wards is common and many find acute wards frightening places. The Alternatives Study (TAS) (Study 10) examined residential alternatives to standard acute psychiatric hospitals in England. One hundred and thirty-one residential alternative services in England were identified. These community-based services were mainly characterised by a less severely ill client group, fewer medical and nursing staff and fewer services that had on-duty on-site night staff. However, these less clinically oriented units still had significant collaboration with NHS mental health services, and accepted referrals from NHS mental health staff. The researchers estimated that there are just under 1300 beds in these alternative units compared to about 12,400 acute beds for adults in standard psychiatric hospitals in England, roughly 1 in 10 beds outside of standard acute beds. These alternatives "represent an important, but so far undocumented, uncoordinated and unevaluated component of the national mental health economy, mainly within the statutory sector." Crisis houses are community-based service models that lie somewhere in between hospital services and other community services; residential crisis models vary considerably and include clinical crisis houses, specialist crisis houses, crisis team beds, recovery houses and non-clinical alternatives; and they tend to have 24-hour staffing by trained mental health staff and support workers. Only limited evidence is available on the effectiveness of crisis houses, and evaluating their impact is complicated further by the diversity of service models, making it difficult to compare studies and draw firm conclusions or make any recommendations for policy.[58]

Study (11) noted that the TAS study (Study 10) found that service users prefer crisis houses to hospital, but this preference was not explained by the care, the amount of staff–service user contact, or even differences in outcomes. Sweeney took the work of the TAS study further by seeking explanations for service users' greater satisfaction with crisis houses. This was a mixed methods study. Researchers collected data from four crisis houses in two London mental health trusts and compared data with the same measures from 16 acute wards in the same trusts. For the qualitative component they interviewed 29 service users.

Three major themes emerged:

1. Basic human qualities lie at the heart of therapeutic alliances. Service users in both environments valued relationships with staff who were caring, honest, empathic and approachable.
2. Service users wanted staff to talk to them more, listen to them more, and demonstrate therapeutic counselling skills in structured and unstructured interactions.
3. A focus on recovery and hope were also important, though less so than the above factors.

This study confirmed the findings of the TAS study of greater satisfaction in crisis houses than acute wards, and better therapeutic relationships between staff and service users in crisis houses.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

Mental health problems that begin in childhood and adolescence can have a range of negative impacts on individuals and families that can continue into adult life. Mental illness in children is common and the majority of adult mental health problems are first manifest before the age of 15.[59] One in 10 children and young people between the ages of 5 and 16 years living in Britain has a diagnosable mental health problem but severe mental illness, as we have defined in the introduction to this review, is rare in children and young people. Child and adolescent mental health services are provided through a network of services: universal services (Tier 1), targeted services (Tier 2), Specialist Community services (Tier 3) and highly specialist services for severe and highly complex mental health needs (Tier 4).

YOUNG PEOPLE RECEIVING TREATMENT WITHIN INPATIENT SETTINGS

Study (12) investigated the evidence in the area of risk for young people moving into, through, and out of inpatient mental health care. Young people who had been inpatients, together with carers, managers and professionals, helped to prioritise the types of risk that should be included in the study. Among the key recommendations was that young people receiving treatment within inpatient settings should be able to lead as normal a life as possible. Feeling separated from life outside and the subsequent

difficulties experienced on returning home were identified as some of the key issues. Service providers need to pay close attention to less obvious risks such as risks associated with friendship and peer relations, risk of stigma and discrimination, schooling, and family life. Young people often feel homesick, but often experience post discharge depression and suicidal ideation. Managing the risks of stigma and discrimination should be a high priority for policy makers, as should partnership with families during inpatient care.

ONGOING RESEARCH

Ongoing research is mapping the use of acute day units as alternatives to inpatient care and comparing outcomes for those in crisis, including impact on admissions (Study C).

STABILISING AND MANAGING PHYSICAL AND MENTAL HEALTH

AVOIDING RELAPSE

Avoiding relapse after the first psychotic episode is important because with each successive relapse, the illness becomes more difficult to treat and the probability of a full recovery declines. Studies have shown that success in preventing relapse is poor. Although 85% of people who develop psychosis recover fully from the first episode, 50% may relapse within 18 months and as many as 80% may relapse within 5 years. Study (13), the HELPER programme, is an NIHR research programme aimed at developing three linked interventions to prevent relapse of psychosis and deterioration in the physical health of people after a first episode of psychosis: (i) an evaluation of cognitive remediation in combination with cognitive behavioural therapy (CBT), (ii) training staff to deliver a healthy living intervention, and (iii) integrated motivational interviewing plus CBT. This research was exploratory in nature and designed to make the case for larger definitive trials with relapse as a primary outcome measure. Across the three trials there was little evidence that any intervention reduced relapse.

IMPROVING ADHERENCE TO ANTI-PSYCHOTIC MEDICATION

Non-adherence to medication is a normal phenomenon replicated in areas of physical and mental health. Poor adherence to long-term antipsychotic injectable medication in patients with psychotic disorders is associated with a range of negative outcomes, and ways to improve adherence are needed. Study (14) investigated whether offering financial incentives is effective and cost-effective in improving patient adherence. This was a cluster randomised controlled trial and participants in the intervention group received £15 for each long-term antipsychotic injectable medication. Patients in the control group received treatment as usual. The study found that patients who were offered money attended more often and reported a better quality of life. However, when the money was stopped, patients returned to missing appointments as before. So while financial incentives were shown to be effective in improving adherence to injectable medication, the effects were not sustained following the one year period during which the incentives were offered.

INVOLVING FAMILY MEMBERS IN CARE PLANNING

Deinstitutionalisation of mental healthcare has moved a large part of the burden of care for people with SMI to their families. Family involvement can lead to better outcomes for people with mental illness such as fewer inpatient admissions, shorter inpatient stays and better quality of life, although some studies have found this not to be the case in some families of people with schizophrenia.[60] Study (15) was a systematic review that investigated the involvement of families in three-way communication between health professionals, families and adult patients with psychosis. Family involvement can include specialised interventions such as psychoeducation, family interventions and therapies to reduce expressed emotion and lessen the chances of relapse in SMI. The researchers found that despite a vast positive evidence base for family involvement, it is often not implemented in routine mental healthcare. Families generally feel isolated, uninformed, not listened to or taken seriously. The study concluded that involving families in care may require a cultural and organisational shift towards working with families. This can only be achieved if clinical teams are trained to have an open, non-judgemental approach towards a therapeutic alliance between staff, families and patients, an approach which is embraced by the whole organisation.

MAINTAINING PHYSICAL HEALTH

In order to drive improvement in the physical healthcare of people with severe mental illness, primary care practices are incentivised under the quality and outcomes framework (QOF) to improve the access to physical health checks for their patients with SMI. This is reinforced by recent guidance for commissioners on improving physical health of people with SMI.[61] In England, secondary care is incentivised under Commissioning for Quality and Innovation (CQUINs) payments framework to do cardiometabolic assessments on inpatients with severe mental illness.

The NICE guideline on schizophrenia[62] puts an emphasis on maintaining physical health. Rethink's Integrated Physical Health Pathway[63] developed in collaboration with professional bodies, promotes joint working between the mental health and primary care sectors to support the physical health of people with SMI.

There is a high prevalence of smoking among people with SMI. Helping people with SMI to stop smoking would help improve their health, increase longevity and also reduce health inequalities. NICE has published guidance on a number of interventions, including mandatory recording of smoking status by mental health trusts; education for mental health workers on smoking cessation; smoke-free policies on NHS trust grounds; and rapid referral to enhanced smoking cessation services.[64] Study (16) is a pilot randomised control trial of a smoking cessation intervention for severe mental ill health (SCIMITAR) which was set in primary and secondary care mental health services in England; 97 people aged between 19 and 73 years who smoked between 5 to 60 cigarettes a day were recruited to the RCT. The smoking cessation intervention was behavioural support and medication, and was delivered by mental health professionals trained in delivering the intervention. This was compared with usual GP care in the control group. The study found that the odds of quitting at 12 months was higher in the intervention group but did not reach statistical significance. A definitive trial of a bespoke cessation intervention has been prioritised by the NIHR and the SCIMITAR pilot forms a template for a fully powered RCT.

Another important area of physical health in people with severe mental illness is sexual health. There is a high degree of variability in sexual activity among people with SMI,[65] for example people with schizophrenia are less likely than those with other major psychiatric disorders to be sexually active, possibly due to the known effect of antipsychotics on libido. People with SMI have the same right as the general population to have sexually intimate relationships, have families and be sexually healthy. Previous research has found that high-risk sexual behaviour is more common in people with SMI, as well as higher rates of blood borne viruses such as HIV and Hepatitis C.[66] Study (17) was a systematic review that evaluated the effectiveness of sexual health risk reduction interventions (such as educational and behavioural interventions, motivational exercises and counselling) for people with SMI. The study found that there was insufficient evidence to fully support or reject the identified sexual health interventions. The researchers noted the need for well-designed, UK-based trials of sexual health interventions for people with SMI, as well as training and support for staff implementing sexual health interventions.

ONGOING RESEARCH

Ongoing research includes an early testing of an intervention, partly delivered by smartphone, to detect and prevent relapse in people with schizophrenia (Study D). Other digital health approaches include early work to assess a computerised resource to combat paranoid delusions, which could ultimately be delivered online via a smartphone app (Study E) and a study that is looking at a web-based monitoring service for people with bipolar disorder in primary care. (Study F).

Ongoing studies are also addressing the role of family and carers, including a trial of an online Relatives' Education and Coping Toolkit (REACT) as a resource to help relatives of those with recent-onset psychosis (Study G). REACT was preceded by a feasibility trial that showed that the toolkit was feasible and a potentially effective intervention to improve outcomes for relatives.[67] A further study will explore the barriers and facilitators to the implementation of REACT in the NHS to see how it can be best used and implemented (Study H).

Another study is looking at the feasibility of a new approach involving families of people at risk of psychosis (Study I). More research is also targeting certain communities such as the co-production and evaluation of an e-learning resource to improve knowledge about schizophrenia and engagement with services in African Caribbean families (Study J). Another tailored intervention for African Caribbean people with schizophrenia and their families will assess benefits when delivered by experienced community workers (Study K).

Ongoing research is also looking at interventions to improve physical health, including a large trial testing a structured lifestyle education programme, based on tested diabetes interventions, to help people with schizophrenia to lose weight (Study L). Another programme of work will develop and test an intervention to detect and manage cardiovascular risk better for people with severe mental illness in primary care (Study M). Looking at promoting sexual health, a study will test the acceptability of a new approach delivered by staff in mental health trusts (Study N).

SUPPORTING RECOVERY, SELF-MANAGEMENT AND ENGAGEMENT

People with severe mental illness generally consider 'recovery' to be a journey of small steps, characterised by a growing sense of agency[68] starting with everyday activities and moving to participation in employment and education. The recovery approach says that a person with SMI should be allowed to set their own outcomes[69] and, in recent years, helping people to live the kind of life that they want, whether or not their experience of psychosis continues, is the main focus.

INPATIENT MENTAL HEALTH REHABILITATION SERVICES SUPPORTING RECOVERY

Many people with SMI often have complex problems preventing their discharge home following an acute admission. Almost all NHS trusts across England have inpatient mental health rehabilitation units and most are community based. Study (18) is a programme of research comprising a number of studies aimed at providing a detailed understanding of NHS inpatient mental health rehabilitation services across England (the REAL (Rehabilitation Effectiveness for Activities for Life) research programme). The programme included (i) a national survey of NHS mental health rehabilitation services, (ii) development of a training intervention for staff to facilitate service user's activities, (iii) evaluation of the training intervention through a cluster RCT, and (iv) a longitudinal cohort study to identify components of care associated with better clinical outcomes. The main findings of the programme showed that quality of care was positively associated with service users' autonomy, experiences and perceptions of therapeutic care. The staff training intervention was found not to be clinically effective as staff reverted to previous practice once the intervention team left. Over half the service users in the cohort study were successfully discharged from hospital over 12 months.

SUPPORT TO FIND WORK

This Cochrane review[70] looked at the effectiveness of supported employment, including individual placement and support (IPS), compared with other approaches to vocational rehabilitation or treatment as usual. The reviewers included 14 RCTs involving 2265 individuals. Supported employment (featuring intensive support and coaching to find work) was found to increase the length and time of people's employment. People on supported employment also found jobs quicker. Supported employment and IPS were shown to be better than other approaches for these outcomes. However, quality of evidence was not always high and there was little information of impact on mental health and wellbeing, days in hospital and costs.

The study provides evidence that NHS mental health rehabilitation services deliver high quality care that successfully supports service users with complex needs in their recovery.

INDIVIDUAL PLACEMENT AND SUPPORT

Unemployment is common in young people recovering from a first episode psychosis. Individual placement and support (IPS) is a form of vocational rehabilitation which involves rapid job search combined with minimal pre-vocational preparation and ongoing support. Much research has been done on IPS, and the results suggest it is effective compared to alternative interventions.[71] Early intervention teams are among the few specialist mental health teams in England that have adopted the IPS approach and have vocational workers fully embedded within their teams. However, it has generally been poorly implemented because many clinicians discourage return to work through a fear that employment might be too stressful for their patients and may precipitate relapse. Study (19) investigated whether training early intervention staff in 'motivational interviewing' would improve the chances of young people with SMI getting employment. A pragmatic, cluster RCT was conducted in England with four early intervention teams. The ENDEAVOR study (Enhancing Delivery and Outcomes of Vocational Rehabilitation) included a trained vocational specialist who provided supported employment services to the service users. The study found that employment outcomes were improved by addressing the staff's ambivalence about service users returning to work, suggesting that providing clinical staff with specific training in techniques to address service users (and their own) motivational conflicts may enhance their chances of competitive employment.[72]

PERSONALISED AND RECOVERY FOCUSED CARE PLANNING

Care planning processes in mental health community services and on inpatient wards should be personalised and conducted in collaboration with the service user and should be focused on recovery. Two NIHR funded studies were conducted across six NHS mental health Trusts and Health Boards in England and Wales: first, recovery-focused mental health care planning and co-ordination in community health services: Collaborative Care Planning Project (COCAPP), Study (20) and second, recovery-focused mental health care planning and co-ordination in acute inpatient mental health settings (COCAPP-A), Study (21).

The COCAPP study found that good relationships are important for service users, carers and care coordinators in care planning and supporting recovery, but that people do not always feel involved in discussions about their own care or safety, indicating that there is a gap between national policy aspirations for recovery-focused, personalised care planning and co-ordination and the actual everyday

SUPPORTING THROUGH WORK

Emily came to her local supported employment service after her stepfather heard about how they can help people find work. Emily has a serious mental health condition and has been under psychiatric care in the past. She was finding it difficult to find employment following a long period out of work and having limited job experience.

When she first approached the service, Emily's confidence was at an all-time low. A range of activities, have built up her confidence levels, including going out with staff to hand in her CV / speculative letters to employers and speak with managers about her skills. It took a few months, but she gradually regained her confidence.

Emily was supported to secure voluntary work at a charity shop. This developed her skills and she really enjoyed the work. The shop also enabled Emily to complete a customer service qualification. At this point, Emily said she felt great in herself and started to go out on her own and approach employers to apply for positions. As she has anxiety, she asked for help to support her at interviews.

Following an interview, Emily was offered a position as a housekeeper. She is now working 16 hours per week in this role and she can retain her benefits for a year to see how she gets on. Staff at the employment service continue to work with Emily in order to sustain her confidence and skills and promote her recovery.

Case study provided for this review by Rethink (www.rethink.org)

experiences of service users, carers and care co-ordinators. COCAPP-A found that there is positive practice taking place within acute inpatient wards with evidence of widespread commitment to safe, respectful, compassionate care, but the majority of service users and carers did not feel that they had been genuinely involved in the recovery process. Across both studies there was a lack of agreement in understanding of recovery and personalisation. The researchers recommended future research should focus on personalised, recovery-focused working and shared decision-making in risk assessment and management.

ENHANCING SOCIAL RECOVERY

People who were treated by early intervention services can go onto develop chronic social functioning problems that can persist into adulthood. Study (22) assessed the efficacy of early intervention services plus social recovery therapy in patients with first episode psychosis. The researchers conducted an RCT (SUPEREDEN3) at four early intervention services in the UK. The study found, after 9 months of intervention, those receiving social recovery therapy in combination with early intervention services showed clinically and statistically significant improvements compared to those receiving early intervention services alone. The findings suggest that social recovery therapy might be useful in improving functional outcomes in people with first episode psychosis. A larger more definitive trial is required to examine these effects over the longer term.

PSYCHOLOGICAL APPROACHES TO PROMOTING RECOVERY

Service users see recovery as a process of establishing hope, restoring sense of self and rebuilding their lives. Although recovery-orientated services are recommended for adult mental health, there is little evidence to support this. The overall objective of Study (23) was to complete a series of linked projects to understand and promote recovery from psychosis and bipolar disorder (BD) in a way that is acceptable and empowering for

SUPPORTING THROUGH WORK

Martin has a diagnosis of schizophrenia. Previously he was a poly-substance user and this caused him to become mentally unwell. In 2010 he had a relapse of his mental health and during that time he was detained by the police on two occasions, with incidents of challenging and violent behaviour, at times requiring rapid tranquilisation by staff.

Martyn stopped taking illegal substances in 2011 and completed three years with the early intervention team before residential care followed by supported independent living from a specialist team.

The very nature of Martyn's mental illness meant that, for him, without proper structure and input he would quickly become alienated and disengaged. Staff supported Martyn to continue to play football with the Early Intervention Team, pay his bills and set up support plans for him. This went well at first but slowly Martyn appeared to lose confidence, became anxious and refused to go. Other support plans fell by the wayside as Martyn went in on himself mentally. It became an effort for him to open his door and a short time later, even to see his family.

His medication was looked at and tweaked several times. Martyn would meet with staff but mostly on his terms and when he was ready. His anxiety became so bad that he was unable to attend groups for more than five minutes and when he did he would be shaking with anxiety.

It was important that staff kept regular contact with him and to challenge him when his standards of personal care and flat tidiness slipped. Staff were not always successful in attempts to empower him through this period, but persisted in trying.

Eventually with the correct level of medication and staff support, Martyn's quality of life slowly began to improve. He regained contact with his family, eventually going to them for Sunday dinners, Christmas and having the occasional holiday abroad with them. He quit smoking, a remarkable achievement for someone whose anxiety was so great that he chain smoked.

It took a lot of work and gentle steps to get Martyn back to a place where his anxiety didn't overtake him so drastically and where he could function well from day to day.

Case study provided for this review by Rethink (www.rethink.org)

service users. The programme consisted of 6 linked projects to (i) generate a concept of recovery from a service user's viewpoint, (ii) address the gap in the knowledge regarding subjective judgement of recovery; (iii) examine preferences for psychological treatment using a patient preference trial; (iv) explore the psychological mechanisms underlying the link between experience of psychosis and suicidal ideations; (v) understand the subjective recovery experiences of people with recent BD and (vi) develop a novel measure of recovery in BD and a new intervention for early BD.

All projects were conducted in collaboration with service users and the research team included two service user researchers. The research provided significant advances in the understanding and facilitation of recovery in both psychosis and BD, and a number of implications for clinical practice emerged from this research programme.

SELF-MANAGING MENTAL HEALTH

Digital technology is changing the way people learn about and manage their illnesses, but little is known how people with SMI seek information about their mental health on the web. Study (24) investigated online mental health information-seeking behaviour by people with psychosis and the acceptability of a mobile mental health digital application. Twenty-two people with psychosis were interviewed for this study. The researchers found that internet use was widespread among the interviewees, particularly seeking information about their psychosis, diagnosis, medication and side effects. Some people discussed the information with their clinicians, but some did not for fear of undermining their clinician's authority. The researchers concluded that a partnership approach to online health-information is needed where clinicians encourage patients to discuss information they have found online as part of a shared decision-making process. The findings also suggest that a mental health app would be well received.

Study (25) evaluated a Web-based Enhanced Relapse Prevention (ERP) intervention, which is a structured intervention for mental health staff to deliver face to face.[73] ERP is a psychological intervention specifically developed for adults with bipolar disorder (BD) and has been shown to improve symptoms and prevent relapses and hospitalisation.[74] A single-blind, parallel, primarily online RCT (n=96) over 48 weeks compared ERPonline plus usual treatment, with "waitlist control" plus

usual treatment for people with BD. The researchers found that web-based interventions may prove an important, inexpensive, feasible, and acceptable step forward in creating a choice of evidence-based interventions for people with BD at different stages of recovery. However, given high functioning and low relapse rates in this study, testing clinical effectiveness for this population would require very large sample sizes.

Five Year Forward View for Mental Health encourages the involvement of people with mental health problems in decisions about their long-term care, for example recommending that patients be more involved in medication reviews. The National Institute for Health and Care Excellence (NICE) guidelines on the treatment of schizophrenia emphasise the importance of doctors and patients making collaborative decisions about drug treatment, based on informed discussion. The Medication Review Tool consists of a form to help patients identify pros and cons of their current antipsychotic treatment and any desired changes that they may have. Study (26) investigated the use of the Medication Review Tool by people with severe mental illness. The RCT allocated patients to either the Medication Review Tool or usual care. This was a small study and not large enough to provide definitive data, but it showed that it was possible to introduce a Medication Review Tool to improve patients' ability to take part in discussions and decisions about their antipsychotic medication.

Many people with schizophrenia experience periods of active psychosis followed by periods of relative stability (although auditory hallucinations may remain in the background). Training techniques can teach people with schizophrenia how to detect and recognise the early warning signs of mental illness. Studies indicate that if a person with schizophrenia is able to notice even small changes in signs and symptoms, this can predict illness and relapse, and enable help-seeking to prevent or delay relapse. Study (27) evaluated prior research in interventions to train people with schizophrenia to recognise early warning signs of psychosis for its effectiveness. The study found that the evidence suggests there are positive benefits of early warning signs training, such as reducing rates of relapse and hospitalisation, however the overall quality of the evidence was judged to be very low, so it was not possible to conclude that early warning signs interventions would have the same beneficial effects in the population.

ACTIVELY MANAGING PERSONAL NETWORKS

People's personal networks are important in shaping identity, and for people with SMI, are important for recovery, but the social aspects of living with SMI, such as friendship and wider connectedness, are not prioritised sufficiently by services. Study (28) investigated the personal networks of people with severe mental illness made up of connections to people, places and activities and their impact on wellbeing. The purpose was to describe personal wellbeing networks, looking for differences in network structure, people's ability to utilise and exchange resources, and to understand the role of practitioners in personal wellbeing network development. Data were collected from 150 network-mapping interviews and 41 in-depth follow-up interviews with people with SMI; in-depth interviews with 30 organisation stakeholders and 12 organisation leaders; and 44 telephone interviews with practitioners. While this exploratory study has limitations, the findings suggest that there is potential for people with severe mental illness and practitioners to use the personal wellbeing network mapping approach to support recovery.[75]

PEER SUPPORT WORKERS

Peer support worker roles are increasingly being employed in the mental health workforce, mainly in the NHS and the voluntary sector, using their experience for the benefit of other people with mental health problems. However, the evidence demonstrating the benefit of peer worker-based interventions has largely been inconclusive and from outside the UK. Study (29) interviewed 89 peer workers, co-workers, managers and service users about their views and experiences of the peer worker role. The employment of service user researchers to carry out the research was fundamental to this project and especially relevant to peer support research. Two service user researchers conducted key aspects of data collection and analysis, and people with lived experience of using mental health services were core members of the research team, designing and leading the research. The most important issues found were around valuing and supporting peer workers to use their personal experiences of mental health problems. The researchers concluded that organisational cultures need to change to support the adoption of new peer worker roles.

CO-PRODUCTION AND ENGAGING SERVICE USERS

Early literature suggests that NHS service users struggled to have a real impact on decision-making at either individual or strategic levels. Over the last decade, mental health services have been at the forefront of involving service users in decision-making about services. Study (30) investigated the impact of service user involvement in mental health in terms of service development, delivery, commissioning and personal benefit to users. The same question was asked of front line staff. Other research questions asked managers about their response to user-led organisations, investigated the role of users as governors on trust boards, and the implications of personalisation in health and social care. The researchers concluded that service users have become an integral part of the system, described as a new social movement that has changed in the last 30 years due to organisational change and complexity. However, the researchers raised concerns about personalisation (a way in which service users may control their own care) as the team could locate very few mental health service users who actually had personal budgets. In all the organisations studied, peer support was a critical factor.[76]

ONGOING RESEARCH

There are a number of research programmes underway to explore aspects of recovery and self-management. These include development of an intervention to expand the social networks of patients with psychosis and test impact on patient outcomes and wellbeing (Study O). Another study is looking at the best way of delivering recovery-focused early intervention services (Study P). The role of volunteers in mental health services will be explored, including testing of a particular befriending scheme and its impact on outcomes (Study Q). Recognising that carers and families are not always involved in planning care, a study will combine observational work for insights on why this does not happen with interventions to train mental health staff and methodological work to provide better measures of family involvement (Study R). A research programme is also carrying out a large trial of peer workers to support discharge from hospital to the community for people with severe mental illness (Study S).

LOOKING AHEAD

This review has highlighted a range of research funded by NIHR to support people living with severe mental illness. These include studies at different stages, from early intervention through to supporting longterm recovery and wellbeing. Evidence in this review show the strengths of different research methods to provide insights into the experience of care and evaluate services. The last ten years has seen more research into treatment and care for people living with SMI.

But there are still important gaps in what we know. During the course of this review, some areas have been identified where more research is needed. This is not a systematic analysis, but indicates just some of the areas of continuing uncertainty. This ranges from greater understanding of the social determinants of severe mental distress to research into the access and effectiveness of services for particular black and minority ethnic groups. We need more high quality evaluations of different organisational models and their cost-effectiveness, including approaches such as peer worker support. We do not know enough about the relationship between nurse staffing and outcomes, especially safe levels on acute inpatient wards. Important work has been done to understand the experience of those using services[77] and this could be enhanced to get new insights into quality of care. And new methods will be helpful, including participatory research involving communities and led by service user researchers.[78]

In a more systematic way, the James Lind Alliance (JLA) has identified particular priorities in relation to schizophrenia and bipolar disorder. These relate to specific treatments, as well as broader service questions. The JLA Priority Setting Partnerships bring together clinicians, patients and carers to agree research priorities through a structured and careful process to identify the most important gaps in knowledge. The following priorities have informed and will influence future research supported by NIHR and other funders.

At the end of 2017, NIHR launched a themed call on mental health across its programmes[40]. Building on good work already completed, new research should strengthen our knowledge on what works to support people with severe mental illness to live their best lives.

James Lind Alliance top 10 research priorities for Schizophrenia (2011)

1. What is the best way to treat people with schizophrenia that is unresponsive to treatment?
2. What training is needed to recognise the early signs of recurrence?
3. Should there be compulsory community outpatient treatment for people with severe mental disorders?
4. How can sexual dysfunction due to antipsychotic drug therapy be managed?
5. What are the benefits of supported employment for people with schizophrenia in terms of quality of life, self-esteem, long-term employment prospects and illness outcomes?
6. Do the adverse effects of antipsychotic drugs outweigh the benefits?
7. What are the benefits of hospital treatment compared with home care for psychotic episodes?
8. What are the clinical benefits and cost-effectiveness of monitoring the physical health of people with schizophrenia?
9. What are the clinical, social and economic outcomes - including quality of life and the methods and effects of risk monitoring - of treatment by acute day hospitals, assertive outreach teams, in-patient units, and crisis resolution and home treatment teams?
10. What interventions could reduce weight gain in schizophrenia?

James Lind Alliance top 10 research priorities for Bipolar Disorder (2016)

1. What causes bipolar disorder?
2. How can treatments be tailored to individuals?
3. What is the most effective combination of self-management approaches, therapy and medication?
4. What are the best ways to manage suicide risk among people with bipolar disorder?
5. What could be done for people who do not get better with treatment?
6. What are the best ways to manage the side-effects of medication (including weight gain, problems with thinking and memory, and emotional numbness)?
7. Why does it take so long to get a diagnosis of bipolar disorder, and how could time to diagnosis be shortened?
8. Which are the best medications for treating episodes and for prevention of relapse in bipolar disorder?
9. How effective are talking therapies such as counselling, dynamic psychotherapy and cognitive behaviour therapy (CBT)?
10. Can medications with fewer side-effects be developed?

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STUDY SUMMARIES AND REFERENCES

STUDY SUMMARIES - PUBLISHED

STUDY 1

Understanding Causes and Developing Effective Interventions for Schizophrenia and Other Psychoses.

Published, 2016, Jones/Perez

This randomised controlled trial evaluated an intervention to enable general practices to identify and refer young people at high risk of developing psychosis. The researchers developed the Liaison with Education and General PracticeS (LEGS) intervention and looked at whether this led to more people at high risk, being referred by GPs to an early intervention service. General practices in Cambridgeshire and Peterborough were randomly assigned to receive either low-intensity liaison (28 practices), which was a postal campaign to help with identification and referral, or high-intensity liaison (26 practices), which included a specialist mental health professional to liaise with each practice as well as the postal campaign. The intervention was run between 2010 and 2013. The primary outcome was the number of high risk referrals per practice. The researchers found that the high intensity intervention doubled GPs' identification and referral of young people with high risk mental states as well as those with first episode psychosis and other mental health problems. Cost analysis indicated this intervention had clinical and economic value. The researchers also followed 60 young people (aged 16-35 years) at high risk for 2 years in the Prospective Analysis of At-risk mental states and Transitions into psycHosis (PAATH) study. Only three individuals transitioned to first episode psychosis. Most of the participants at high risk had significant depression and anxiety and many had suffered childhood trauma. Such early identification means services can offer appropriate and timely treatment. The researchers examined the incidence of new referrals for psychosis, finding considerable psychosis morbidity in diverse, rural communities. They also developed the population-level prediction tool, PsyMaptic, to estimate the numbers of young people who require early-intervention services across the country.

Programme Grants for Applied Research 2016. https://doi.org/10.3310/pgfar04020

STUDY 2

Reducing duration of untreated psychosis: care pathways to early intervention in psychosis services.

Published, 2013, Birchwood

This study looked at the care pathway components to understand the duration of untreated psychosis (DUP) and their links with delays in accessing specialised Early Intervention Services (EIS) in Birmingham. The researchers collected data on 343 individuals aged 14-35 years with first episode psychosis (mean age of onset was 21.6 years). The researchers also conducted interviews with 14 families. The median DUP was 50 days. They found that a third of individuals had a DUP of more than 6 months. The main contribution to DUP was found to be from delays within mental health services, followed by help-seeking delays. A delay in reaching EIS was correlated with longer DUP. Delays were often caused by under-recognition of symptoms, poor disclosure and/or disengagement with services. These findings led to changes in local services, including a new clinical youth service in South Birmingham for young people (aged 16-25 years) who display signs of emotional or mental distress. In addition, a media-based public health campaign was implemented, aimed at reducing the stigma associated with mental illness and improving help seeking behaviour particularly in young people.

British Journal of Psychiatry 2013. https://doi.org/10.1192/bjp.bp.112.125500

STUDY 3

Don't turn your back on the symptoms of psychosis: a proof-of-principle, quasi-experimental public health trial to reduce the duration of untreated psychosis.

Published, 2016, Connor

This study looked at the feasibility and impact of a new youth access pathway for first episode psychosis, enabling direct access to Early Intervention Services (EISs) to reduce duration of untreated psychosis (DUP) in Birmingham. The intervention 'Youth Space' consisted of a direct care pathway for 16-25 year olds to access EISs, and a community psychosis awareness campaign including raising community awareness in the community, a youth-friendly website, a psychosis information line, and youth advisors. The intervention targeted help-seeking behaviours and mental health services delays. It provided prompt clinical assessment in a youth appropriate setting, rapid access and expert assessment, provision of brief CBT (cognitive behaviour therapy) and home visits for repeat non-attendance. The researchers evaluated the intervention by comparing DUP in two areas of the city receiving early detection (n=77) vs detection as usual (n= 74). The researchers found that DUP in the intervention area was reduced from a median of 71 days (mean 285) to 39 days (mean 104). There was no change in the control area. Delays in help seeking behaviour was also reduced in the intervention area. The researchers concluded that their intervention is a feasible approach to address DUP. Further research is needed to evaluate its effectiveness.

BMC Psychiatry 2016. https://doi.org/10.1186/s12888-016-0816-7

STUDY 4

Early detection of psychosis via community and educational organisations: a feasibility study.

Published, 2015, Lloyd-Evans

This study implemented a one-year community awareness programme in an inner London Early Intervention Service (EIS), which targeted staff in non-health service community organisations. The aim was to reduce treatment delay for people experiencing first episode psychosis. The programme included psycho-educational workshops and offered direct referral routes to EIS. It targeted staff working with young people in non-health organisations (for example housing and employment services and youth organisations). It ran for a year from 2009-2010. The researchers evaluated programme feasibility and impact on duration of untreated psychosis. Forty-one workshops at 36 community organisations were attended by 367 staff. A further 19 follow up workshops were run, and 16 services were allocated an EIS link worker. EIS link workers offered monthly meetings and point of contact for each organisation. Staff knowledge and attitudes to psychosis and mental health services improved significantly after the workshops, however, only 6 of 110 new service users reached EIS directly via community organisations a year after the intervention. As well as finding the intervention led to very few new referrals through non-health pathways, there was no significant difference in mean or median duration of untreated psychosis for new referrals to the service in the year of the intervention, compared to the year before. Discussions with stakeholders (including front-line staff, managers and services users) highlighted that barriers to referrals still remained, including uncertainty about the early signs of psychosis and disengagement by young people when they became unwell. The authors concluded that further research is needed to identify ways in which duration of untreated psychosis can be reduced.

BMC Psychiatry 2015. https://doi.org/10.1186/s12888-015-0485-y

STUDY 5

Improving outcomes for people in mental health crisis: a rapid synthesis of the evidence for available models of care.

Published, 2016 Paton

This review looked at the clinical effectiveness of the models of care for improving outcomes at each stage of the Crisis Concordat pathway. The Crisis Concordat, a national agreement between services involved in the care of people in crisis, was established to improve outcomes for people experiencing a mental health crisis. The four stages of the crisis care pathway are: access to support before crisis point, emergency access to crisis care, quality treatment and care in crisis, and promoting recovery. The researchers searched the literature for evidence around the care pathway, and located one review of reviews, six systematic reviews, nine guidelines and 15 primary studies. The evidence for access for support before crisis point was very limited. There was evidence of benefits for liaison psychiatry teams in improving service-related outcomes in emergency departments, but the evidence was not of high quality. Similarly, there was limited evidence regarding models to improve emergency access to crisis care to guide police officers with reference to their Mental Health Act responsibilities. There was a large evidence-base promoting recovery with various interventions recommended by NICE. The researchers concluded that many of the studies were of low quality and many gaps were identified along the crisis care pathway. More UK research is needed on the clinical effectiveness of crisis care, especially interventions to prevent people reaching crisis point and recovery options for individuals attending specialist mental health hospital care.

Health Technology Assessment 2016. https://doi.org/10.3310/hta20030

STUDY 6

The city 128 extension: locked doors in acute psychiatry, outcome and acceptability.

Published, 2008, Bowers

This study looked at the issue of locked doors in adult psychiatric wards. The researchers examined routinely collected data as well as conducted interviews and surveys. From 2004 to 2005, a survey of 136 wards was undertaken, collecting information of patients, staff, service organisation, and containment events including door looking, absconding and drug/alcohol use. The researchers conducted interviews from three sample wards (35 individuals) with patients, staff and visitors. Absconding rates across all wards were very low (0.49 mean daily rate). Exit security was found to make significant use of technology, such as swipe cards, CCTV, key pads and intercoms. Most wards had exits that automatically unlock for fire alarms, and fire exits that could be released by patients. A third of wards had double exit doors. The study found that there was no relationship between absconding rates and exit security. Interviews indicated that patients did not feel informed about door locking policies and knowledge was gained through personal discovery. Both staff and patients had a clear view of the vulnerability of patients who absconded. Overall, the researchers concluded that locking the ward door reduced but does not eliminate absconding. Door locking increased feeling of social exclusion and depression, and associated with an increased risk of self-harm, but had no effect on alcohol or illicit drug use. The researchers recommend that acute admission wards should have a single main exit, unlocked during the day, with maximum visibility to the staff. Patients and families/friends should be informed about the door policy.

Report for the National Co-ordinating Centre for NHS Service and Organisation R&D. 2008. www.journalslibrary.nihr.ac.uk/programmes/hsdr/081604163/#/

STUDY 7

Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial.

Published, 2015, Bowers

This study evaluated ten Safewards interventions that enable staff to reduce the frequency of patient incidents in acute psychiatric wards that may threaten safety. The Safewards model highlights various staff actions that can impact on conflict or containment. The researchers recruited staff and patients in 31 psychiatric wards and 9 NHS trusts. Wards in the intervention arm implemented a package of ten Safewards interventions, which included mutually agreed standards of behaviour by and for patients and staff, how to manage flashpoints, regular patient meetings and a set of self-management tools for staff to offer patients who were distressed, such as hand oils, stress reducing items and light displays. The primary outcomes were the rates of conflict and containment. They found that these simple interventions aimed at improving staff and patients ward experience could significantly reduce the frequency of conflict and containment. For example, for shifts with conflict or containment incidents, the intervention condition reduced the rate of conflict events by 15% relative to the control intervention. The rate of containment events for the intervention condition was reduced by 23%. However, there was a large quantity of missing data in the intervention and control arms, and the intervention was only delivered for a short time period (3 months). Nonetheless, the researchers concluded that Safewards interventions can provide positive gains for staff and patients and recommended that a further trial is needed to determine replicability of the results.

International Journal of Nursing Studies, 2015. https://doi.org/10.1016/j.ijnurstu.2015.05.001.

STUDY 8

Seclusion and psychiatric intensive care evaluation study (SPICES).

Published, 2017, Bowers

The researchers examined the patient records of one NHS trust (2008-2013) to look at the outcomes of patients who were secluded (locked in a robust room alone) or transferred to a specialist high security ward with a high staff-to-patient ratio (PICU). These interventions are two methods for the management of disturbed behaviour of psychiatric patients in acute psychiatric hospitals. Compared to patients who were not subject to these interventions, the researchers found that these patients were more likely to be aggressive again afterwards, and their care needs also tended to be more expensive. However, the researchers noted that cause and effect cannot be conclusively determined. In a second study, the researchers interviewed 81 nurses at eight hospitals in England with and without seclusion rooms and on-site PICUs. The nurses also had a video test on restraint-use timing. When there was no seclusion available, the nurses used more rapid tranquillisation, nursing the patient in a side room and seclusion in an ordinary room. Hospitals without PICUs used more seclusion and de-escalation. Overall, this project found that the availability of seclusion and PICUs influences how disturbed behaviour is managed. However, the authors caution that it remains unclear as to whether these interventions reduce or worsen violence.

Health Service Delivery Research 2017. https://doi.org/10.3310/hsdr05210

STUDY 9

Understanding the increasing rate of involuntary admissions in NHS Mental Health Care.

Published, 2014, Weich

This study examined the rate of compulsory admission to inpatient mental services in England in 2010/11. The researchers accessed data from the Mental Health Minimum Data Set, and the analysis included 1,287,730 patients. Compulsory admission was defined as time spent in an inpatient mental illness bed subject to the Mental Health Act (2007). Patients were excluded if they were detained due to emergency assessment only, guardianship or supervision of community treatment. The researchers also consulted with users of mental health services, carers, and senior NHS mental health service managers and clinicians. The researchers

found that 3.5% of patients had at least one compulsory admission; 84.5% of the variance in this outcome were based on individual characteristics, whist 6.7% variance was between local areas, 6.9% between provider trusts and 2.7% between GP practices. The data showed that patients of black ethnicity were almost three times more likely to have compulsory admission compared to white patients. Compulsory admission was greater in socioeconomically deprived areas. The authors recommend that future research should look at the causes of observed variance in compulsory admission rates and should take a mixed-methods approach.

Health Service Delivery Research 2014.
https://doi.org/10.3310/hsdr02490

STUDY 10

Inpatient and residential alternatives to standard acute psychiatric wards in England.

Published, 2009, Johnson

The aim of this research was to identify and describe all inpatient and residential alternatives to standard acute psychiatric wards in England. The researchers carried out a national cross-sectional survey of alternatives to standard acute inpatient care. They found 131 such services, most of which were hospital-based and in deprived areas. Community-based service types included clinical crisis houses, specialist crisis houses, crisis team beds, and non-clinical alternatives managed by the voluntary sector. Hospital-based service types included general therapeutic wards, wards for specific groups and short-stay wards. Some types of care available within hospital services were less likely to be provided in community alternatives, such as psychological treatments, structured activity programmes and medication review. The researchers concluded that standard acute psychiatric wards represent an important, but unevaluated, sector of mental health services.

The British Journal of Psychiatry, 2009.
https://doi.org/10.1192/bjp.bp.108.051698

STUDY 11

An investigation of therapeutic alliance and its relationship to service user satisfaction in acute psychiatric wards and crisis residential alternatives (TAS 2).

Published, 2014, Sweeney

This mixed-methods study interviewed service users who had attended crisis houses and acute psychiatric wards to better understand their experiences of staff-service user relationships. The researchers collected quantitative data from 108 individuals (regardless of diagnosis) who had been a resident in a crisis house for at least 1 week. Data was also collected from 247 participants who had been resident in acute wards for a minimum of 2 weeks. Qualitative interviews were conducted with 29 service users and 16 staff from acute wards and crisis houses. Hospital patients were more likely to be diagnosed with schizophrenia, and crisis house residents more likely to be diagnosed with personality disorder or depression. The researchers used a variety of quantitative measures such as the Client Satisfaction Questionnaire and Recovery Assessment Scale, and interviews covered respondents' views about the characteristics of good staff-service user relationships and factors that promoted or hindered good relationships. Overall, the researchers found that respondents experienced better therapeutic relationships between staff and service users and felt greater satisfaction with crisis houses than acute wards. The researchers found that diagnostic and demographic characteristics were not associated with satisfaction, suggesting that service user satisfaction was related to their surroundings. Good therapeutic relationships were characterised by kind, warm and empathic staff. These results reflect previous findings concerning greater satisfaction with crisis houses.

Health Service Delivery Research 2014.
https://doi.org/10.3310/hsdr02220

STUDY 12

An evidence synthesis of risk identification, assessment and management for young people using tier 4 inpatient child and adolescent mental health services.

Published, 2015, Hannigan

This study was an evidence synthesis on what is known about the identification, assessment and management of risk in young people (11-18 years) with complex mental health needs entering, using and exiting tier 4 inpatient child and adolescent mental health services in the UK. First, the researchers scoped the literature from two databases, to identify the types of risks faced by this group of individuals. An analysis of this literature (124 articles) was supplemented by input from a range of stakeholders including young people who had been inpatients, carers, managers and professionals. This led to the identification of two risk areas: dislocation and contagion. The researchers defined dislocation as the risks of being removed from normal life, of experiencing challenges to identity and of being stigmatised, and risks to family, friendships and education. Contagion referred to the risks of learning unhelpful behaviour and making unhelpful relationships. The researchers then searched 17 databases and relevant websites for evidence around these two risks, including outcomes, costs, policies and service responses. Forty articles were identified along with 20 policy and guidance documents. From this data set, the researchers concluded that there is little evidence to support the identification, assessment and management of the dislocation and contagion risks. However, the studies were often of limited quality and none had a cost analysis. The documents did indicate that young people undergoing treatment within inpatient settings should be able to lead as normal a life as possible. More research is now required to better understand these less obvious risks.

Health Service Delivery Research 2015.
https://doi.org/10.3310/hsdr03220

STUDY 13

Early phase treatment for the prevention of relapse in first episode schizophrenia.

Published, 2013, Marshall

This study evaluated three exploratory randomised controlled trials aimed at preventing relapse and/or deterioration in physical health in people with first episode psychosis. All trials took part in the north-west of England with participants aged 16-35 years who had recently experienced a first episode of psychosis. The three trials were: 1) cognitive remediation (CR) to improve metacognition and enhance engagement in subsequent cognitive behaviour therapy (CBT), with 61 participants drawn from a waiting list of people referred to routine CBT; 2) a healthy-living intervention to control weight in individuals taking antipsychotic medication, where participants (105) were required to have a body mass index (BMI) of ≥25 kg/m2; and 3) integrated motivational interviewing and CBT (MiCBT) to reduce cannabis use, where participants (110) were diagnosed with cannabis use/dependence. CR involved 13 sessions over 12 weeks, the healthy living intervention consisted of 8 face-to-face session plus group activities over 12 months, and MiCBT was delivered as brief (12 sessions over 4.5 months) or long (24 sessions over 9 months) formats. Overall, there was no effect of CR on psychotic symptoms, but the amount of CBT subsequently required was significantly less after CR. There was no significant BMI reduction in the healthy-living trial. Outcome data for the MiCBT trial was not yet reported. Although none of the trials had significant success, the researchers concluded that CR required more research.

Programme Grants for Applied Research 2015.
https://doi.org/10.3310/pgfar03020

STUDY 14

Financial incentives to improve adherence to antipsychotic maintenance medication in non-adherent patients - a cluster randomised controlled trial: FIAT.

Published, 2016, Priebe

This randomised controlled trial looked at the use of incentives for attending appointments to receive antipsychotic medication (injections) by individuals with schizophrenia. The researchers recruited participants (aged 18-65 years) who had a diagnosis of schizophrenia, schizoaffective psychosis or bipolar illness, receiving ≤75% of their prescribed medication. Seventy-three mental health teams participated from 29 NHS trusts, and 141 patients consented to take part (78 intervention and 63 control). The intervention lasted for 12 months, with a 24 month follow-up. Participants in the intervention group received £15 for each medication appointment they attended, whilst the control group received treatment as usual. Outcome data was available for 131 patients. Baseline adherence (attending medication appointments) was 69% in the intervention group and 67% in the control group, and during the intervention adherence was significantly higher in the intervention group (85% versus 71%). Once the money was stopped, adherence was then similar across both groups with no significant difference 6 months and 24 months follow-ups. The average cost of the incentive was £303, but costs between the intervention and control group were not significantly different. The researchers interviewed 45 patients and 59 clinicians; both groups felt positive about the incentive, although a few patients felt guilty about accepting the money. The authors concluded that financial incentives can be an effective way of improving medical adherence and is also cost-effective.

Health Technology Assessment 2016.
https://doi.org/10.3310/hta20700

STUDY 15

Family involvement in the treatment of patients with psychosis.

Published, 2014, Eassom

This systematic review looked at the barriers and facilitators to family involvement in the treatment of patients with psychosis. Forty-three studies were included, 23 based in the UK and 32 focused only on staff perspectives. The papers included data from 588 professionals, 321 patients and 276 family members. Most studies were cross-sectional and 13 were naturalistic observations. Many papers discussed the use of the behavioural family therapy approach, psychosocial interventions or family psychoeducation. The researchers found that facilitating the training and ongoing supervision needs of staff are necessary but not sufficient conditions for consistent family involvement. Lack of resources, poor support from managers and de-valuing or de-prioritising family work were all key barriers to family involvement. Strong leadership, whole team coordination, active collaboration with families and ongoing support are important facilitators for effective involvement. The researchers concluded that organisational cultures can hinder or facilitate involvement, and suggested that family involvement is only successful when there is a shared goal of all members of the clinical/services team and enabling working practices.

BMJ Open 2014. https://doi.org/10.1136/bmjopen-2014-006108

STUDY 16

Smoking Cessation Intervention for severe Mental Ill Health Trial (SCIMITAR): a pilot randomised control trial of the clinical effectiveness and cost-effectiveness of a bespoke smoking cessation service.

Published, 2015, Peckham

The aim of this pragmatic, two-arm, parallel-group, pilot RCT was to develop and test a bespoke smoking cessation (BSC) service specifically tailored to individual patients with severe mental illness. The overarching objective was to establish the clinical effectiveness and cost-effectiveness of the BSC intervention compared with usual general practitioner (GP) care. The BSC service was delivered by a mental health professional trained to deliver smoking cessation behavioural support, who provided an individually tailored smoking cessation service based on current guidelines for smoking cessation services but with enhanced levels of contact and support. Participants randomised to usual GP care were advised to see their GP or to consult with usual NHS quit smoking services with no specific adaptation or enhancement in relation to SMI. The primary outcome was carbon monoxide (CO)-verified smoking cessation at 12 months. In the absence of a CO measurement, self-reported smoking cessation was used. Aspects of health economics and service utilisation were collected by questionnaire in order to measure cost-effectiveness. At 12 months, 36% of participants had stopped smoking in the BSC group, compared with 23% in the usual-care group. The adjusted odds ratio was 2.9 (95% confidence interval 0.8 to 10.5) indicating a greater likelihood of smoking cessation in the BSC group than the usual-care group, but this was not statistically significant. Estimates of effect based on an underpowered pilot trial show a direction of effect across a range of outcomes that are in favour of a BSC intervention. There was some evidence of lowered mood in the BSC intervention and this issue needs to be explored further in a fully powered trial.

Health Technology Assessment 2015.
https://www.journalslibrary.nihr.ac.uk/hta/hta19250/#/abstract

STUDY 17

The effectiveness of sexual health interventions for people with severe mental illness: a systematic review.

Published, 2014, Kaltenthaler

This systematic review evaluated the effectiveness of sexual health risk reduction interventions for people with severe mental illness living in the community. The researchers included 13 randomised controlled trials, all based in the USA, that compared sexual health risk reduction interventions with usual care. The content of the interventions varied between studies, however, most included HIV intervention programmes (that focused on providing education to prevent or reduce the risk of HIV and strategies and skills development for safer sex). Interventions were generally delivered by trained facilitators, mental health counsellors or mental health professionals, and lasted from 4 to 15 sessions. Standard usual care included HIV educational sessions, health promotion, money management, waiting list or no treatment. The researchers used a narrative synthesis approach to combine the research findings. There was no clear and consistent evidence that the interventions reduced the total number of sex partners or improved behavioural intentions in sexual risk behaviour. However, the evidence indicated that the interventions had a positive effect on attitudes about and use of condoms, measures of HIV knowledge, sexual behaviours and practices. However, the researchers caution that the results are not robust given the large variability between studies, small sample sizes and low quality of studies. They recommend that high quality, well-designed UK based trials are needed in this important area.

Health Technology Assessment 2014.
https://www.journalslibrary.nihr.ac.uk/hta/hta18010/#/abstract

STUDY 18

The Rehabilitation Effectiveness for Activities for Life (REAL) study: a national programme of research into NHS inpatient mental health rehabilitation services across England.

Published, 2017, Killaspy

This research programme investigated NHS inpatient mental health rehabilitation services across England. Scoping work

indicated that quality of care in NHS mental health rehabilitation services in England is higher than similar facilities across Europe. The researchers initially conducted a national survey of relevant NHS services, and 133 Trusts across England took part. Most inpatient mental health rehabilitation units were community based, providing on average 14 beds and had an average length of stay of 18 months. Most service users had a diagnosis of psychosis. The researchers also developed and evaluated a 'hands-on' staff training programme to help staff engage service users in activities on and off the unit. They recruited 40 units that scored below average on quality assessment measures from the survey. The main findings of the programme showed that quality of care was positively associated with service users' autonomy, experiences and perceptions of therapeutic care. The staff training intervention was found not to be clinically effective as staff reverted to previous practice once the intervention team left. However a realist evaluation identified feasible adjustments to strengthen it. Over half the service users in the cohort study were successfully discharged from hospital over 12 months. Factors associated with this were service users' activity levels, social skills and the recovery orientation of the unit (which includes collaborative care planning with service users and holding hope for their progress). The study provides evidence that NHS mental health rehabilitation services deliver high-quality care that successfully supports service users with complex needs in their recovery.

Programme Grants for Applied Research 2017.
https://www.ncbi.nlm.nih.gov/books/NBK425139/

STUDY 19

Improving employment outcomes for young people with first episode psychosis.

Published, 2014, Craig

This study assessed whether a motivational interviewing intervention for clinical staff could enable them to provide better occupational choices for their patients. Four early intervention teams based in London and the Midlands, who already provided individual placement and support (IPS), were selected to take part. All teams had a vocational specialist who provided employment support based in the IPS model. Two teams were randomised to receive the intervention. The motivational interviewing technique focused on attitudinal barriers to employment, aimed at addressing staff concerns about the value and risks of return to open (competitive) employment. Staff receiving the intervention attended a 3 day course, with refresher sessions. The researchers recruited 159 participants, aged 18-35 years not currently in work or full-time education and expected to remain under the care of the early intervention service for at least the subsequent 12 months. Although not an inclusion criteria, all participants expressed a desire to return to work. Occupational outcomes were obtained from 134 patients (84%) at 12 month follow up. The researchers found that more patients in the intervention teams achieved employment by 12 months compared to the IPS-only teams (29/68 versus 12/66). The authors concluded that the motivational interviewing intervention successfully addressed clinicians' ambivalence about their patients returning to work suggesting that providing clinical staff with specific training in techniques to address service users (and their own) motivational conflicts may enhance their chances of competitive employment.

British Journal of Psychiatry 2014.
https://doi.org/10.1192/bjp.bp.113.136283

STUDY 20

Cross-national comparative mixed-methods case study of recovery-focused mental health care planning and co-ordination: Collaborative Care Planning Project (COCAPP).

Published, 2015, Simpson

This study looked at care planning and coordination in community mental health settings and whether it is organised to help people's recovery and whether this is carried out in a personalised way. The researchers identified six NHS trusts/ health board sites in England and Wales. They reviewed relevant policies and literature and surveyed staff and service users to explore their views on recovery, empowerment and therapeutic relationships (n=649). They also interviewed managers, clinical staff care coordinators, service users and carers (n=117) and reviewed 33 care plans. The researchers found that good relationships were important for all groups in care planning and supporting recovery but that service users did not always feel involved in their care and risk assessments were often kept from service users. Understandings of recovery and personalisation varied among the service users and staff and staff reported too much paperwork. The researchers cautioned that the survey response rate was low (between 9-19%). However, they concluded that new ways of working should be investigated to increase staff contact time with service users and carers, with a focus on recovery.

Health Service Delivery Research 2016.
https://doi.org/10.3310/hsdr04050

STUDY 21

Cross-national mixed methods comparative case study of recovery-focused mental health care planning in acute inpatient mental health settings (COCAPP-A).

Published, 2017, Simpson

This study looked at the care planning processes in acute mental health wards. The researchers focused on 19 mental health wards in six NHS sites in England and Wales. They conducted a survey of staff (n=290) and service users (n=301), case studies involving interviews with staff, service users and carers (n=76), and reviewed care plans (n=51) and care review meetings (n=12). Overall, the service users rated the quality of care and therapeutic relationships highly when the ward seemed to be more recovery-focused. Both service users and carers said that most care was good and individualised. Across all sites, staff rated the quality of therapeutic relationships as significantly higher than service users. Although staff highlighted the importance of involving service users in care planning, the interviews and care plan reviews indicated that this did not always happen. Staff were keen to help with recovery, but there were different understandings of recovery and a focus on recovery was considered more difficult when the service user was very distressed and/or had been detained under the law. A key priority for staff was keeping everyone safe, which was recognised by service users, although staff did not always discuss safety measures with the service users. The researchers concluded that this study highlighted the commitment to safe, respectful and compassionate care in mental health wards. They suggested that future research should look at ways in which staff can increase their contact time with service users to promote recovery-focused, personalised care.

Health Service Delivery Research 2017.
https://doi.org/10.3310/hsdr05260

STUDY 22

SUstaining Positive Engagement and Recovery (SuperEDEN) – the next step after Early Intervention for Psychosis.

Published, 2018, Fowler

This was an RCT to evaluate the efficacy of enhancing social recovery from First Episode Psychosis (FEP) by supplementing Early Intervention Services (EIS) with Social Recovery Therapy (SRT). The intervention took place at four specialist EIS in the UK. Participants (aged 16-35 years) had non-affective psychosis, attended EIS for 12-30 months, and had severe social disability (defined as being engaged in less than 30 hours per week of structured activity). EIS was provided by specialist teams, consisting of intensive recovery-oriented case management, supported employment, peer support

and family work, alongside CBT for psychosis and medication management. The SRT intervention was developed by the researchers as an outreach and case management package. SRT was delivered by a therapist and consisted of engaging the individual, assessing motivations and goals, preparing for new activities, and activity engagement. Participants were assessed at baseline, 9 months post-intervention and at 15 months follow up. The primary outcome was time spent in structured activity at 9 months. 154 participants took part, 75 were assigned to SRT plus EIS, and 79 assigned to EIS only. 143 participants provided data at 9 months. The study found that receiving SRT plus EIS was significantly associated with an increase in structured activity of 8.1 hours, greater than EIS alone. The authors concluded a more definitive trial with long-term follow up is now needed.

The Lancet Psychiatry 2018.
https://doi.org/10.1016/S2215-0366(17)30476-5

STUDY 23

Psychological approaches to understanding and promoting recovery from psychosis.

Published, 2016, Morrison

This programme of research aimed to understand and promote recovery in psychosis and bipolar disorder (BD), with service user involvement central to the programme. The researchers undertook six related projects to understand what is meant by recovery by individuals with psychosis and BD, how to measure recovery as defined by service users, what psychological factors promote recovery, how recovery, symptoms and psychological well-being are related, and the factors that may predict recovery. The researchers also conducted three interventions. The first intervention evaluated cognitive-behavioural (CB) approaches to guided self-help (89 participants). The second intervention evaluated CB therapy for understanding and preventing suicide in psychosis (49 participants), and the final intervention evaluated a CB approach to assist with recovery in recent onset BD (67 participants). Overall, the researchers developed feasible and valid measures of recovery. They found that factors such as reduced negative emotions, increased self-esteem and hope are predictive of recovery. The interventions they developed also showed beneficial effects for individuals with psychosis, suicidal thinking and BD. The researchers concluded that the interventions now required larger definitive trials to evaluate the effectiveness.

Programme Grants for Applied Research 2016.
https://doi.org/10.3310/pgfar04050

STUDY 24

App to support Recovery in Early Intervention Services (the ARIES study): Usability testing and pilot randomised controlled trial of a supported self-management smartphone application for psychosis.

Published, 2016, Aref-Adib

This study explored the use of online mental health information seeking. The researchers recruited 22 people with psychosis based in London (aged ranged from 21 to 57 years). They asked them about their current and historical use of online mental health information and their use of technology. The researchers found that the use of the internet to obtain mental health related information was widespread amongst the participants. Eighteen individuals used the internet to help them make sense of their psychotic experiences and their diagnosis, and also to seek information about their medication and its side effects. Two individuals discontinued their medication use because of the information they found, without discussions with their clinician. However eight individuals actively discussed the information with their clinician and this gave them a sense of empowerment and independence. The researchers concluded that individuals with psychosis are seeking information from the internet, and this could be used collaboratively with their clinician to guide their treatment. A partnership approach should be encouraged, as the gathering of such information could have impact in the patient's health care decisions. The researchers said there is scope for the development of a mental health app that could provide useful information.

BMC Psychiatry 2016. https://doi.org/10.1186/s12888-016-0952-0

STUDY 25

Assessing feasibility and acceptability of web-based enhanced relapse prevention for bipolar disorder (ERPonline): A randomised controlled trial.

Published, 2017, Lobban

This randomised controlled trial evaluated the feasibility and acceptability of a web-based enhanced relapse prevention intervention (ERPonline) for individuals with bipolar disorder. The researchers recruited 96 participants with bipolar disorder who were randomised to ERPonline or waitlist control (WL). ERPonline was developed with extensive input from individuals with bipolar disorder to adapt a manual-based format to a web platform and consisted of 12 modules. Participants interacted with the site so an individualised staying-well plan could be developed. The researchers found that access to ERPonline was associated with a significantly more positive model of bipolar disorder at 24 and 48 weeks, increased monitoring of early warning signs of depression at 48 weeks, and hypomania at 24 and 48 weeks. ERPonline did not impact on medication adherence or clinical outcomes, but relapse rates were low for both intervention and control groups. ERPonline cost £19,340 to create. The researchers concluded that the intervention provides an inexpensive and accessible option for people seeking ongoing support following successful treatment.

Journal of Medical Internet Research 2017.
https://doi.org/10.2196/jmir.7008.

STUDY 26

Development and preliminary evaluation of a Medication Review Tool for people taking antipsychotic medication.

Published, 2014, Moncrieff

The researchers conducted a pilot evaluation of a Medication Review Tool they developed to assist people to participate more effectively in discussion about antipsychotic drug treatment. The tool enabled patients to identify the benefits and disadvantages of their current antipsychotic treatment, and any changes they wanted to make. Participants also had access to a linked website containing information about medication. The researchers recruited participants diagnosed with psychotic disorders (18-35 years) from community mental health services. Sixty patients were randomised to receive either the Medication Review tool or usual care. When the patients attended their scheduled medical consultation, those in the intervention arm completed the tool with the assistance of a health professional and took the completed form to their consultation. The researchers used the Decision Self Efficacy scale (DSES) as the primary outcome measure. After 3 months, there was no difference on the scores of the DSES, symptoms, side effects, antipsychotic doses, or patient satisfaction. There was a small increase in positive attitudes to antipsychotic medication in patients who used the tool compared to the control group. Feedback from the patients indicated that they valued the tool as it enabled them to identify positive and negative aspects of their antipsychotic use. The researchers concluded a tool could be used by patients to discuss their medication and further research into this area is needed.

BMC Psychiatry 2016.
https://dx.doi.org/10.1186%2Fs12888-016-0921-7

STUDY 27

Training to recognise the early signs of recurrence in schizophrenia.

Published, 2013, Morriss

This review looked at the literature on the effectiveness of early warning signs interventions on time to relapse, hospitalisation, functioning and symptomatology. Early warning signs interventions are designed to train people with a diagnosis of schizophrenia to recognise early warning signs of recurrence episodes. This can include education, self-monitoring, and early action strategies such as seeking help early. The review included 34 studies involving 3554 people with schizophrenia or other non-affective psychosis over 16 years of age. The main findings indicated that there are positive benefits of training in early warning signs. It significantly reduced relapse rates compared to usual care (23% versus 43%) and significantly reduced re-hospitalisation compared to usual care (19% versus 39%). There was a lack of evidence on patient satisfaction and cost estimates. The researchers caution that training in early warning signs was mainly used alongside other psychological therapies, so it is difficult to untangle the most beneficial component parts. Furthermore, the researchers assessed the quality of the included studies to be low, so recommend future high quality research assessing the effectiveness of early warning signs interventions.

Cochrane Database of Systematic Reviews 2013.
https://doi.org/10.1002/14651858.CD005147.pub2

STUDY 28

Improving community health networks for people with severe mental illness: a case study investigation.

Published, 2015, Pinfold

This exploratory study looked at the personal wellbeing networks of individuals with severe mental illness (SMI) using an approach that explored a person's connections to all the places, activities and people that were important in their lives. The researchers collected network-mapping interview data from 150 individuals with SMI, and they subsequently interviewed 41 individuals from this cohort to explore how they managed and developed their connections over time. The researchers also interviewed 41 organisation stakeholder or leaders, and 44 practitioners. The researchers found three types of personal wellbeing networks in the data which they named diverse and active, family and stable, and formal and sparse. They found that wellbeing and social capital (access to resources) varied both within network types and between them. The researchers also found that whether a person lived alone or not, their housing status, formal education and long-term sickness or disability were significantly associated with a participant's network type. Whilst health-care practitioners recognised social factors as important for recovery, they highlighted system-level barriers that prevented them for addressing these fully. Such barriers included workload, administrative bureaucracy and limited time with clients. The researchers concluded that people with SMI could be better supported to develop their personal networks to benefit their well-being.

Health Service Delivery Research 2015.
https://doi.org/10.3310/hsdr03050

STUDY 29

New Ways of Working in mental health services: assessing and informing the emergence of Peer Worker roles in mental health service delivery.

Published, 2014, Gillard

This qualitative study used a comparative case study approach to explore the role of peer workers in a variety of settings. The researchers chose 10 different case settings, comprising mental health NHS trusts, voluntary sector service providers and partnerships between the NHS and voluntary sector or social care providers. Paid and unpaid peer workers were employed in a variety of roles in psychiatric inpatient settings, community mental health services and black and minority ethnic specific services. The researchers interviewed 89 participants including service users, peer workers, (non-peer) co-workers, line managers, strategic managers and commissioners. Interviews contained a range of questions to explore experiences and views about peer worker adoption and roles. The researchers used a framework approach to look at the data between different settings and groups. They found that whilst peer worker roles were more established in the voluntary sector, adopting such roles in the NHS posed a number of challenges to fit into existing cultures of practice. However, peer workers were able to bring their lived experiences into their roles, and could engage people in the services by building strong relationships. Overly formal role could result in a barrier to engagement. The researchers recommend more research is needed into the effectiveness of peer worker interventions and a cost analysis.

Health Service Delivery Research 2014.
https://doi.org/10.3310/hsdr02190

STUDY 30

How do managers and leaders in the National Health Service and social care respond to service user involvement in mental health services in both its traditional and emergent forms? The ENSUE study.

Published, 2014, Rose

This study investigated the extent of service user involvement (SUI) in mental health on shaping policy agendas and key decisions. The study took place in three NHS Foundation Trusts (FTs) in rural and urban areas. The researchers initially conducted a set of surveys with service users and found that there was high SUI, and they perceived that this produced a positive impact on service development and delivery. Frontline staff also encouraged SUI. The researchers then explored user-led organisations (ULOs), which showed they need to be flexible and adapt to a complex organisational culture. Rather than traditional styles of confrontation and campaigning, service users adopt more corporate and professional roles. The researchers also looked at the role of service user governors in NHS FTs, finding that they were working within a system of cultural norms but were beginning to organise collectively. The researchers concluded that service users and managers are working in a climate of dynamic and complex organisational change, where user involvement is an integral part. They indicate that has led to SUI as a new social movement. They suggest the next step is exploring how service users may personalise their involvement and take control of their own care.

Health Service Delivery Research 2014.
https://doi.org/10.3310/hsdr02100

STUDY SUMMARIES - ONGOING

STUDY A

Does better quality of primary care influence admissions and health outcomes for people with serious mental illness (SMI)? A linked patient-level analysis of the full patient care pathway.

Due to publish 2019, Jacobs

This study is looking at whether better management of serious mental illness (SMI) in general practice, improves outcomes for people with SMI. The researchers will make use of the Quality and Outcomes Framework (QOF) indicators, which were introduced in 2006 whereby general practices receive financial rewards for achieving specific quality targets for different conditions. The researchers will measure the quality of SMI by achievement on relevant SMI QOF indicators, such as having care plans in place, and doing a physical review. The study will also investigate non-QOF quality indicators derived from current literature, Patient

and Public Involvement and Steering Group input which could be used in primary care to manage patients with SMI. The quality indicators include inappropriate polypharmacy and continuity of care. Outcome measures will include hospital admissions for SMI, emergency admissions for Ambulatory Care Sensitive Conditions, accident and emergency (A&E) attendances, costs for SMI patients in primary and secondary care, and mortality. The researchers will develop a data set covering the full patient care pathway using routine data from different sources.

https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/135440/#/

STUDY B

PARTNERS2: development and pilot trial of primary care based collaborative care for people with serious mental illness.

Due to publish 2019, Birchwood

This project aims to develop and evaluate a collaborative care model for people with schizophrenia and bipolar disorder. The researchers will help primary care and community based mental health services to work more closely with each other. This will be achieved through enhancing the role of experienced mental health workers in GP surgeries, who will act as both therapist and co-ordinator to support individuals to access other relevant services and activities. This professional would see the service user on a regular basis, enable them to help themselves to facilitate recovery and liaise with community/voluntary organisations and secondary mental health care when necessary. The researchers will be working with GPs, psychiatrists and service commissioners in Birmingham, Manchester and South Devon.

https://www.clahrcprojects.co.uk/impact/projects/partners2-development-and-pilot-trial-primary-care-based-collaborative-care-people

https://europepmc.org/grantfinder/grantdetails?query=pi:%22Birchwood+M%22+gid:%22RP-PG-0611-20004%22+ga:%22DH/NIHR%22

STUDY C

Acute Day Units as Crisis Alternatives to Residential Care AD-CARE.

Due to publish 2020, Osborn

This study will assess the use of Acute Day Units (ADUs), which are used during crisis care in some areas across England. The project includes three work streams, including collating data on all ADUs across England to explore aspects such as admission data staffing and user case mix. The researchers will then select 5 ADUs as case studies, and will look at routine data, user/family experience, clinician and patient-rated outcome measures. They will also recruit 400 individuals who have attended ADUs and compare to 400 individuals discharged from the crisis care team in the same Trust/locality without ADU input. Main outcomes include readmission to acute pathway at 6 months, and satisfaction with services. The researchers will interview a smaller sample of service users, carers and stakeholders.

https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/152417/#/

STUDY D

EMPOWER: Early Signs Monitoring to Prevent Relapse and PrOmote Wellbeing, Engagement and Recovery.

Due to publish 2019, Gumley

This is a pilot randomised controlled trial of an intervention to detect and prevent relapse in people with schizophrenia. The researchers aim to recruit individuals with schizophrenia (aged 16+) who have been admitted to a psychiatric inpatient service at least once in the previous 2 years for a relapse of psychosis. The intervention will be delivered on smartphones with online support, delivered within a Stepped Care Relapse Prevention Pathway. Participants will be recruited from mental health services based in the UK and Australia. The researchers will obtain a number of measures, including symptoms, service engagement, adherence to early signs of monitoring, number of help-seeking attempts, and changes in relapse management. This results from the pilot will be used to inform a larger trial.

https://www.journalslibrary.nihr.ac.uk/programmes/hta/1315404#/

STUDY E

Cognitive Bias Modification for Paranoia: A novel attempt to treat paranoid delusions.

Due to publish 2019, Yiend

This study is evaluating the feasibility of the Cognitive Bias Modification for paranoia (CBM-pa) intervention for patients with paranoia. CBM-pa is a computerised, self-administered psychological procedure that involves reading text inviting paranoid interpretations, but then generating responses reflecting an alternative, non-paranoid interpretation. CBM-pa aims to manipulate paranoid biases toward more adaptive processing. The researchers will evaluate whether CBM-pa could be a targeted therapy, looking at the acceptability of the intervention. They aim to recruit 60 stabilised outpatients, presenting with persistent distressing paranoia, to receive either CBM-pa or text-reading control (both in addition to treatment as usual). Each participant will receive one 40-minute session per week for 6 weeks, with 1 and 3 months follow-ups. Eight participants will be interviewed about their experiences of the intervention.

https://europepmc.org/grantfinder/grantdetails?query=pi:%22Yiend+J%22+gid:%22PB-PG-0214-33007%22+ga:%22DH/NIHR%22

STUDY F

Collaborative Care Model for Bipolar DisOrder (COMBO).

Due to publish 2018, Attenburrow

This feasibility study is assessing True Colours (TC), a web-based symptom monitoring service for people with mood instability and bipolar disorder in primary care. The TC service encourages patients to answer questions about their symptoms (usually weekly), and the answers are plotted on a graph which can be personally annotated. The service allows the individual to monitor and manage their own symptoms and share their information with their health professionals, allowing for early identification of relapses. The research aims to assess the feasibility of using True Colours in Primary Care as a tool to develop a collaborative care model for the management of bipolar disorder. The study has currently recruited eight patients and six GPs. All individuals are trained to use TC and interviewed to understand their experiences.

https://www.clahrc-oxford.nihr.ac.uk/research/collaborative-care-model-for-bipolar-disorder-combo

STUDY G

An online randomised controlled trial to evaluate the clinical and cost effectiveness of a peer supported self-management intervention for relatives of people with psychosis or bipolar disorder: Relatives Education and Coping Toolkit (REACT).

Due to publish 2019, Lobban

This randomised controlled trial is comparing REACT, and Resource Directory including treatment as usual, to Resource Directory and treatment as usual. The Relatives' Education and Coping Toolkit (REACT) is an online evidence-based toolkit of supported self-management for relatives of people with recent onset psychosis. The Resource Directory provides information about how to access available online support. The researchers aim to recruit 666 relatives over 18 living in the UK who support someone with psychosis or bipolar disorder. The primary outcome is relatives' distress (GHQ-28). Outcome measures will be taken at baseline, and 3 and 6 months later.

http://bmjopen.bmj.com/content/7/7/e016965.full?ijkey=gjxltwISmLK8GQ4&keytype=ref

STUDY H ONGOING

IMPlementation of A Relatives Toolkit (IMPART study): Examining the critical success factors, barriers and facilitators to implementation of an online supported self-management intervention in the NHS.

Due to publish 2018/2019, Lobban

This case study project will explore the barriers and facilitators to the implementation of The Relatives' Education and Coping Toolkit (REACT) in the NHS. The toolkit is an evidence-based online supported self-management intervention for relatives of people with recent onset psychosis. REACT is divided into manageable modules, has been co-produced with relatives, and has shown to significantly reduce distress and increase perceived ability to cope. The researchers will also develop a national implementation plan, as REACT fulfils NICE Guideline recommendations to provide an education and support programme to relatives. The researchers will assess REACT across 6 NHS Trusts.

https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/140416/#/

STUDY I

Combined individual and family therapy in comparison to treatment as usual for people at risk of psychosis: A feasibility study.

Due to publish 2019, French

This feasibility study is investigating whether a combined individual and family CBT (IFCBT) intervention is an acceptable, feasible and potentially effective treatment option for individuals at risk of psychosis. IFCBT aims to minimising transition to psychosis, reduce distress, increase quality of life and reduce disability. Seventy-six individuals will be randomised to one of two conditions. In the treatment as usual group, participants will be monitored for 1 year to assess levels of transition to full psychosis and in the intervention group they will be monitored for one year plus receive IFCBT. Assessments will be carried out at baseline, 6 month and 12 month follow up. The researchers will also conduct interviews with participants (n=15-20) and family members/ carers (n=15-20) to understand experiences of therapy and trial participation.

https://europepmc.org/grantfinder/grantdetails?query=pi:%22French+P%22+gid:%22PB-PG-1014-35075%22+ga:%22DH/NIHR%22

STUDY J

Co-production and evaluation of an e-learning resource to improve knowledge about schizophrenia and engagement with services in African Caribbean families.

Due to publish 2018, Edge

This study aims to co-produce and pilot an educational e-learning resource with African Caribbean stakeholders to improve family attitudes and knowledge about schizophrenia to facilitate engagement with services. Collaborative working with key stakeholders will determine how best to construct and deliver a culturally-appropriate e-Learning intervention. This information will be used to design the intervention (including 'look' and 'feel'), as well as developing content to illustrate key topics about schizophrenia from carer, service user and healthcare professional perspectives. The topics will be determined by stakeholders but are likely to include: diagnosis, symptoms, and approaches to treatment, as these are topics raised by members of this community who were involved in developing the research. Factual information, for example, about schizophrenia and its management together with culturally-relevant content such as alternative conceptualisations of mental health and illness (illness models) will also be included. The intervention will be tested in a pilot RCT in which 20 individuals will be randomised to receive the intervention. The intervention will be accessible via computers, tablets, laptops and smartphones. A DVD version might be produced if consultation determines that this is warranted. Trial participants can be from any ethnic background but must have a family member who is of African-Caribbean origin and who has been diagnosed with schizophrenia or related psychoses. The researchers will collect outcome data (knowledge about psychosis and attitudes to mental illness) and qualitative information about perceptions of the intervention and participants' experiences of using it. In addition to being able to test their knowledge, participants will also be able to reflect on their personal experiences (e.g. via a 'Things I wished I'd Known' page) and share these via the intervention to improve future iterations. Members of the control group, who will complete the same outcome measures as those in the intervention group, will receive the intervention after 3-months' follow-up.

https://europepmc.org/grantfinder/grantdetails?query=pi:%22Edge+D%22+gid:%22PB-PG-0212-27109%22+ga:%22DH/NIHR%22

STUDY K

Culturally-adapted Family Intervention (CaFI) for African Caribbeans with schizophrenia and their families: A feasibility study of implementation and acceptability.

Due to publish in full 2018, Edge

This primary aim of this study is to assess the feasibility of culturally-adapting, implementing and evaluating a family intervention for service users of African-Caribbean backgrounds who have been diagnosed with schizophrenia, and also for their families. The secondary aim was to test the feasibility and acceptability of delivering CaFI (culturally-adapted family intervention) via Family Support Members (FSMs) or 'proxy families' where biological families were not available. CaFI was successfully co-produced using qualitative and consensus methods with current and former service users of African-Caribbean descent, their families/caregivers, advocates (including voluntary sector organisations) and healthcare professionals. The intervention was delivered in acute, rehabilitation and community settings in Manchester by therapists with experience of working with families who received cultural awareness training as part of the study. The feasibility trial recruited 31 family units and successfully delivered CaFI, comprising 10 one-hour sessions of therapy, within a 20-week therapy window. High retention rates were achieved with 24 of the 26 family units that commenced CaFI completing all 10 sessions. CaFI received high (above 80%) acceptability ratings from services users, their families and FSMs. It was also positively rated by therapists. Reported service user benefits included improved symptoms (better mood, less paranoia) and social functioning (engaging in volunteering and/or actively planning to return to work and full-time education). Therapeutic alliance was positively rated by all groups. Service users' quality of life (health utility index) improved; especially among those not in contact with their families who participated via FSMs. Staff, families, and service users reported improved communication and engagement. The intervention now needs to be tested in a fully-powered randomised controlled trial (RCT) to evaluate its clinical and cost-effectiveness compared with usual care. Further work is also required to determine whether culturally-adapted interventions like CaFI would have broad appeal across ethnic minorities groups as well as to service providers, commissioners and policy makers. In this context, working with FSMs where no biological families are available (such as with refugees and forensic populations where Black and other ethnic minorities are over-represented) would mark an important development in tackling ethnically-based disparities in accessing evidence-based care.

CaFI Study Report (full report available later in 2018, early findings published in first look summary):

Edge, D., A. Degnan, S. Cotterill, B. K., J. Baker, R. Drake and K. M. Abel (In Press). "Culturally-adapted Family Intervention (CaFI) for African Caribbeans with schizophrenia and their families:

A feasibility study of implementation and acceptability " NIHR Journals.

First look summary: https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/12500162/#/

STUDY L

STEPWISE: STructured lifestyle Education for People WIth Schizophrenia.

Due to publish 2018, Holt

This randomised controlled trial assessed the effectiveness of a group-based structured education programme for individuals with schizophrenia to help them lose weight. The researchers recruited 441 adults with schizophrenia, schizoaffective disorder or first episode psychosis, from 10 UK Mental Health Trusts. The intervention was based on the psychological theories and behaviour change techniques of the Diabetes Education and Self-Management for ON-going and Newly Diagnosed (DESMOND) programme. The 12-month intervention comprised four 2.5 hour weekly sessions, with further contact every two weeks and group sessions at 4, 7 and 10 months. 341 participants completed the trial. At 12 months, the weight reduction did not differ between groups and physical activity, dietary intake and biochemical measures were unchanged. Although intervention was neither clinically nor cost-effective, both participants and facilitators expressed high levels of interest in and acceptability for the intervention.

https://www.journalslibrary.nihr.ac.uk/programmes/hta/122805#/

STUDY M

Prediction and management of cardiovascular risk for people with severe mental illnesses. A research programme and trial in primary care. (PRIMROSE).

Due to publish 2018/9, Osborn

This programme of research aims to evaluate the effectiveness and cost-effectiveness of an intervention for practice nurses who work with individuals who have SMI and cardiovascular disease (CVD). The researchers will develop a nurse-led intervention that aims to reduce the CVD risk in SMI in primary care. They will also develop a new web-based CVD risk score tool, specifically for individuals with SMI, which will be made available to NHS clinicians. The intervention will be developed with input from service users, practice nurses and GPs, and other relevant individuals. The researchers will evaluate the intervention in a cluster randomised controlled trial, where the intervention will be compared to treatment as usual in 40 general practices and involve 400 people with SMI. The primary outcome is cholesterol level after one year.

https://europepmc.org/grantfinder/grantdetails?query=pi:%22Osborn+D%22+gid:%22RP-PG-0609-10156%22+ga:%22DH/NIHR%22

Publications from this study:

Primrose CVD risk score work:

https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2043173

http://bmjopen.bmj.com/content/7/9/e018181

Focus group study:

http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0136603

Trial protocol and paper:

https://trialsjournal.biomedcentral.com/articles/10.1186/s13063-016-1176-9

http://www.thelancet.com/pdfs/journals/lanpsy/PIIS2215-0366(18)30007-5.pdf

Big database work on statins and people with severe mental illnesses:

http://bmjopen.bmj.com/content/bmjopen/7/3/e013154.full.pdf

http://www.schres-journal.com/article/S0920-9964(17)30303-1/pdf

STUDY N

The RESPECT Study (Randomised Evaluation of Sexual Health Promotion Effectiveness informing Care and Treatment): a feasibility study of an intervention aimed at improving the Sexual Health of People with Severe Mental Illness.

Due to publish 2018, Hughes

This feasibility study is an RCT to promote sexual health for people with severe mental illness, and evaluate how this can be delivered within mental health services. The researchers will design a manualised behavioural intervention to promote sexual health by assessing and targeting specific needs. Service users, clinicians and academics will help design the intervention. The researchers will use a variety of quantitative measures, including sexual health knowledge violence in relationships, and quality of life. They aim to recruit 100 participants and will also interview a subsample to assess the acceptability of the intervention. The results will be used to inform a larger trial.

https://www.journalslibrary.nihr.ac.uk/programmes/hta/1417201/#/

STUDY O

SCENE: Improving quality of life and health outcomes of patients with psychosis through a new structured intervention for expanding social networks.

Due to publish 2022, Priebe

This programme of seven work packages will investigate an intervention for enhancing social networks of individuals with psychosis to improve their quality of life. The researchers will explore the social networks of 100 patients with psychosis across a range of rural and urban areas (Devon, East London, Luton/Bedfordshire and North East England). Using this information, alongside data collected from focus groups and interviews with patients and stakeholders, the researchers will design an intervention to expand the social networks of patients with psychosis, develop a training module for health professionals and develop an NHS implementation plan. The researchers aim to recruit 453 patients to a pilot randomised controlled trial to evaluate the 6 month intervention, with measures taken at baseline, 6, 12 and 18 months.

https://europepmc.org/grantfinder/grantdetails?query=pi:%22Priebe+S%22+gid:%22RP-PG-0615-20009%22+ga:%22DH/NIHR%22

STUDY P

Building Resilience and Recovery through Enhancing Cognition and quality of LIfe in the early PSychosEs (ECLIPSE).

Due to publish 2022, Wykes

This programme of research is investigating the optimal method of providing cognitive remediation therapy (CRT) in Early Intervention Services. CRT aims to improve cognitive and functional recovery. The researchers will assess cost-effectiveness and seek views from service users, staff and service providers. The research consists of four stages, including the development of a web-supported training programme for cognitive remediation therapists and the evaluation of three different methods of providing CRT across ten EIS teams. The findings will help guide UK-wide implementation of CRT.

https://www.journalslibrary.nihr.ac.uk/programmes/pgfar/RP-PG-0612-20002/#/

STUDY Q

Volunteering in Mental Health Care for People with Psychosis (VOLUME).

Due to publish 2018, Priebe

This programme of research is exploring the benefits of volunteers in mental health services for people with psychosis, where volunteers provide unpaid care and are often part of one-to-one befriending schemes. It consists of a synthesis of the

literature and mapping of current NHS volunteering programmes; the researchers have also explored the experiences with 20 volunteers and 20 patients with psychosis who have received one-to-one volunteer input over a period of at least six months. A volunteering scheme was designed, and an exploratory randomised controlled trial in East London to compare patient outcomes following a 12 month befriending intervention has been completed. The programme is now in the phase of analysis and will report this year.

https://www.journalslibrary.nihr.ac.uk/programmes/pgfar/RP-PG-0611-20002/#/

STUDY R

Enhancing the quality of user involved care planning in Mental Health Services (EQUIP).

Due to publish 2018, Lovell

This programme grant is looking at the effectiveness and cost effectiveness of user and carer involvement in care planning in mental health services. The researchers will develop, evaluate and implement a user/carer-led training package for mental health professionals to improve the ways in which users and carers are involved in planning. The researchers will also design and evaluate a patient reported outcome measure (called PROM) to assess this level of involvement. The study will take place in Manchester Mental Health and Social Care Trust and Nottingham Healthcare Trust. The researchers will develop tools such as a care planning audit tool, materials to empower users and carers to facilitate change, and training materials for mental health services.

https://europepmc.org/grantfinder/grantdetails?query=pi:%22Lovell+K%22+gid:%22RP-PG-1210-12007%22+ga:%22DH/NIHR%22

STUDY S

Enhanced discharge from inpatient to community mental health care (ENRICH): a programme of applied research to manualise, pilot and trial a Peer Worker intervention.

Due to publish 2020, Gillard

The aim of the ENRICH programme is to improve the discharge experience from psychiatric inpatient care for mental health service users, prevent readmission, reduce costs and improve individual recovery. The researchers will investigate the effectiveness and cost-effectiveness of a peer worker intervention to enhance discharge. The researchers will develop a manual with input from expert panels, which will involve ways to train and support Peer Workers, and then run a pilot trial. This will be used to inform a large randomised controlled trial conducted across six Mental Health Trusts. The primary outcome is readmission to psychiatric inpatient care within one year of discharge. Other measures will include behavioural and service user outcomes.

https://europepmc.org/grantfinder/grantdetails?query=pi:%22Gillard+S%22+gid:%22RP-PG-1212-20019%22+ga:%22DH/NIHR%22

STUDY REFERENCES (COMPLETED NIHR STUDIES FEATURED IN THIS REVIEW)

Aref-Adib, G., et al., A qualitative study of online mental health information seeking behaviour by those with psychosis. BMC Psychiatry, 2016. 16: p. 232. **(Study 24)**

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IMPROVING THE HEALTH AND WEALTH OF THE NATION

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 March 2018

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4:20pm

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
	Richard Wright	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Director of Finance & Deputy Chief Executive
	Dr John Sykes	Medical Director
	Carolyn Green	Director of Nursing & Patient Experience
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Lynn Wilmott-Shepherd	Interim Director of Strategic Development
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Kathryn Lane	Deputy Director of Operational Services
	Joe Wileman	Head of Programme Delivery
	Sue Turner	Board Secretary (minutes)
For item DHCFT 2018/033	Lt Col Duncan Jenkins	Commanding Officer of 162 Regiment, Royal Logistic Corps
For item DHCFT 2018/033	Catherine Suckling	Ministry of Defence Assistant Regional Employer Director, East Midlands
For item DHCFT 2018/033	Helen Raisbeck	Cognitive Behaviour Therapist
For item DHCFT 2018/033	Catherine Parker	Cognitive Behaviour Therapist
APOLOGIES:	Mark Powell	Chief Operating Officer
VISITORS:	Rosemary Farkas	Public Governor, Surrounding Areas

DHCFT 2018/032	**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 Chief Operating Officer, Mark Powell, who was represented by Deputy Director of Operational Services, Kathryn Lane. Caroline Maley reminded everyone that this meeting was the last Public Board meeting taking place on a Wednesday afternoon and that from 1 May all Board meetings to be held in public session will commence at 9:30am on the first Tuesday of each month. Caroline Maley referred to the Declarations of Interest Register and informed the Board that on 26 March she had been appointed as a Governor of Brooksby Melton College and that the Register of Directors Interests should be amended accordingly. Non-Executive

	Director, Richard Wright's declaration had been updated since the last meeting and would be corrected to state that he remains Chair of the UTC Sheffield Multi Academy Trust but is no longer a member of the Advisory Board of Sheffield National Centre for Sport and Exercise Medicine. **ACTION: Declarations of Interest to be updated in respect of Caroline Maley and Richard Wright**
DHCFT 2018/033	**ARMED SERVICES COVENANT** Chief Executive, Ifti Majid, welcomed Lieutenant Colonel Duncan Jenkins, Commanding Officer of 162 Regiment, Royal Logistic Corps and Catherine Suckling, Assistant Regional Employer Director for the Ministry of Defence who had been invited to take part in the signing of the Armed Forces Covenant. They were joined by Helen Raisbeck the Trust's veteran champion and Catherine Parker who both currently provide a service to the Armed Forces Community on behalf of the Trust. The Board heard from Helen Raisbeck about her work in psychotherapy and the treatment she provides for veterans who need specialist understanding of their military culture and background. Catherine Parker talked about her role as a clinician and how important it is to give veterans the care and service they need so they can overcome the trauma they may have experienced. Lieutenant Colonel Duncan Jenkins described how people who leave the armed forces have skills that are varied and sometimes need support in transferring their military skills to the civilian workplace. Their spouses also need support so they can engage in the workplace and return to their chosen professions. Research also indicates that NHS organisations who employ ex-service personnel reflect positively on how military skills fit in with their organisation's needs. The Board acknowledged the sacrifices that armed forces personnel and their families have made over the years and committed to support the Armed Forces Community. The transferability of their skills and experience that could enhance our organisation was acknowledged and the Trust would celebrate the skills that veterans can bring. A communication will be issued to all staff to show how reservists and members of the wider Armed Forces Community would be supported. The Board reflected on how the Armed Forces Covenant is a promise from the nation that those who serve or have served in the Armed Forces, and their families, are treated fairly and confirmed that Chief Operating Officer Mark Powell would be the Trust's Executive Director Sponsor of the Armed Forces Covenant. The Covenant fits with the Trust's vision and values and it will make a positive difference to people's lives by improving health and wellbeing. Through signing the Covenant the Board committed to support all of those in the Armed Forces Community who have contact with the Trust whether as patients, staff, carers or the general public. The signing of these pledges will enable the Board to take direct action to support the health and wellbeing of those who are serving, have served and their families. **RESOLVED: The Board of Directors:** **1) Received and signed up to the Armed Forces Covenant** **2) Confirmed that Chief Operating Officer Mark Powell would be the Trust's Executive Director Sponsor of the Armed Forces Covenant**
DHCFT 2018/034	**MINUTES OF THE MEETING DATED 28 FEBRUARY 2018** The minutes of the previous meeting, held on 28 February were agreed and accepted as an accurate record subject to the removal of the last sentence of the fourth paragraph of the item DHCFT 2018/023.
DHCFT	**ACTIONS MATRIX AND MATTERS ARISING**

2018/035	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 2018/023 Integrated Performance and Activity Report (IPR):** In response to Non-Executive Director, Anne Wright, requesting further information on cancelled consultant appointments and whether patients who were cancelled resulted in subsequent DNAs (Did Not Attend), Deputy Director of Operational Services, Kathryn Lane, advised that a piece of work was taking place to assess whether these cancellations resulted in DNAs. The results of this assessment will be included in the IPR to be submitted to the next meeting on 1 May. **ACTION: DNA and cancelled consultant appointment assessment to be included in IPR to be submitted to the next meeting on 1 May** **DHCFT 2018/024 Deep Dive – Joint Eating Disorders Service:** Ifti Majid informed the Board that he had raised the need to increase the threshold for funding for eating disorders services at the Mental Health Sub-Group (part of the Derby City Health and Wellbeing Board). This has also been raised with commissioners, who have confirmed that eating disorders will be included as part of the Mental Health Investment Standard (MHIS) for 2019/20. As a result we are now working on ways to link eating disorders services with children's and adult services to achieve connectivity.
DHCFT 2018/036	**CHAIR'S UPDATE** Caroline Maley's report provided an update on the recent meetings and visits to staff and services since the last meeting was held on 28 February. She reflected that this meeting was held during some of the worst winter weather and she thanked all staff for the remarkable effort that was made to ensure the Trust's services ran without interruption. One of the main highlights of the month was Caroline's visit to Walton Hospital to see how staff are operating and this enabled her to gain a better understanding of the development of the CPA (Care Programme Approach). Caroline noted the number of governor vacancies that have arisen within the Council of Governors and appreciated that recruitment is being overseen by the Director of Corporate Affairs who is working with the Communications and Involvement Team to seek to recruit new governors over the coming months. Deputy Trust Chair, Julia Tabreham, referred to the new streamlined membership within the Health and Wellbeing Boards that was mentioned in the Chair's report and asked if there could be potential risks or benefits in this being a smaller group of members. Caroline explained that there are other meetings being held outside of the Health and Wellbeing Boards that will provide direct links and she hoped that having a smaller membership would avoid any duplication of discussions. **RESOLVED: The Board of Directors noted the activities of the Trust Chair throughout March**
DHCFT 2018/037	**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 Majid made reference to the recent changes within the obligations of the Fit and

	Proper Persons Requirement (FPPR) that are applied to all executive and non-executive director posts within the Trust that were set out in his report. He assured the Board that the strength of the Trust's annual process has been reviewed to ensure the Trust remains compliant with the most up to date guidelines. Ifti was pleased to report that the Trust was able to present its specialist skills in physical healthcare improvements of people with serious mental illness when he chaired the East Midlands Mental Health Clinical Transformation and Substantiality Network on 7 March. He was proud that the Trust had been able to demonstrate its work that is supported by the local public health team to achieve the best possible outcomes for people. Ifti informed the Board that he had 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 was pleased to report that it is the confirmed intention of the CCGs to comply with this requirement and Chris Clayton had also given this assurance to NHS England. Director of Nursing and Patient Experience, Carolyn Green, referred to efficiencies being made through Quality, Innovation, Productivity and Prevention (QIPP) and emphasised that anything disinvested from our Trust should be reinvested into mental health services and specialist services. Ifti took time to thank Interim Director of Strategic Development, Lynn Wilmott-Shepherd, for her commitment and dedication whilst she has been working in this role. He drew attention to the work Lynn has overseen in developing the Trust's strategy as well as driving the success of the mental health work stream as part of Joined up Care Derbyshire and he wished her well in the next stage of her career when she leaves the Trust at the end of May. Ifti also paid tribute to colleagues throughout the Trust who ensured that services continued to function throughout the recent cold spell, particularly in the north of the county which was badly affected by snow. He and the Board extended thanks to all staff who had worked hard to keep services operating throughout this difficult period. Carolyn Green, took the opportunity to inform the Board that Learning Disabilities (LD) services have asked the Board to champion people with LD and that we listen to their voice and employ people within the organisation with LD. **RESOLVED: The Board of Directors noted and scrutinised the Chief Executive's update**
DHCFT 2018/038	**<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 February that focussed on workforce, finance, operational delivery and quality performance. The Trust continues to perform well against many of its key indicators, with maintenance or improvements continuing across many of the Trust's services and this could be seen within the body of the report. The issues identified in previous reports continue to be worked on through plans that were previously referenced in the Integrated Performance Report. Deputy Chief Executive and Director of Finance, Claire Wright, presented the report from a financial perspective. We are nearing the end of the year and the majority of work covered by the Finance and Performance Committee is concerned with next year's financial plan. She was pleased to report that she was still confident that the Trust will achieve its control total although achieving next year's plan would be very challenging. Director of People & Organisational Effectiveness, Amanda Rawlings, drew attention to the information contained in the new People Flow Metrics graph. This graph was first

	reviewed at the People and Culture Committee and was considered to be extremely helpful in giving a greater understanding of the flow of new starters and employees leaving the Trust. The data showed that although there are vacancy hot spot areas this is not a problem across the whole of the organisation. Compliance with the high level requirements of mandatory training was raised as a concern and work is underway to ensure staff can be released from services to attend mandatory training programmes. Carolyn Green assured the Board that although non-compliance with mandatory training was included on the risk register work was taking place to fast-track staff onto role specific mandatory training. This will be monitored by the Trust Management Team meetings (TMT) to ensure we return to our contracted quality standard level. Carolyn Green was pleased to report that quality levels remained steady during February and had no exceptions to bring to the Board's attention from a quality perspective. Kathryn Lane reported from an operational perspective that clustering remains challenging as well as consultant cancellations and outpatient DNAs (Did not Attend). A report on appointment cancellations was presented and discussed in detail at the Finance & Performance Committee where it was recognised that a large proportion of cancellations related to medical sickness, recruitment issues or appointments having to be rescheduled to fit in more urgent appointments. This is a challenging problem to overcome and utilising different ways of working would take a long time to implement. She was pleased to report that the target for CPA (Care Programme Approach) review over the last twelve months had been achieved despite the ongoing challenges with care co-ordination. The IPR also showed unusual performance with seven day follow ups although a good performance overall had been maintained in this area. Non-Executive Director, Geoff Lewins, also referred to clinical absences and saw that a significant improvement had been made with consultant absences and assured the Board that the Finance and Performance Committee had spent a considerable amount of time discussing alternative methods of working. Caroline Maley referred to outpatient cancellations and requested that future reports show the reasons why clinicians are absent from work. Kathryn Lane clarified that although data collection can sometimes be difficult this detail on absences could be included in forthcoming reports. In response to Non-Executive Director, Anne Wright, asking whether recruitment issues are discussed at the Finance and Performance Committee as well as the People and Culture Committee, Kathryn Lane assured her that the Finance and Performance Committee is taking the lead on the reshaping of the neighbourhoods. Work is also taking place to develop a more integrated workforce to ensure that when a clinician is absent the work is covered by other members of staff. Recruitment issues are also regularly discussed at other performance meetings across the organisation. Ifti Majid referred to Delayed Transfers of Care (DTOC) and expressed his frustration that service users with mental health problems were not receiving the same priority of DTOC escalation as acute hospitals. He understood that this is sometimes due to the need for specialist accommodation requirements. The need to use the same mechanisms used in acute hospitals is to be escalated to local authorities and commissioners on behalf of our patients using our services. Julia Tabreham concurred and thought that DTOC was a symptom of systemic problems within social care and that solving this issue would need to be carried out through a multi-agency approach. **ACTION: IPR to contain clinical absence detail associated with outpatient cancellations** **ACTION: The need to use the same DTOC methods of escalation as acute hospitals is to be escalated to local authorities and commissioners** **RESOLVED: The Board of Directors considered the Integrated Performance**

	Report and obtained limited assurance on current performance across the areas presented.
DHCFT 2018/039	**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 around safety and 'Always Events'. This was highlighted by Carolyn as a clear, action-orientated and pervasive practice or set of behaviours that provides aspects of the patient experience that are important to patients, their care partners, and service users. Healthcare providers must aim to perform them consistently for every individual, every time. Attention was drawn to the NICE guideline and specification for mental health liaison that requires services to meet the one hour standard and the five year forward view. The Board was assured that learning obtained from other trusts had shown that the Trust provides in-reach and advice to all acute wards on the continuation of medicines and effective integrated clinical treatment. 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. Non-Executive Director, Richard Wright, reflected on the report from IM&T (Information Management & Technology) received by the Finance & Performance Committee on actions that are taking place to improve the performance of the Paris system (electronic patient record system). He asked Carolyn if she was confident that these actions can be resolved in line with the priority that IM&T will have given to them. Carolyn assured the Board that these actions have been discussed and prioritised at the Clinical Reference Group and a number of the actions contained in the Quality Position Statement have already been delivered. Also included in the report was the Learning from Deaths Mortality Report that was submitted to the Quality Committee on 8 March. Medical Director, John Sykes, assured the Board that neither he, or the Quality Committee had found any cause for concern relating to the CQC's recommendations of how the NHS should investigate patient deaths. He added that compared to other organisations our rates are comparable and that all deaths that occur are reviewed in order to obtain learning, even when they have occurred through natural causes. Anne Wright, who is also the NED Lead for Mortality and Learning From Deaths, asked if an action plan had been developed around learning from deaths through substance misuse and was assured that trajectories were being developed, followed up and improved. Julia Tabreham made the point that completing Serious Incident (SI) investigations in a timely manner requires a significant investment of time and professional input and we need to have enough resource in place to ensure this process does not become overly demanding. John Sykes assured the Board that our SI process is extremely robust in meeting the challenges involved and implementing recommendations following the resolution of incidents and investigations. The Board accepted this Mortality Report and noted that it had been published on to the Trust website prior to end of March 2018, as per national guidance. **RESOLVED: The Board of Directors:** **1) Received the Quality Position Statement and gained significant assurance on safety with the Trust** **2) Accepted the Mortality Report and agreed for it to be published on to the Trust website as per national guidance**

DHCFT 2018/040	**STRATEGY REFRESH 2018-21** 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 Trust Strategy 2016-21. Lynn Wilmott-Shepherd, presented the draft Strategy Refresh for 2018-21 to the Trust Board for approval. The Board understood that the strategy had been refreshed to more clearly articulate intentions around how the Trust aims to put people first in order to live its values, how the Trust develops its leaders to create the environment where people experience the Trust's values, and how the Trust fits within system-wide and partnership working. In response to Carolyn Green asking how the strategy could be cascaded to staff, Lynn advised that she was working closely with the Communications Team and business managers to ensure the strategy is widely circulated within the organisation. The Board approved the refreshed Trust Strategy for 2018-21 and agreed that as the Board has signed up to the Armed Forces Covenant this should be included in the refreshed Trust Strategy. **ACTION: Armed Forces Covenant to be included in the refreshed Trust Strategy** **RESOLVED: The Board of Directors:** **1) Noted the contents of the plan and obtained assurance that there has been wide consultation within the organisation** **2) Approved the refreshed Trust Strategy for 2018-21, subject to final design work, branding and inclusion of the Armed Forces Covenant**
DHCFT 2018/041	**BUSINESS PLAN 2018-19** Lynn Wilmott-Shepherd presented the Trust Board with the final Business Plans for clinical divisions, clinical support services and corporate areas. She explained that the draft plans have been amended with the comments from the January and March TMT meetings and she was seeking final approval of the plans from the Board. She will also be working closely with Carolyn Green to make sure this plan is connected correctly with CQC recommendations. Lynn clarified that each division and corporate area clearly understood that the business plan will help them achieve their strategic goals and STP aims. The Quality Strategy and People Strategy are linked into the business plan and TMT (Trust Management Team) and COATs (Clinical Operational Assurance Teams) are the areas where the strategy and the business plan can be embedded and be performance managed. The Board considered the business plan was work in progress. The next step would be to articulate how the Trust Strategy, People Strategy and the Business Plan is cascaded through the organisation so people delivering front line care understand what they need to achieve in order to comply within the Trust Strategy and the Business Plan. **RESOLVED: The Board of Directors noted the contents of the business plan and was assured that the plan was in the process of development**
DHCFT 2018/042	**BOARD ASSURANCE SUMMARIES AND ESCALATIONS** Assurance summaries were received from meetings of the Quality Committee, Audit and Risk Committee and People and Culture Committee. Committee Chairs summarised the escalations that had been raised and these were noted by the Board as follows: **Quality Committee:** Committee Chair, Julia Tabreham, updated the Board on key items

	that were discussed and decisions made. The Committee continued to see a rise in pressure on services and focussed on assurance of continuity and prevention. The emergent risk to staff from patient assaults was also raised as a concern. The Committee was aware of the rise in unexpected service user deaths and was assured that there are no untoward patterns. Some CQC actions remain outstanding and are being closely monitored. The Trust is not expected to achieve the national target for flu vaccinations which is 75%. The key risks anticipated in achieving the national target for flu and physical healthcare improvements meant that the Committee could only obtain limited assurance on delivery of investment allocated to CQUIN implementation. The Committee formally escalated to the Board evidence of a breach in the Equalities Act relating to age discrimination. This risk has already been included in the risk register under Safety and Quality BAF risk 1a. Ifti Majid undertook to raise this formally with commissioners. **ACTION: Age discrimination breach within the Equalities Act to be raised with commissioners** **Audit and Risk Committee:** Chair, Geoff Lewins, reported that the Committee had undertaken a deep dive into BAF risk 4b on governance business planning process and agreed to reduce the likelihood rating of this risk from 4x5(20) to 3x15 (15). This completed the last of the deep dives included in the 2017/18 schedule. The Committee had early sight of the draft 2017/18 Annual Report, Quality Account and Annual Governance Statement and was significantly assured that these drafts are on target for final approval by the Committee in May. Similarly the internal and external auditors were able to confirm that their work is on track for completion. Significant assurance was obtained relating to the governance processes and arrangements that are set in place to oversee progress of Deloitte phase 3 recommendations relating to the Committee. A positive benchmarking report was received from the internal auditors which has been forwarded to members of the Finance and Performance Committee. The Committee looked at the counter fraud plan and reviewed the counter fraud self-assessment and was satisfied that this could be issued in its present form. The BAF risks for 2018/19 were reviewed and the Committee agreed arrangements for its members to achieve a better understanding of these risks at the Board Development Session scheduled for 18 April. **People and Culture Committee:** Chair, Margaret Gildea, informed the Board that the March meeting would be the last meeting to be held under the Committee's old format. It is hoped that from April onwards a more streamlined attendance would prove more effective. A high level overview of the Committee's end of year effectiveness report was received which set out the activity that has been undertaken during the year. The Committee also reviewed the people priorities and the BAF progress that has been achieved throughout 2017/18. The Committee closed off the last remaining GIAP action that it has oversight for (WOD2). The People Strategy was reviewed and approved for submission to the Board at today's meeting. The Committee had discussed how the Trust could use the Apprentice Levy and agreed that it would use the levy to invest in a small scale Apprentice Nurse Training pilot scheme to improve and secure a clinical workforce for the future. Risks related to training compliance within specific areas of training such as positive and safe, resuscitation training, safeguarding and physical health were highlighted to the Board as significant risks. The Staff Health and Wellbeing Strategy has been escalated to the Executive Leadership Team (ELT) for discussion. Risks relating to mandatory training compliance have been escalated to ELT for onward monitoring. Caroline Maley thanked the Board Committee Chairs for their feedback. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries and Escalations**
DHCFT 2018/043	**<u>DRAFT PEOPLE STRATEGY</u>**

	Amanda Rawlings presented the draft People Strategy to the Board that had been developed to support the revised Trust Strategy and which provides five key aspects of putting 'People First' and making the Trust a great place to work. The Board recognised that the strategy outlined the key priorities that will be focussed upon over the next three years to retain, develop and attract staff supported and enabled by a focus on management and leadership and inclusion. The development of the strategy involved a wide range of staff, including the Staff Engagement Group and it has been revised and discussed with the Executive Leadership Team and the People and Culture Committee. The strategy will be developed further once the Board supports the direction of travel. The strategy will also be worked on further with the Communications Team to create a more visual and engaging version that will be widely communicated and available on the Trust's website and will also be used as recruitment material. Caroline Maley commented that the strategy was a good piece of work and was easy to read and digest. The Board understood that Amanda Rawlings had consulted widely to produce a well-informed third draft and approved the strategy and delegated authority to ELT and the People and Culture Committee to address measures going forward with the implementation of the strategy. **RESOLVED: The Board of Directors received, and approved the draft People Strategy and delegated authority to ELT and the People and Culture Committee to address its direction of travel throughout the Trust.**
DHCFT 2018/044	**STAFF SURVEY RESULTS** Amanda Rawlings updated the Board on the initial NHS Staff Survey results which showed the Trust's current position based on the 2017 all staff survey. The Board took assurance that the results showed that the staff survey is progressing in a more positive direction than previous years. Claire Wright observed the visible difference in the response rates between clinical and corporate areas. She also requested that analysis of the staff survey should include focus on REGARDS (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation) groups. It was also clear to the Board that more work needs to be undertaken to ensure staff appraisals are more effective in setting staff objectives. The Board considered that overall the staff survey showed good improvements which is a reflection of the hard work that has taken place to improve staff engagement and the culture of the Trust. **RESOLVED: The Board of Directors:** **1) Received and reviewed the 2017 NHS Staff Survey results** **2) Discussed the initial focus areas from the 2017 results and agreed the priorities for 2018**
DHCFT 2018/045	**GENDER PAY GAP (GPG)** This paper presented by Amanda Rawlings covered the requirements under the new GPG reporting and set out the results of GPG in the Trust. 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. The Board noted the statistical analysis, gaps between genders and the actions that have been taken in committing the Trust to addressing the imbalance in the workforce. GPG tools will be used to address the gaps and variations between genders and the Trust will

	go beyond this to equalise the balance by developing our own robust methods to identify where gaps exist. The Board discussed the need to be more supportive and positive in addressing the family commitments of staff in leadership positions as these roles are often seen as untenable by staff with families. The Board approved the GPG data analysis and agreed that a clear explanation of GPG reporting would be communicated to staff on the intranet and any questions that arise will be clearly addressed. The results of the Trust's GPG data analysis and the steps we intend to take to close the gaps will be published on the Trust's external website and Government Equalities Office by 30 March 2018. **RESOLVED: The Board of Directors:** **1) Noted the statistical analysis and gaps between the genders.** **2) Approved 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 30 March 2018.** **4) Noted 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.**
DHCFT 2018/046	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN EMBEDDEDNESS UPDATE</u>** Director of Corporate Affairs, Sam Harrison, updated the Board on the embeddedness of actions undertaken as part of the Trust's Governance Improvement Action Plan (GIAP). All actions within the GIAP were completed and signed off by the Trust Board in May 2017 and ongoing implementation of the actions was embedded as 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. The Board agreed that the report provided assurance that the GIAP actions have now been fully completed and they are embedded into business as usual with the Trust's work. The Board was confident that these recommendations are now set within the Trust's governance practice and will be sustained through the work of Board assurance Committees and reviewed and developed as part of ongoing work to ensure compliance with NHSI's well-led governance framework. **RESOLVED: The Board of Directors:** **1) Received 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) Agreed that this assurance report completes the review of sustained implementation of actions to address all GIAP recommendations.** **3) Noted 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.**
DHCFT 2018/047	**<u>BOARD EFFECTIVENESS SURVEY</u>** Sam Harrison presented her report which provided the Board with the results of the Board Effectiveness Survey conducted in November 2017. 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. The fourth and most recent survey was undertaken in November 2017. This survey was developed to include opportunity for free comments from respondents. 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 Reference was made to the mixed response received to question 12 "When corrective action is taken, changes made are embedded. It is rare for our Trust to have issues that reoccur". Comments acknowledged the work that has been undertaken but also suggest that there is still work to do and that further time and cycles need to pass to ensure embeddedness. The Board acknowledged 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. Good feedback had also been received from Deloitte over the past year. Work will be sustained to ensure the good practice reflected in responses is maintained and the Board Development Programme for 2018/19 has been developed to support ongoing training and development of the Board. The survey is to be completed again in October 2018. **RESOLVED: The Board of Directors:** **1) Noted the outcome of the Board Effectiveness Survey November 2017.** **2) Agreed that effective Board practices would be sustained and supported through the Board Development programme 2018/19.** **3) Agreed that the survey should be completed again in October 2018.**
DHCFT 2018/048	**<u>BOARD ASSURANCE FRAMEWORK (BAF) FIFTH AND FINAL ISSUE 2017/18</u>** This report detailed the fifth and final issue of the BAF for 2017/18 and the initial draft headline risks for the BAF for 2018/19. Sam Harrison gave a brief overview of the end of year position. 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 work stream. 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 were shown in the report, 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. It was understood that since the Board Development session held on 14 February 2018 to consider strategic risks, Board members had proposed the headlines risks for the 2018/19 BAF and these were further considered and amended following review by ELT on 12 March, and Audit and Risk Committee on 20 March. A further 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. The Board took significant assurance from the report and duly approved the fifth and final issue of the BAF 2017/18 and approved the headline risks for the 2018/19 BAF. **RESOLVED: The Board of Directors:** **1) Approved this fifth and final issue of the BAF for 2017/18 and received significant assurance with 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) Approved the initial headline risks for the 2018/19 BAF and the proposal for the BAF to be further worked up and agreed by Audit and Risk Committee**

	members on 18 April and the Board of Directors on 1 May 2018.
DHCFT 2018/049	**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 mitigation plans relating to mandatory training compliance will be recorded in the BAF. **ACTION: BAF to record mitigation plans relating to mandatory training compliance**
DHCFT 2018/050	**MEETING EFFECTIVENESS** It was agreed that appropriate items for discussion in public session were included on the agenda which enabled informed discussion of strategic issues. It was thought that discussions were more effective when reports were taken as read as it was clear that many papers had previously been discussed in detail at Board Committees. In view of this, Sam Harrison felt it would be helpful to state the nature of previous debate at other forums where reports are considered and undertook to factor this detail into the covering report template. **ACTION: Board report template to be revised to capture other forums where reports are discussed**
DHCFT 2018/051	**2018/19 BOARD FORWARD PLAN** The 2018/19 forward plan was noted for information.
DHCFT 2018/052	**REPORT FROM COUNCIL OF GOVERNORS MEETING 21 MARCH 2018** The report on the meeting of the Council of Governors held on 21 March was noted for information.

The next meeting of the Board to be held in Public Session will take place at 9:30 on Tuesday, 1 May 2018.

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

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - APRIL 2018			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
28.2.2018	DHCFT 2018/017	Declarations of Interest	Sam Harrison	Declarations of Interest to be updated in respect of Julia Tabreham and Richard Wright	28.3.2018	Declarations of Interest corrected in respect of Julia Tabreham and Richard Wright	Green
28.2.2018	DHCFT 2018/024	Deep Dive – Joint Eating Disorders Service	Ifti Majid	Funding for Eating Disorders to be escalated through the Health and Wellbeing Board and commissioners	28.3.2018	Raised at Mental Health Sub-Group (part of the Derby City Health and Wellbeing Board) and commitment made to give more detail at main Health and Wellbeing Board - support received but they are not a commissioning organisation. Listed under MHIS for this year and next year's investments. Commissioner view is that there are other priorities e.g. Community, Crisis Teams for this year but looking at £300k for 2019/20.	Green
28.2.2018	DHCFT 2018/024	Deep Dive – Joint Eating Disorders Service	Carolyn Green	**Action transferred to Quality Committee** Introduction of a combined initiative with specialist areas to be captured in the new Eating Disorders Strategy	28.3.2018	A revised eating disorder strategy will be submitted to the Quality Committee within a six month delivery date - **action transferred to Quality Committee and captured on Quality Committee actions matrix**	Green
28.2.2018	DHCFT 2018/026	Board Assurance Summaries	John Sykes	Report on trends of ethnicity and the Mental Health Act to be submitted to the Board	28.3.2018 30	Reverse Commissioning Group's recommendations will be addressed by MHAC Operational Group and report submitted to MHAC once these recommendations are known.	Amber
28.3.2018	DHCFT 2018/035	Matters Arising - DHCFT 2018/023 IPR	Mark Powell	DNA and cancelled consultant appointment assessment to be included in IPR to be submitted to the next meeting on 1 May	1.5.2018	This detail has been included in IPR submitted to May meeting.	Green
28.3.2018	DHCFT 2018/038	Integrated Performance Report (IPR)	Mark Powell	IPR to contain clinical absence detail associated with outpatient cancellations	1.5.2018	This detail has been included in IPR submitted to May meeting.	Green
28.3.2018	DHCFT 2018/038	Integrated Performance Report (IPR)	Mark Powell Ifti Majid	The need to use the same DTOC methods of escalation as acute hospitals is to be escalated to local authorities and commissioners	1.5.2018	Verbal update on progress will be made at 1 May Board meeting.	Yellow
28.3.2018	DHCFT 2018/040	Strategy Refresh 2018-21	Lynn Wilmott-Shepherd	Armed Forces Covenant to be included in the refreshed Trust Strategy	1.5.2018	Armed Forces Covernance added to Strategy 2018-21 on Team Derbyshire page	Green
28.3.2018	DHCFT 2018/042	Board Assurance Summaries and Escalations	John Sykes Ifti Majid	Age discrimination breach within the Equalities Act to be raised with commissioners on behalf of the Quality Committee	1.5.2018	Verbal update on the equality issue regarding access for elderly patients will be made at 1 May Board meeting.	Yellow
28.3.2018	DHCFT 2018/049	Identification of any issues arising for inclusion or updating in the Board Assurance Framework (BAF)	Amanda Rawlings	BAF to record mitigation plans relating to mandatory training compliance	1.5.2018	BAF is being updated to reflect the situation with training compliance. ELT have requested a short, medium and long term plan. Short term plan has been prepared and medium and long term plan recovery will be supported by the recruitment of additional capacity and increasing supply of training.	Green

Resolved	**GREEN**	7	70%
Action Ongoing/Update Required	**AMBER**	1	10%
Action Overdue	**RED**	0	
Agenda item for future meeting	**YELLOW**	2	20%
		10	100%

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 1 May 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 March 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 11 April 2018, I visited staff based at Dale Bank View in Swadlincote. I joined a Multi Discipline Meeting (MDM) where a range of issues were discussed and plans put in place to support service users. My visit was hosted by Lesley Edwards, and the locum consultant was Dr Syad Hussain. This visit was very useful for me to attend as it supported the messages that the Board has received about the pressures on our community teams, and the shortage of resources. In particular this base has struggled to fill its consultant post, and has had many locums, leading to pressure on services user and a lack of consistency in their treatment.

   At the end of the MDM, the team heard from Catherine Parker from the Cognitive Behaviour Therapy team and two of her colleagues, who are a central service, on the services that they provide and how the team could use the services offered.

   As always it was an opportunity to hear from staff at the front line, and there are a number of observations that I have brought back for discussion with the executive team. What was pleasing to hear is that they enjoy having visits from Ifti (on the road), and from me. At times they feel a little on the periphery of the Trust.

3. On Thursday 12 April, I visited the Beeches Perinatal Unit at the Radbourne Unit. My visit was hosted by Cheryl Sticka, who I had briefly met at Walton Hospital last month. I was able to spend some time with a member of the community team, getting an understanding of the size of area that this team covers, as well as the work that they do, and how it has changed over time. A visit to the ward showed a very calm and peaceful environment, as well as a compassionate and caring team looking after families who use their services.

Council of Governors

4. I welcomed a new governor, Adrian Rimington, to the Trust on 3 April. I hope that Adrian enjoys his role as a governor and will bring to us the experience as a service user and a user of the voluntary sector support network. 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 are currently recruiting new Governors (public and staff) over the coming months.

5. I attended the Governance Committee of the Council of Governors on 17 April, 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. This meeting was followed by training for Governors on Mental Health Awareness, delivered by Derbyshire Mental Health Forum, and was well received by those who attended.

Board of Directors

6. We are now working with our NeXT director placement, Avtar Johal. The NeXT Director Scheme is being run by NHSI, providing support to senior people from groups who are under-represented on trust boards to help develop the skills and expertise necessary to become a director. Our Trust volunteered to take part with an express view of targeting the BAME group, where we see our weakness in the composition of our Board. Avtar will be attending a range of meetings of the Trust, including Board, Council of Governors and Committee meetings as well as being mentored by Margaret Gildea and Julia Tabreham as experienced NEDs (Non-Executive Directors). We are currently working with Avtar for approximately 6 months until the end of September, when we will review the success of the placement.

7. During the month of March I have contributed to the 360 degree feedback for our Executive Directors. This process is essential if we are to learn and grow as an organisation, and I am pleased that we are continuing to develop our processes to harness the input from others.

8. Board development took place on 18 April and continued to see our preparation for the CQC Inspection. There has been a lot of work put into the preparation for the CQC inspection by a number of people, and I would personally like to thank them for all that they do – on top of what is already a busy time.

9. The Remuneration and Appointments Committee met on 18 April 2018, and a summary of that meeting can be found as appendix 1 to this report.

10. I continue to meet with Non-Executives on a one to one basis quarterly, and since the last report I have met with Richard Wright.

System Collaboration

11. The STP meeting planned for 20 April 2018 was cancelled, in order to give time for contract agreement to be completed. This will be covered in the CEO report later on this agenda.

12. I met with Paul Devlin, Chair of Lincolnshire Partnership Trust on 10 April to learn more about the Chair role in the CQC inspection, and to provide some guidance to me on what I will face in an interview as Chair. Paul is part of CQC inspection teams as a Chair and has been very willing to provide support and advice to us in the preparation for our inspection in the next few months. This meeting was also a valuable opportunity for me to share my Chair experience with a colleague.

Regulators: NHS Providers and NHS Confederation and others

13. The NHS Providers Chiefs and Chairs meeting took place on London on

22 March. A key note speaker was Chris Hopson, whose overview of the NHS and in particular the provider sector was insightful and useful to us. 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.

14. On 19 April, I attended a dinner in Nottingham with Niall Dickson and Stephen Dorrell, CEO and Chair of the NHS Confederation. This meeting was attended by Chairs and some CEOs from Lincolnshire, Leicestershire, Nottinghamshire and Derbyshire. It was an informal opportunity to discuss issues which we are all wrestling with, largely around system, legal structures for the NHS and finances.

15. NHSI Midlands and East Chairs meeting will take place on 25 April 2018 in Leicester and I will comment on this in my next report.

16. On 27 April I will be attending a gathering to discuss Unlocking the Midlands Productivity: Aligning Mental Health, Skills and Innovation. I will comment on this in my next report.

Beyond our Boundaries

17. On Thursday 29 March I attended a board development session run by the Good Governance Institute (GGI) and NHSI in Birmingham. The theme was System Leadership, and it was attended by a range of executive and non-executive directors from across the region. It was notable that no acute trusts attended, which was an interesting observation when talking about system leadership. The facilitator was Mark Butler, the Development Director of GGI. A take away from the day is a list of questions which Trust Boards may wish to answer about the system. This is attached as appendix 2 to this report.

18. On 19 April, Ifti Majid and I joined a group of Multi Academy Trust CEOs at an East Midland Academy Trust Network meeting, to share our experience of system leadership in the NHS, providing insight and comparison with the challenges that education is facing. There are many parallels for the education system, and I believe it is valuable for us to share our experience with them.

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

Appendix 1

Update from Remuneration & Appointments Committee Held on 18 April 2018

The following items were discussed:

Chief Executive's remuneration review

The Committee discussed the benchmarking of CE remuneration and proposed a salary review in principle, subject to satisfactory outcome of the CE appraisal, to bring in line with median rates.

Executive Remuneration policy 2018

The Committee agreed the refreshed Executive Director Remuneration Policy that had been revised to capture the latest guidance on Executive Director Remuneration provided by NHS Improvement.

Board Development Programme 2017/18 and plan for 2018/19

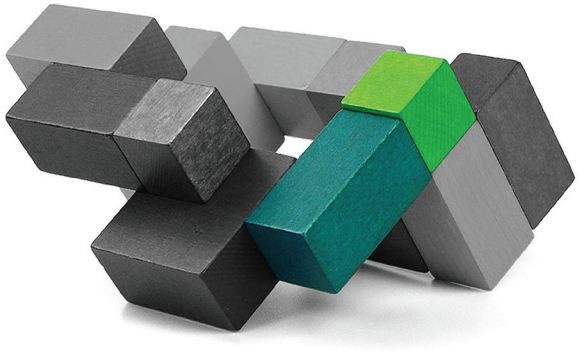
The summary of Board Development sessions undertaken in 2017/18 was considered and significant assurance received that this reflected a broad range of topics to support sustained effective Board operation.

The Committee received assurance that an outline programme is set in place for 2018/19 to cover a range of strategic, interpersonal, operational and wider issues and that this will be refined in year to accommodate arising needs and opportunities. The programme aims to support sustaining effective Board practice and seeking to further improve and develop the whole Board in carrying out its role.

Year-end effectiveness report 2017/18

The Year End effectiveness report was received and discussed. Full assurance was received that the Committee had been effective in carrying out its remit as defined by its terms of reference.

Board Member Development Programme
for NHS Trusts and NHS Foundation Trusts



System leadership – key questions for NHS Boards

29TH MARCH 2018 - Birmingham

The below set of questions were generated by attendees at the 29th March Board member development event. These are focused on the theme of system leadership, and can be utilised by NHS Boards as prompts to develop their understanding and involvement in system leadership.

1. What issues can only be addressed at the system level?
2. What system(s) are we in?
3. Is there a vision and purpose to our system leadership?
4. Who is the citizen / population group in this system context?
5. What do we need to achieve for this group in the short, medium and long-term?
6. How do we generate trust in the system?
7. What is the external view of our organisation? How do we know this?
8. Do we know the other players in the system, both individuals and organisations?
9. What are the behaviours we want demonstrated in the system? How are these embedded?
10. How are decisions made
    a. at organisational level?
    b. at system level?

Good Governance Institute

NHS Improvement

11. What can we influence?

12. Do we understand patient choices and how service users navigate through the system?

    a. Where do we fit in?
    b. What are the collective boundaries and overlaps?

13. Which measures are we going to use to gauge success?

14. How is our risk appetite shaping our approach to system leadership?

    a. What authority do we have to take individual and collective risks?
    b. Can we identify 'red lines' and the consequence of identifying these?

15. What happens when we go 'off track'?

16. How do we communicate the system goals and the journey we're on?

    a. Who is responsible for this communication?

17. Who is in charge?

18. How do we best utilise NED networks and influence?

19. What are the capacity implications of our system leadership decisions?

20. What are the implications of all of the above for the way our Board works?

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 May 2018

Dying to Work Charter

Purpose of Report

Board members are asked to support and engage in the Trust signing the Dying at Work Charter in partnership with our Staff Side Representatives and the TUC. By signing the Dying to Work Charter we are pledging to how we will support, protect and guide our colleagues throughout their employment, following a terminal diagnosis.

The charter includes the following statements:

- We recognise that terminal illness requires support and understanding and not additional and avoidable stress and worry.
- Terminally ill workers will be secure in the knowledge that we will support them following their diagnosis and we recognise that, safe and reasonable work can help maintain dignity, offer a valuable distraction and can be therapeutic in itself.
- We will provide our employees with the security of work, peace of mind and the right to choose the best course of action for themselves and their families which helps them through this challenging period with dignity and without undue financial loss.
- We support the TUC's Dying to Work campaign so that all employees battling terminal illness have adequate employment protection and have their death in service benefits protected for the loved ones they leave behind.

We will be formally signing the charter on Friday 15 June at 4pm. The Charter will be signed by the Trust Chief Executive and the TUC Regional Secretary with the support of the Chair, Board members, Staff Side Representatives, Governors and Pauline Latham OBE, Conservative MP for Mid-Derbyshire.

Executive Summary

The TUC are pressing for additional employment protection for terminally ill workers who need greater protection.

Many workers get a serious illness at some time in their working lives. They may require time off, often many months, to get treatment or recover. The TUC has produced guidance on how to deal with long-term illness, or return to work for those who are disabled as a result of an illness or injury. When there is no effective treatment, workers can face huge emotional stress, fear and uncertainty.

A terminal illness is a disease that cannot be cured or adequately treated and there is a reasonable expectation that the patient will die within a relatively short period of time. Usually, but not always, they are progressive diseases such as cancer or advanced heart disease.

By signing the charter we are actively making a stance on how we will support staff

when diagnosed with a serious or life limiting illness. There are some key requirements:

1. To sign the charter in partnership with our Staff Side Representatives – Staff Side are fully engaged and in support of the Charter
2. Review sick pay and sickness absence procedures – Our sick pay and policy provides the support both financially and procedurally to staff who have a serious or life limiting illness
3. Provide an Employee Assistance Programme – The Trust has an Employee Assistance Programme in place
4. Provide training to line and managers and HR staff – on how to deal with terminal illness, this includes how to discuss future plans of any employee who is diagnosed with a terminal illness and on what adaptations to work arrangements that may be necessary – The Trust's HR team will provide expert advice to managers when they have a member of staff with a serious or life limiting illness and will be upskilling our managers
5. Notify all employees that we have signed the charter and the commitments contained within it – we will be actively sharing our pledge to current and future colleagues

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.	

Assurances

The Board can be assured that the Trust is committed to signing the charter and ensuring that the appropriate policies and training is in place to care for our staff.

Consultation

- We have agreed to move forward to signing the charter by working in partnership with our Staff Side Representatives.
- We will be actively communicating with our current and future staff that we have signed the charter and the support that will available to staff should they find they are impacted by a serious or life limiting illness

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 support that the Trust in signing the Dying to Work Charter and to attend the signing ceremony on 15 June if available

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

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

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. NHS England has released an 'enhanced annex' to the mental health delivery plan for 2018/19. This Mental Health Delivery Plan Enhanced Annex aims to provide additional information which may guide the implementation of 18/19 Mental Health deliverables. This Annex is especially recommended for Integrated Care System (ICS, formerly known as Accountable Care System ACS) based readers, however may be used by any regional teams or STPs to support mental health delivery.

   The annex reminds us about the 20 KPIs that NHS England will be expecting all STP areas to report on through the year. These areas include Children and Young People, perinatal Services, IAPT, Core Adult Mental Health Services (Crisis, Early Intervention and Older Adults/Dementia).

   The further clarity around expectations liked to the delivery of the mental health five year forward view is very helpful. For example NHS England are clear: '*It is for ICS/STP partners to determine locally the expenditure required to deliver high quality mental health care to meet the needs of their population, based on their baseline performance, prevalence etc. to meet the transformation standards set out in the MHFYFV. However, allocations must be spent on the purposes for which they were originally intended and cannot be used to cross-subsidise other services or supplant existing spend'*

   The report also makes it clear the expectations on us as providers to provide complete compliance with mental health minimum data set requirements and through the course of the year we can expect to see further amendments to the

   I am pleased to see the profile given to co-production particularly around how we design and commission services. The report references Rethinks 'coproduction in commissioning' document and notes the 6 core principles that will be expected:

   - Recognising people as assets
   - Building on people's existing capabilities
   - Mutuality and reciprocity
   - Peer support networks
   - Blurring distinctions
   - Facilitating rather than delivering

In Derbyshire all senior members of the mental health workstream have already been training in co-production alongside colleagues in Derbyshire County Healthwatch.

2. Each year NHS Providers carry out a survey of all provider Organisations to understand the views of providers in relation to the regulatory environment. This survey has historically acted as a good barometer of the pressures and challenges the provider sector is facing and this year is no different with the survey noting the striking changes in the regulatory landscape over the last twelve months, the revised CQC regime as well as NHS Improvement and NHS England's focus on more system operation as well as separate providers. Some of the highlights of this year's report include:

    - Trusts are concerned that the regulatory framework is not keeping pace with the developments taking place on the ground. They highlighted that the oversight of STPs and ICSs risks becoming an extra layer of performance management. Respondents also questioned whether STPs and ICSs can take on oversight and assurance roles for local systems without a statutory footing.
    - The results demonstrate that there is a lack of clarity about the national policy direction for the system architecture, which only one in five (20%) trusts believe is clear.
    - Respondents reported that there has been an increase in the regulatory burden and in the number of ad hoc requests from the regulators over the last 12 months, with 67% reporting an increase. While the regulators have taken steps to coordinate their approaches with each other and other national bodies, these efforts have not yet been reflected in trusts' experiences. Trusts report that they continue to experience duplication in the requests from the regulators and other national bodies.
    - There is optimism about the potential positive impact of changes to CQC's inspection model over the last year and the majority of respondents agreed that the new inspection approach would enable CQC to prioritise inspections more effectively and help them improve services and quality of care.

Local Context

3. At the Joined up Derbyshire 'Place Board' during April the Board that is leading the development of Place agreed:

    - The need to focus on the prioritised delivery of the falls pathway across Derbyshire as this pathway has already been developed and approved within the system. Recognition was given to the benefits in relation to avoiding the use of bedded care that would come from this pathway delivery.
    - A group will be set up to focus on the process for implementing Comprehensive Geriatric Assessment (CGA) as a gold standard intervention in the care of frail older people in keeping with recommendations from the Royal College of GPs, the British Geriatric Society and the Silver Book.
    - Following on from a regional frailty event on 27 March 2018, a Derbyshire frailty work-stream will be convened to oversee the delivery of a consistent approach to the frailty agenda across the county. It is proposed that this will kick off with a Frailty Summit during June.

These three areas are important to the development of pathways within our Trust.

4. Derbyshire County Health and Wellbeing Board (HWB) confirmed its revised Terms of Reference Following the recent Governance Review of the HWB the Terms of Reference following a review that focused on:

   - The HWB's fit with the Derbyshire Sustainability and Transformation Partnership (STP) system-wide governance structure, particularly in relation to how the HWB could provide appropriate challenge to health and social care partners, demonstrate public accountability as well as defining the strategic vision for health and social care in Derbyshire.
   - The size and composition of the HWB to ensure that it does not duplicate the STP Board or other STP groups, but continues to represent the wide range of partners which need to be engaged.
   - The sub-structure to the HWB which would be required to drive forward strategy development and implementation.

   Key areas discussed at the April meeting included the 2016/17 Safeguarding Children and Safeguarding Adults Board. We also heard the work associated with the implementation in Derbyshire of the Special Educational Needs & Disabilities (SEND) reforms. This is a complex but welcome change moving away from 'done to statementing' to inclusive assessment, self and family determination and co-produced health and education care plans. In the County this was a significant task with some 3500 statements that needed to be converted to care plans and this month all but 109 have been completed.

   We also had an enlightening demonstration of how simple regular exercise that can be delivered whilst sitting down can improve balance and agility and therefore reduce falls leading to unnecessary admission to hospital – we were even encouraged to take part in the demonstration!

Within our Trust

5. During April Executive Directors took part in their 'mentee preparation training' led by Associate Professor Stacy Johnson linked to our ground breaking Reverse Mentoring for Diversity and Inclusion project. The Board will remember that this project is all about colleagues in our Organisation from a BAME (British. Black, Asian, and minority ethnic group) mentoring Executive Directors with the specific purpose of sharing insights about what it feels to be from a BAME group and work in our organisation, this is all about listening, learning and taking action, not about individual mentors personal issues but with respect to the organisation's culture as a whole. The process is closely governed and will follow a four domain framework model. In addition through links with the University of Nottingham this work will be part of a formal research study.

6. On 17 April it was great that our new substance misuse partnership was formally

launched at an event at Derbyshire Cricket Ground led by Derby City public health. The event introduced stakeholders to the 4 year Substance Misuse Strategy as well as giving stakeholders the opportunity to get involved and understand how they would be able to contribute. This was a great showcase event for the partnership we lead and demonstrates the strength of clinicians and operational leaders working closely together to define and deliver an innovative model of care and support.

7. Ten years ago, the Trust officially entered into the Multicentre Study of Self-harm in England partnership (ourselves, Oxford University and Manchester University) funded by the Department of Health. This ten years of innovation, influence, sustainability, commitment and the marrying of research and clinical practice together is a significant milestone. The focus of the Multicentre Study of Self-harm is with the South Liaison team, CAMHS (Child and Adolescent Mental Health Services) Rise and Research team. The Trust's involvement with such a significant national research project, continues to result in many high impact journal publications and findings that strongly influence national policies and strategies; many of which can be seen to have directly led to improvements in patient care and safety. Without the dedication of the clinical staff to help ensure that the research is embedded within their day-to-day clinical practice alongside quality support from the research team, such important work would not be possible.

8. Since the last Board I have held *Ifti on the Road engagement events* at:

    - Bay Heath House, Chesterfield (Central Neighbourhood Team)
    - Killamarsh Clinic
    - Pre ELT engagement session at St Andrews House, Derby

    Key themes that emerged from these sessions included:

    - Admin career structure
    - Benefit of new delivery models with examples of how well nurse led clinics and non-medical prescribers were working
    - Differing views about the effectiveness of neighbourhoods but a general sense that the review currently being worked on would benefit from more pace
    - An issue about agenda for change mileage discriminating against the lower paid workforce eg support workers in the community
    - Opportunities and risks where there were medical vacancies
    - The need for greater clarity around some care pathways.

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

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

Any implementation of national policy in our Trust would include a repeat Equality

Impact Assessment even though this will have been completed nationally.

That said some of the reports both nationally and within the Derbyshire system have the potential to have an adverse impact on people with protected characteristics for example the work around co-production will require differing approaches to be taken with a range of local communities, a 'one size fits all' consultation approach will not enable true involvement from protected groups (REGARDS).

Internally the Trust is reviewing its transformation quality impact assessment to ensure it dove tails with wider system transformation scheme QIA's and to ensure it is truly acknowledging of the differences needed between different communities. It is more complex than to say that through a general QIA there is no impact because as each community has differing needs so they would have differing outcomes against a QIA.

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

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

The specific focus we have on assessing ourselves rigorously against the EDS2 (Equality Delivery System 2) 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 – 1 May 2018

Future of Quality Position Statement

Purpose of Report

The purpose of this paper is to present plans for the future of the Quality Position Statement.

Executive Summary

The Quality Position Statement has been presented to the Trust Board since June 2014. It was introduced to ensure the Board was quality focused, to provide information on National Quality changes, to consider changes to strategy, highlight and give assurance/ issues under the health regulators essential standards. The paper is always action focused setting out what will happen next, who is responsible for completing the actions and overtime this has resulted in \ reduction of ad hoc briefings or single papers being presented.

The position statement gives a collective voice of quality and provides access and transparency to the public on quality issues. To this point in time the model has been mainly used by the Nurse Director. The lens of the Nurse Director may be too narrowly focused and Quality is everyone's business in our Trust. Often Non-Executive Directors consider quality standards and the operationalisation of these standards to only reside with the Nurse and Medical Director, which is not in keeping with a unitary board.

It is proposed therefore that a matrix approach to the essential standards is introduced modelling continuous quality improvement in all domains.

Boards that only work to their specialist area of expertise are often weaker in their composition and resilience This model will enable all Board members to lead a portfolio of work which is not just their technical expertise. Maturity in leadership is the ability for Directors to take on and be the voice for the executive not just in their area of expertise and demonstrate the capability to lead a legislative issue or grandparent a transformational change in an area where they may lack the formal technical expertise.

The proposed model set out in this paper is critical to our future success as a unitary board with collective accountability and responsibility. The reporting matrix is based on:

1. The standards and prompts called the 'Key Lines of Enquiry' or KLOEs that the CQC will use to answer the five key questions about Trust services.

    - Are they safe?
    - Are they effective?
    - Are they caring?

- Are they responsive?
- Are they well-led?

2. The well led framework published June 2017 and the CQC prompts set out within that document.
3. The use of resources assessment guidance published by CQC in August 2017.

The measures are a selection of those suggested in the guidance with the exception of the use of resources where the actual data lines are set out in the guidance. These are generic across all trusts and may not all apply to our organisation.

As the reporting develops it is planned that the measures are reviewed in line with any new guidance. The reporting template has to be agreed but it is planned that it will include a dashboard to reflect each on the prompts with exception reporting against those indicators that need a more detailed explanation of progress.

Overtime these reports will provide evidence that the essential standards are being met and highlight areas of innovation and improvement to showcase to our regulators.

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

Assurances

- Assurance to the Board that the CQC fundamental standards are being met and where there are any deficits that are established that improvement plans will be noted. Evidence that the board operates as an effective unitary board.
- Assurance that effective systems and processes are in place that enable close working between quality, operational and use of resources functions.
- This model of working is key to ensuring a collective model of board leadership. The Board is requested to endorse this revised model of practice.

Consultation

Discussion has taken place in Executive team meetings. The paper is presented to the trust board for the first time.

Governance or Legal Issues

To maintain our registration of our services with the healthcare regulator the CQC.

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

In developing this model the nine protected characteristics have been considered in reporting there will be evidence of the key line of enquiry and each are will have an equalities lens applied to these key groups

Examples would be that Responsive data should have due regard to differences in gender whether men are using the service, gender re-assignment if this is accessible and for BAME for underrepresented groups are able to access our IAPT service. These issues have been explored in reverse commissioning data analysis and is available to inform our work.

Each domain will include this data wherever it is available and has an impact upon people in line with the Equalities Act.

Recommendations

The Board of Directors is requested to:

1. Accept this proposal.
2. Agree to receive the first report in June 2018.

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

Report prepared by: **Carolyn Green**
Director of Nursing and Patient Experience and
Clare Grainger Corporate Governance Improvement Manager

Future of Quality Position Statement

Introduction

The matrix will be set out using the Care Quality Commission essential standards set out in the provider handbooks. Each Director will take responsibility for an area and report in line with an annual timetable. Each report will use a deep dive approach with data and evidence.

Responsive	**Caring**	**Use of resources CQC and NHS I-**	**Safety**	**Quality and Strategy**	**Well – led CQC and NHS I**	**Effective**
Mark Powell	Carolyn Green	Claire Wright	John Sykes	Gareth Harry	Sam Harrison	Carolyn Green and Amanda Rawlings
June 2018	July 2018	September 2018	October 2018	November 2018	December 2018	February 2019
Data and evidence will be presented incorporating the following areas of essential standards and NHS I.						
KLOE R1 Person-centred care **Measures** Patient satisfaction surveys Complaints and Compliments Access to interpreters, advocacy	**KLOE C1** Kindness, respect and compassion **Measures** Training in equality and diversity Patient feedback on caring Accessible information	**KLOE U1** Clinical services: How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit? **Measures** Emergency readmissions (30 days) Did not attend (DNA) rate	**KLOE S1** Safeguarding and protection of abuse: **Measures** Safeguarding training Recruitment processes Staff survey feedback Patient feedback Complaints	**KLOE W2** Vision and strategy **Measures** Compliance with objectives set out in strategy Staff feedback Quality priorities	**KLOE W1** Leadership capacity and capability **Measures** Staff survey views on leadership Leadership Strategy	**KLOE E1** Assessing needs and delivering evidence-based treatment **Measures** NICE guidance Compliance with equality act Compliance with mental health act Nutrition and hydration standards met

Responsive	Caring	Use of resources CQC and NHS I-	Safety	Quality and Strategy	Well – led CQC and NHS I	Effective
Mark Powell	Carolyn Green	Claire Wright	John Sykes	Gareth Harry	Sam Harrison	Carolyn Green and Amanda Rawlings
June 2018	July 2018	September 2018	October 2018	November 2018	December 2018	February 2019
Data and evidence will be presented incorporating the following areas of essential standards and NHS I.						
KLOE R2 Taking account of the needs of different people **Measures** Compliance with equality act Referral, transfer and discharge processes Reasonable adjustments	**KLOE C2** Involving people in decisions about their care **Measures** Carer involvement Patient feedback Carer support	People: How effectively is the trust using its workforce to maximise patient benefit and provide high quality care? **Measures** Staff retention rate Sickness absence rate Pay cost per weighted activity unit (WAU) Doctors cost per WAU Nurses cost per WAU Allied health professionals cost per WAU	**KLOE S2** Managing risks **Measures** Staffing levels Skill mix Use of bank, agency and locums Risk assessments Staff safety	**KLOE W5** Management of risk and performance **Measures** Quality impact assessment process Outcomes from performance reviews	**KLOE W3** Culture of the organisation **Measures** Raising concerns Staff survey feedback on culture	**KLOE E2** Monitoring and comparing with similar services **Measures** Audits, benchmarking, accreditation, peer review, research resulting in improvements Patient outcome measures

Responsive	**Caring**	**Use of resources CQC and NHS I-**	**Safety**	**Quality and Strategy**	**Well – led CQC and NHS I**	**Effective**
Mark Powell	Carolyn Green	Claire Wright	John Sykes	Gareth Harry	Sam Harrison	Carolyn Green and Amanda Rawlings
June 2018	July 2018	September 2018	October 2018	November 2018	December 2018	February 2019
Data and evidence will be presented incorporating the following areas of essential standards and NHS I.						
KLOE R3 Timely access to care and treatment **Measures** Waiting times Use of technology Cancelled clinics	**KLOE C3** Privacy and dignity **Measures** Incidents of breaches of confidentiality Compliance with data protection requirements - Staff training in IG Healthwatch feedback Number of complaints and compliments	Clinical support services: How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients? **Measures** Medicines costs	**KLOE S3** Safe care and treatment **Measures** Information systems Care planning Records Transitions between services	**KLOE W6** Management of information **Measures** Data security breaches Compliance with Performance measures Use of technology to improve quality of care	**KLOE W4** Governance and management **Measures** Programme of internal and external audit including well led review Accountability framework Staff survey feedback on roles	**KLOE E3** Staff skills and knowledge **Measures** Use of volunteers Staff supervision Staff training and development Revalidation Coaching Mentoring

Responsive	**Caring**	**Use of resources CQC and NHS I-**	**Safety**	**Quality and Strategy**	**Well – led CQC and NHS I**	**Effective**
Mark Powell	Carolyn Green	Claire Wright	John Sykes	Gareth Harry	Sam Harrison	Carolyn Green and Amanda Rawlings
June 2018	July 2018	September 2018	October 2018	November 2018	December 2018	February 2019
Data and evidence will be presented incorporating the following areas of essential standards and NHS I.						
KLOE R4 Concerns and complaints **Measures** Timeliness of complaints responses Lessons learnt from complaints	Patient privacy and confidentiality	Corporate services, procurement, estates and facilities: How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients **Measures** Non-pay cost per WAU Finance cost per £100 million turnover Human resources cost per £100	**KLOE S4** Medicines management **Measures** Patient survey feedback on medicines Medicines management incidents Physical health monitoring	**KLOE W7** Engagement and involvement **Measures** Staff, patient, carer and stakeholder involvement in planning of services	**KLOE W5** Management of risk and performance **Measures** Audit of Risk management processes	**KLOE E4** How staff, teams and services work together **Measures** Staff survey feedback Patient survey feedback on care planning Patient outcome measures 7 day a week working

Responsive	Caring	Use of resources CQC and NHS I-	Safety	Quality and Strategy	Well – led CQC and NHS I	Effective
		million turnover Procurement Process Efficiency and Price Performance Score Estates cost per square metre				
Mark Powell	Carolyn Green	Claire Wright	John Sykes	Gareth Harry	Sam Harrison	Carolyn Green and Amanda Rawlings
June 2018	July 2018	September 2018	October 2018	November 2018	December 2018	February 2019
Data and evidence will be presented incorporating the following areas of essential standards and NHS I.						
		Finance: How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients? **Measures** Capital service capacity Liquidity (days) Income and expenditure margin Distance from financial plan Agency spend	**KLOE S5** Track record **Measures** Infection control d data Patient safety incidents Benchmarking Patient safety planning goals Training in restrictive interventions	**KLOE W8** Are there robust systems and processes for learning, continuous improvement and innovation **Measures** Quality visits Compliance with quality improvement strategy Numbers of staff involved in research		**KLOE E5** Supporting people to live healthier lives **Measures** Physical health care checks Smoking cessation

Responsive	Caring	Use of resources CQC and NHS I-	Safety	Quality and Strategy	Well – led CQC and NHS I	Effective
			KLOE 6 Learning when things go wrong **Measures** Thematic reviews Major incident planning			**KLOE E6** Consent to care and treatment **Measures** Physical restraint data Compliance with MH Act data

Appendix A: The Derbyshire Model of Care (The WHAT) - *"To deliver the most effective and efficient health and social care system for the citizens of Derbyshire delivered through a place-based care system which is effectively joined up with specialist services and managed as a whole"*

The STP defined the aiming point as *'a place-based care system which is effectively joined up with specialist services and managed as a whole'* as described in diagram 1 below.

The approach to developing the Derbyshire single plan for 2018/19 identified that there was a need to clarify understanding of the model of care and align the priority areas of work to specifically deliver the mode. Therefore the original Derbyshire wedge has been adapted (diagram 2) as the basis to develop a plan on a page.

Diagram 1: Aiming Point (page 20 Derbyshire STP).

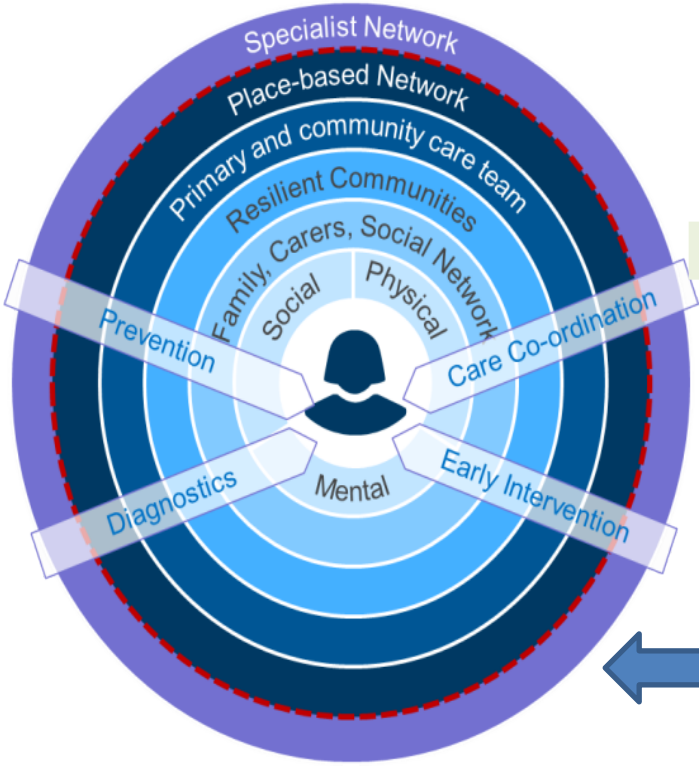
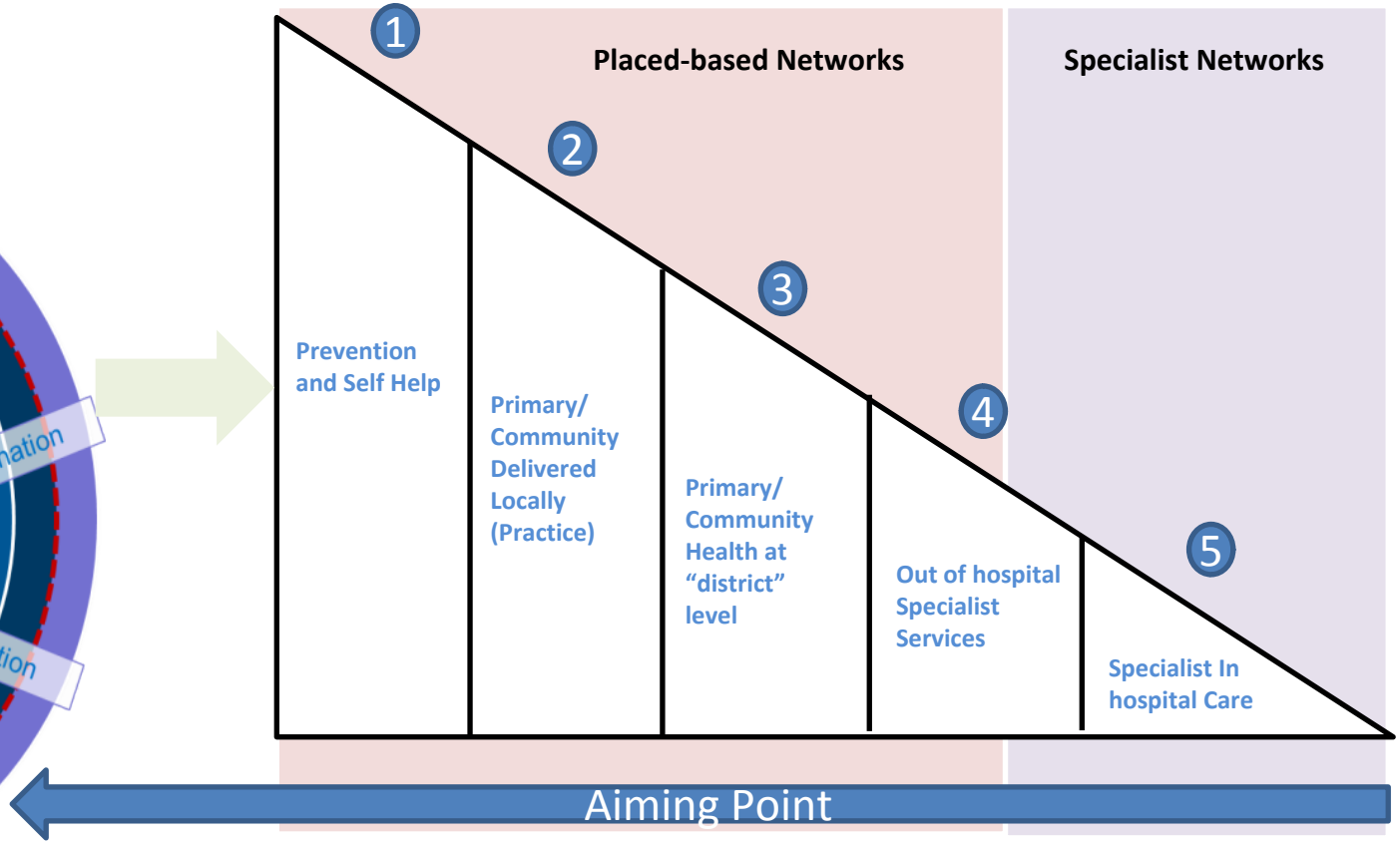


Diagram 2 – Derbyshire Model of Care (adapted Derbyshire Wedge)



Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 May 2018

Integrated Performance Report Month 12

Purpose of Report

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

   As previously forecast the Trust has over achieved the control total surplus by £663k excluding Sustainability and Transformation fund (STF) income. Due to the overachievement of the control total we have received additional STF incentive income of £2.3m. This has resulted in an end of year surplus of £5.8m against the control total of £2.8m.

2. Areas of improving 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 are asked to seek assurance on the issues identified in slide 1.

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

Assurances

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

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

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

Recommendations

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

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

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

Financial Perspective

Highlights
- Overachievement of control total
- Additional STF incentive income
- 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
- 7 day follow-up target has been achieved.

Challenges
- Clustering continues to be a challenge
- CPA Review in last 12 Months
- Cancellations and DNAs in outpatients
- There has been an under 18 admissions to Adult inpatients
- Letters Target have been breached
- Inpatient 28 day readmissions have exceeded the target
    - 3 patients have had their discharge delayed this month
    - % 6-8 Week Breastfeeding coverage target has been breached

People Perspective

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

Challenges
- Monthly and annual sickness absence rates remain high, but are reducing.
- Budgeted Fte vacancies remain high.
- Appraisal compliance rates remain low, but are increasing.

Quality Perspective

Highlights:
- Peak of 24 complaints in January 2018 has reduced in Feb/Mar 2018, now in line with overall trend
- Improving performance in % of Community Treatment Order rights forms received by the Mental Health Act Office

Challenges:
- Significant increase of episodes of patients held in seclusion in March 2018, in response to the clinical needs of four individuals on two wards.
- One Duty of Candour incident in March 2018 involving an allegation against a staff member. Under investigation.
- Action plan is ongoing around the number of outstanding actions following serious incident investigations

FINANCIAL OVERVIEW –March2018

Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Governance	Finance Score	**Finance Score**	YTD	1	1	G		At the end of the financial year the Finance Score is an overall '1' as per the plan. This is an improvement compared to the forecast, due to the reduction in the level of agency expenditure.
		Capital Service Cover	YTD	2	1	Y		
		Liquidity	YTD	1	1	G		
		Income and Expenditure Margin	YTD	1	1	G		
		Income and Expenditure variance to plan	YTD	1	1	G		
		Agency variance to ceiling	YTD	1	2	Y		
	Single Oversight Framework	NHS I Segment	YTD		2	n/a	n/a	
				Plan	**Actual**	**Variance**	**Trend**	
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	-16	861	G		At the end of the financial year the surplus is ahead of plan by £3.0m. This includes additional STF income of £2.3m and non-recurrent income being received earlier in the year. The normalised position 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 have still over achieved the control total of £1.9m.
			YTD	2,765	5,757	G		
		Control Total position ex STF £'000	In-Month	-108	-1,560	R		
			YTD	1,971	2,634	G		
		Normalised Income and Expenditure position £'000	In-Month	-108	-1,004	R		
			YTD	1,971	2,534	G		
Liquidity	Cash	Cash £m	YTD	12.193	21.295	G		Cash is ahead of plan due to non-recurrent income, additional STF income from 2016/17, asset sale, capital accruals and other payables. Capital expenditure is above plan due to additional capital funding from DHSC.
	Net Current Assets	Net Current Assets £m	YTD	8.345	10.849	G		
	Capex	Capital expenditure £m	YTD	3.338	3.722	R		
Efficiency	CIP	CIP achievement £m	In-Month	0.321	0.272	R		CIP is ahead of plan BY £1.0m at the end of the financial year. A significant amount of CIP is non-recurrent in nature.
			YTD	3.850	4.842	G		
			Recurrent	3.850	1.641	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 – MARCH 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%	97.44%	G	→			All NHS metrics are compliant.
			Quarter	95.00%	98.73%	G	↓			
		Data Quality Maturity Index (DQMI) - MHSDS Data Score (Q)	Month	95.00%	96.34%	G	→			
			Quarter	95.00%	96.34%	G	↓			
		IAPT RTT within 18 weeks (Q)	Month	95.00%	100.00%	G	→			
			Quarter	95.00%	99.90%	G	→			
		IAPT RTT within 6 weeks (Q)	Month	75.00%	96.75%	G	↑			
			Quarter	75.00%	94.29%	G	↑			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Month	50.00%	85.71%	G	↓			
			Quarter	50.00%	91.67%	G	↑			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Month	50.00%	66.67%	G	↓			
			Quarter	50.00%	71.74%	G	↓			
		Patients Open to Trust In Employment (M)	Month	N/A	10.11%		→			
			Quarter	N/A	9.67%		→			
		Patients Open to Trust In Settled Accommodation (M)	Month	N/A	59.48%		↓			
			Quarter	N/A	57.65%		↓			
		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%	58.42%	G	↑			
			Quarter	50.00%	54.31%	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	6		↑			
			Quarter	N/A	12		↓			
		Out of Area - Number of Patients PICU (M)	Month	N/A	19		↑			
			Quarter	N/A	47		↑			
		Out of Area - Average Per Day Non PICU (M)	Month	N/A	2.6		↑			
			Quarter	N/A	1.5		↑			
		Out of Area - Average Per Day PICU (M)	Month	N/A	9.8		↑			
			Quarter	N/A	8.7		↑			

OPERATIONAL OVERVIEW – MARCH 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.
			Quarter	90.00%	95.52%	G	→			
		CPA Employment Status	Month	90.00%	97.02%	G	→			
			Quarter	90.00%	97.02%	G	→			
		Patients Clustered not Breaching Today	Month	80.00%	74.69%	R	→			
			Quarter	80.00%	75.37%	R	→			
		Patients Clustered regardless of review dates	Month	96.00%	93.08%	R	→			
			Quarter	96.00%	93.55%	R	→			
		7 Day Follow-up - all inpatients	Month	95.00%	97.22%	G	↑			
			Quarter	95.00%	96.12%	G	→			
		Ethnicity coding	Month	90.00%	90.65%	G	↓			
			Quarter	90.00%	90.65%	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%	93.67%	R	↓			Caseloads and demand make this a very challenging target.
			Quarter	95.00%	93.67%	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

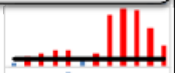
Quarter Current Quarter

Achieving target

Not achieving target

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

OPERATIONAL OVERVIEW – MARCH 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%	8.81%	R	↓			The main reasons for cancellation were clinician absence from work.
			Quarter	5.00%	10.32%	R	↑			
		Consultant Outpatient DNAs	Month	15.00%	15.26%	R	→			A pilot in Killamarsh and North Chesterfield is being undertaken.
			Quarter	15.00%	15.83%	R	→			
		Under 18 admissions to Adult inpatients	Month	0	1	R	↑			A 17 year old was admitted as no CAMHS PICU beds were available at the time.
			Quarter	0	1	R	→			
		Outpatient letters sent in 10 working days	Month	90.00%	88.17%	R	→			Annual leave and late uploads of clinical letters.
			Quarter	90.00%	89.50%	R	↑			
		Outpatient letters sent in 15 working days	Month	95.00%	94.24%	R	↓			
			Quarter	95.00%	95.18%	G	↑			
		Inpatient 28 day readmissions	Month	10.00%	10.24%	R	↑			Associate Clinical Director and Head of Nursing to review each discharge
			Quarter	10.00%	8.80%	G	→			
		MRSA - Blood stream infection	Month	0	0	G	→			
			Quarter	0	0	G	→			
		Mixed Sex accommodation breaches	Month	0	0	G	→			
			Quarter	0	0	G	→			
		Discharge Email Sent in 24 Hours	Month							Process under review
			Quarter							
		Delayed Transfers of Care	Month	0.80%	1.91%	R	↓			3 Patients were delayed
			Quarter	0.80%	3.30%	R	→			
		18 Week RTT Less Than 18 Weeks - Incomplete	Month	92.00%	92.42%	G	↓			
			Quarter	92.00%	93.21%	G	↓			

OPERATIONAL OVERVIEW – MARCH 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%	92.29%	G	↓			
			Quarter	92.00%	92.73%	G	↓			
		Mixed Sex accommodation breaches	Month	0	0	G	→			
			Quarter	0	0	G	→			
		Completion of IAPT Data Outcomes	Month	90.00%	96.43%	G	→			
			Quarter	90.00%	95.92%	G	→			
		Ethnicity coding	Month	90.00%	91.26%	G	→			
			Quarter	90.00%	91.53%	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	→			Some mothers declined visits and due to capacity some are being undertaken in April.
			Quarter	98.00%	99.12%	G	→			
		% 6-8 Week Breastfeeding coverage	Month	98.00%	97.54%	R	↓			
			Quarter	98.00%	99.00%	G	→			
	IAPT	Recovery Rates	Month	50.00%	58.49%	G	↑			Compliant with Targets.
			Quarter	50.00%	54.28%	G	↑			
		Reliable Improvement Rates	Month	65.00%	71.64%	G	↑			
			Quarter	65.00%	69.02%	G	↑			
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	N/A	100.3%		↓			Detailed ward level information shows specific variances
			Quarter	N/A	102.6%		↓			

WORKFORCE OVERVIEW – March 2018

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Mar-18**	10%	**10.38%**	μ	G	↑	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 11.90% (as at January 2018 latest available data). The monthly sickness absence rate is 0.60% lower than the previous month and compared to the same period last year (March 2017) it is 0.90% lower. The annual sickness absence rate is running at 5.38%. The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.19% (as at December 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounted for 28.86% of all sickness absence during March 2018, followed by Surgery at 12.97% and other musculoskeletal problems at 9.72%. The Funded Fte vacancy rate has increased slightly by 0.05% to 5.00%. The number of employees who have received an appraisal within the last 12 months has increased by 1.72% to 80.15%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £740k. Compulsory training compliance has increased by 0.74% to 87.09%.
			Feb-18		10.60%		G		
		Sickness Absence (monthly)	**Mar-18**	5.04%	**4.80%**	μ	R	↓	
			Feb-18		5.40%		R		
		Sickness Absence (annual)	**Mar-18**	5.04%	**5.38%**	μ	R	↑	
			Feb-18		5.41%		R		
		Vacancies (including funded fte flexibility / cover)	**Mar-18**		**5.00%**	κ		↓	
			Feb-18		4.95%				
		Appraisals (all staff - number of employees who have received an appraisal in the previous 12 months)	**Mar-18**	90%	**80.15%**	κ	A	↑	
			Feb-18		78.43%		R		
		Appraisals (medical staff only - number of employees who have received an appraisal in the previous 12 months)	**Mar-18**	90%	**82.41%**	κ	A	↑	
			Feb-18		69.72%		R		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Mar-18**	£0	**£0.740m**	μ	R	↑	
			Feb-18		£0.751m		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Mar-18**	0%	**24.41%**	μ	R	↓	
			Feb-18		27.01%		R		
		Compulsory Training (staff in-date)	**Mar-18**	90%	**87.09%**	κ	A	↑	
			Feb-18		86.35%		A		

Key:

Period Current month and previous month
Plan Trust target
κ 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%)

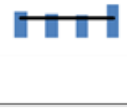
QUALITY OVERVIEW – MARCH 2018

Sub-set	Metric	Period	Plan	Actual	Trend graph by month (rolling 6 months: Oct 17 - Mar 18)	Trend graph by quarter (last 4 qtrs: Apr 17 - Mar 18)	Quality implications
Safe	No of incidents of moderate to catastrophic actual harm Plan: average last fin yr 2016/17 (month)	Month	29	38			The 12 month trend graph identifies a slight increase. We continue to monitor it, and also monitor how any aspect of this might be attributable to improved reporting.
		Quarter	88	112			
	No of deaths of patients who have died within 12 months of their last contact with DHCFT Data as at 04/04/2018	Month	104	134			The increase in Jan 2018 was due to data parameters expanding to now include deaths of people who are: open to IAPT services; whilst on waiting lists; open to substance misuse services. This has led to an overall increase in the last quarter.
		Quarter	312	460			
	No of serious incidents reported to the CCG	Month	5	6			Following peak reporting in May 2017, no of incidents reported to the CCG has stabilised.
		Quarter	16	19			
	No of episodes of patients held in seclusion	Month	10	29			Significant increase in March 2018 in response to the clinical needs of four individuals on two wards. On one ward, one person was secluded nine times and two people were secluded twice each. On another ward, one person was secluded six times.
		Quarter	30	50			
	No of incidents involving patients held in seclusion	Month	16	31			
		Quarter	47	66			
	No of incidents involving physical restraint	Month	48	77			This is directly linked to the above metric
		Quarter	143	165			
	No of incidents involving prone restraint	Month	10	21			Prone restraint is usually at a time of enforced medication administration via an injection. We would often see an increase in this in line with increased use of seclusion. Prone restraint audit and report for Quality committee in plan for May 2018.
		Quarter	29	41			
	No of incidents of physical assault - patient on patient	Month	12	20			There is a slight increasing trend quarter by quarter on patient to staff physical assault, but a decrease in the trend by month.
		Quarter	37	48			
	No of incidents of physical assault - patient on staff	Month	19	40			
		Quarter	56	103			

QUALITY OVERVIEW – MARCH 2018

Safe	No of falls on in-patient wards	Month	32	22			This has recently been looked into via a falls audit on the Cubley Court wards, and reported to the Quality committee.
		Quarter	96	69			
	No of incidents of absconsion	Month	33	21			Lower incidents monthly and quarterly continuing to reflect a general downward trend.
		Quarter	99	55			
	No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	71.26%			Audit planned to look at quality and completeness of safety plans across campus and Neighbourhood services. Pilot planned in Derby City Neighbourhood Team B to review robustness of safety plans.
		Quarter	100%	73.09%			
	Of above, no of patients with a Safety Plan	Month	90%	62.73%			Steady increase in compliance being recorded. This is due in part to people completing safety plans after the final Face risk plan reached a point of needing to be reviewed.
		Quarter	90%	53.94%			
	% of staff compliant with Level 3 Safeguarding Children training New indicator from Nov 17	Month	85%	82.24%			This figure is a new measure solely of Level 3 Training, no longer counting Think Family training. A steady increase in compliance is being recorded, as people compliant via Think Family training undertake Level 3 Training.
		Quarter	85%	NA			
	% of staff compliant with Clinical Safety Planning eLearning	Month	95%	91.95%			This performance will be overseen and actioned as necessary by the Safety Planning Steering Group
		Quarter	95%	NA			
	% of CTRs (Care & Treatment Reviews) completed	Month	100%	Not available			The metric and data remains under review and clarification
		Quarter	NA	NA			
	% of compliance with inpatients VTE assessment	Month	95%	91.44%			This is being monitored and action planned as part of our review of physical health assessment for in-patients
		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 – MARCH 2018

Caring	No of complaints opened for investigation	Month	12	19			Peak of 24 complaints in January 2018. Reduced in Feb/Mar 2018, back in line with overall trend. Monitored in the Feedback Intelligence Group and reported via the Patient Experience Report
		Quarter	37	60			
	No of concerns received	Month	35	36			Monitored in the Feedback Intelligence Group and reported to the Patient Experience Report.
		Quarter	104	107			
	No of compliments received	Month	100	110			Also monitored in the Feedback Intelligence Group and reported via the Patient Experience Report
		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			Five complaints required no further action
		2017/18	NA	0			Two complaints are ongoing
	% of responded to (orange) complaint investigations completed within 40 working days, opened after 01/04/2017	Year	100%	23%			184 (orange) complaints as at 04/04/2018. 88 not responded within 40 working days. 43 responded to within 40 working days. 53 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%			Nine (red) complaints as at 04/04/2018. Three not responded within 60 working days. I responded to within 60 days. Five are 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	1			An incident in March 2018 involves an allegation against a staff member. This is being investigated.
		Quarter	2	2			

QUALITY OVERVIEW – MARCH 2018

Effective	% of in-patients with a recorded capacity assessment	Month	100%	90.06%			Ongoing work to both improve the quality and audit the evidence of this.
		Quarter	100%	92.89%			
	% of patients who have had their care plan reviewed and have been on CPA > 12months	Month	90%	93.01%			Care Plan audit in Neighbourhood services is almost completed. Tool revised for Campus services with roll out in Q1 18/19.
		Quarter	90%	94.21%			
	No of seclusion forms not received by MHA Office	Month	0	4			Of the seclusion episodes recorded on Paris, three were not recorded as incidents and four were recorded as incidents but not recorded on Paris. These are being followed up with the relevant ward mangers. In the preceding five months there were no seclusions not recorded on Paris.
		Quarter	0	0			
	% of CTO rights forms received by MHA Office	Month	100%	97%			Improving performance this month
		Quarter	NA	NA			
	% of in patient older adults rights forms received by MHA Office	Month	100%	96%			Improving performance this month
		Quarter	NA	NA			

QUALITY OVERVIEW – MARCH 2018

Responsive	% of staff uptake of Flu Jabs	2016/17	45%	38.4%			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%	92.05%			Monthly escalation remains in place of policies at risk of going out of date and those that have.
		Quarter	NA	NA			
Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	100%	61.15%			All divisions have action plans around increasing the % of people receiving the target number of clinical and managerial supervision. Short term improvement remains a challenge for some areas, which affects overall performance.
		Quarter	100%	NA			
	% of staff who have received Management Supervision, within defined timescales	Month	100%	72.00%			
		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	29			This is being monitored and reviewed by the Patient Experience Team
		Quarter	NA	NA			
	No of outstanding actions following CQC comprehensive review report (2016)	Month	0	13			Working through the final remaining actions over the next few weeks with operational management colleagues.

Financial Section

Exceptions month 12

- **Over achievement of the control total**

  As previously forecast we have over achieved the control total surplus by £663k excluding Sustainability and Transformation fund (STF) income. Due to the overachievement of the control total we have received additional STF incentive income of £2.3m. This has resulted in a end of year surplus of £5.8m against the control total of £2.8m.

- **Capital Expenditure exceeds plan**

  The Trust's capital expenditure exceeded the plan by £384k at the end of the financial year. However £333k of this related to additional capital funding from the Department of Health and Social Care for cyber resilience.

- **Cash – higher than plan**

  At the end of the financial year cash levels of £21.3m exceeded the plan by £9.1m. This is mainly due to overage income, Sustainability and Transformation Funding (STF) income from 2016/17 which was paid in July along with the proceeds from the sale of an asset in March. There is a high proportion of capital accrual along with other payables.

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

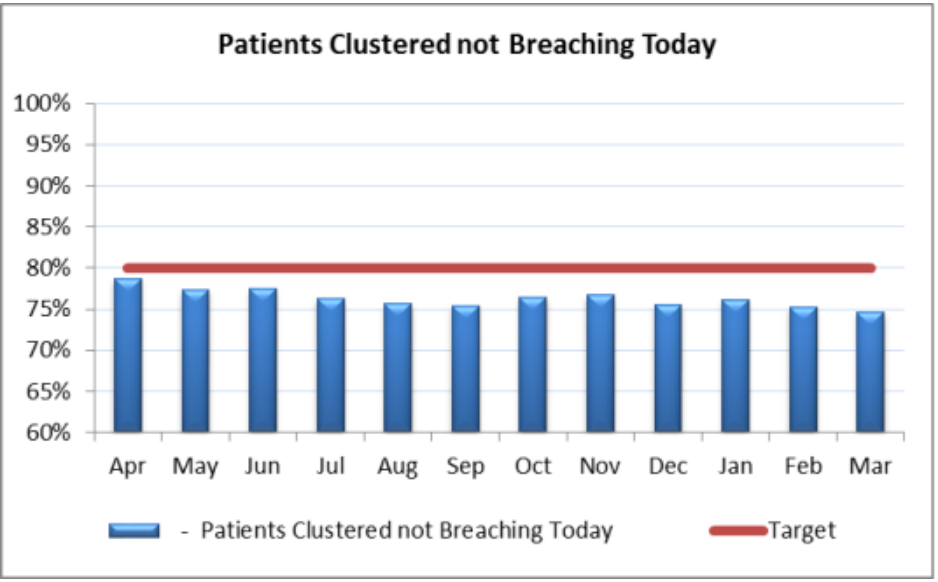
  The total CIP delivered is £4.8m which is an overachievement of £1.0m against the target of £3.8m. Of the £4.8m delivered schemes, £3.2m is non-recurrent in nature. The non-recurrent nature of this year's delivery poses a significant risk to next year's financial performance.

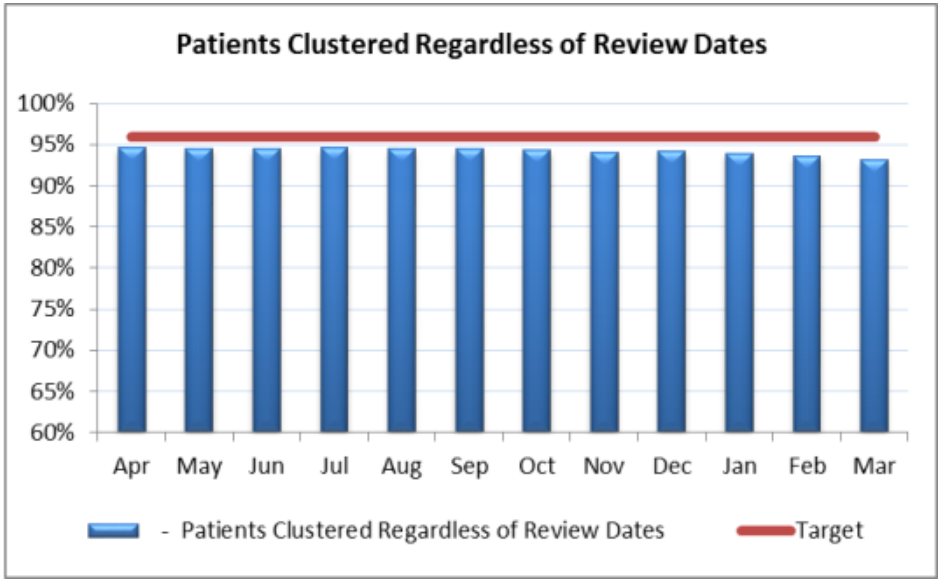
- **Agency expenditure**

  Agency expenditure ended the financial year £740k above the ceiling (24%) which is generating a '2' on the agency metric. This is an improvement to last month's forecast which assumed an overachievement of £0.9m (29%) which would have been a '3' on the agency metric within the Finance Score.
  The actual expenditure on medical agency is below the medical agency target that was set by NHSI.

Operational Section

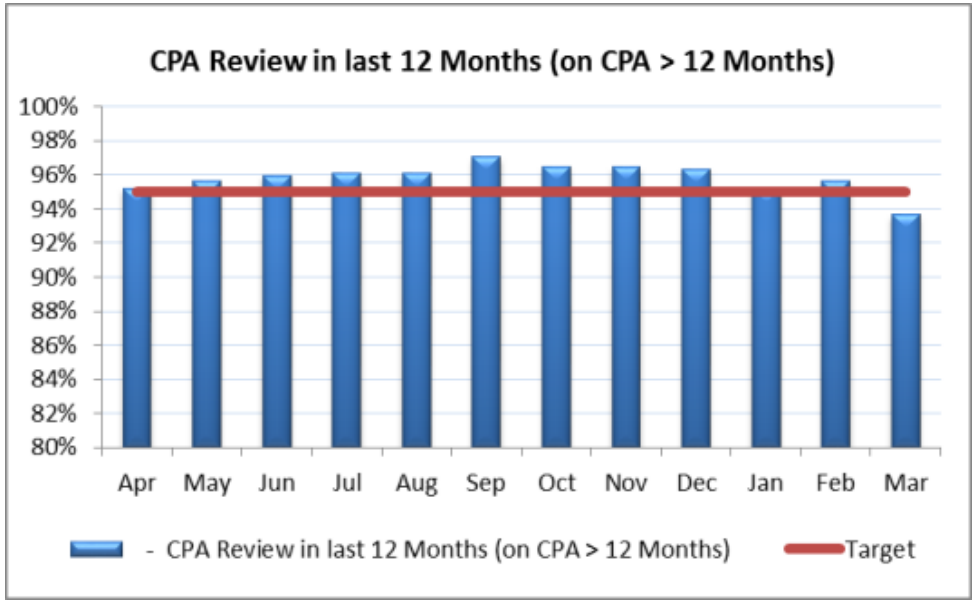
Patients Clustered not Breaching Today and Patients Clustered regardless of review dates





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

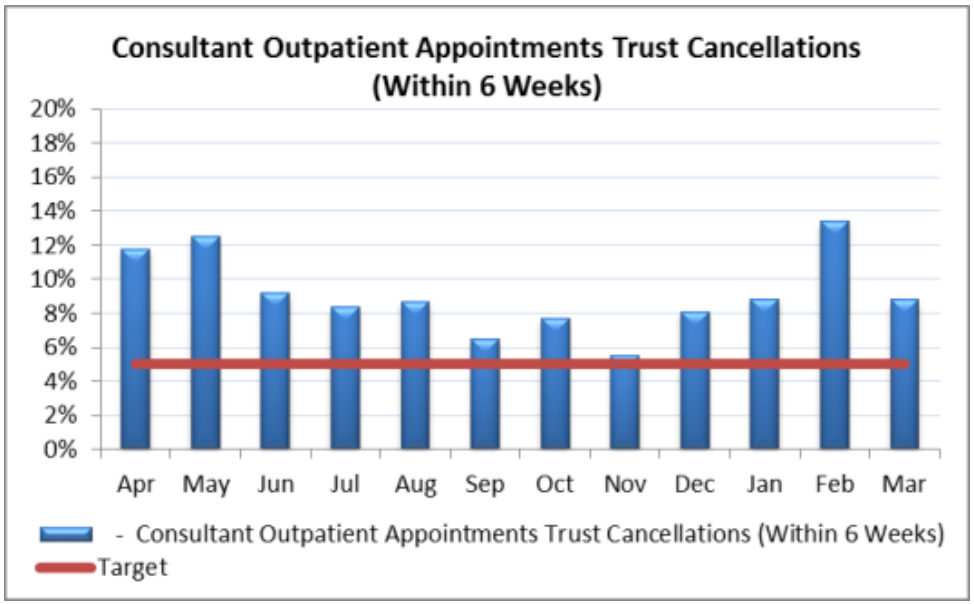
CPA Review in last 12 Months (on CPA > 12 Months)



Caseloads and demand for community services continue to make this a very challenging target to achieve. There have been a series of management changes in the north of the County over the last few months which has impacted on performance. The staffing position is now stable.

We continue to perform favourably when compared with other Trusts. In the latest published data, nationally 80% of patients had a CPA review, with a median rate of 89% across NHS mental health trusts. Derbyshire had the 13th highest review rate in the sample of all NHS mental health trusts.

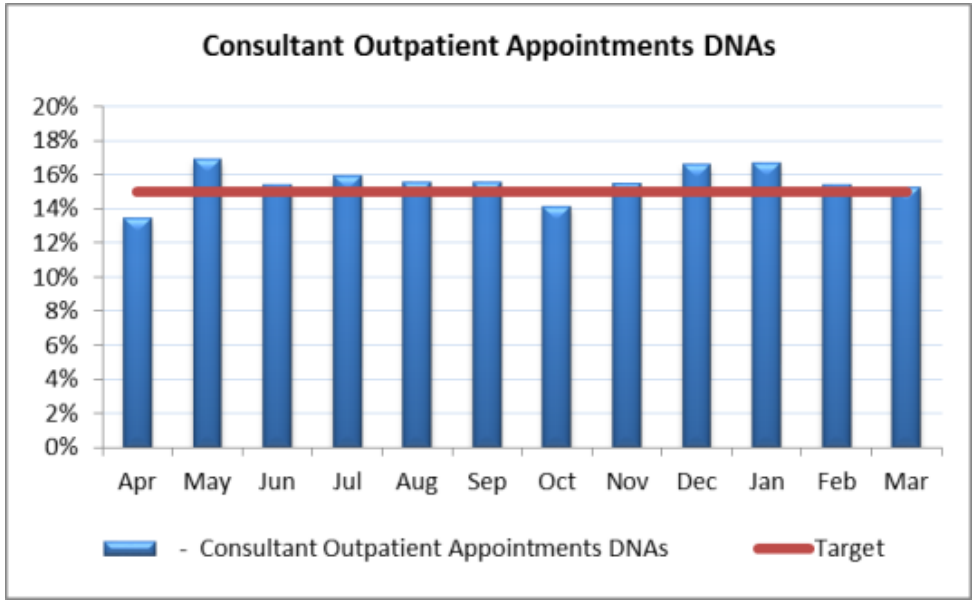
Consultant outpatient appointments Trust cancellations (within 6 weeks)



Reason	n	%
clinician absent from work	209	56%
appointment brought forward	37	10%
clinic booked in error	25	7%
moved - staff issue	22	6%
moved - trust rescheduled	21	6%
clinician must attend training	19	5%
no consultant	14	4%
moved - clinic cancelled	8	2%
clinician must attend meeting	6	2%
clinician on call/ night duty	5	1%
clinician on annual leave	3	1%
estates issue	2	1%
moved - location issue	1	0%
safeguarding conference	1	0%
MHA assessment urgent work	1	0%
Grand Total	**374**	**100%**

374 appointments were cancelled in March. This is 28% fewer than last month. The main reason for cancellation continues to be clinician absence from work.

Consultant Outpatient DNAs



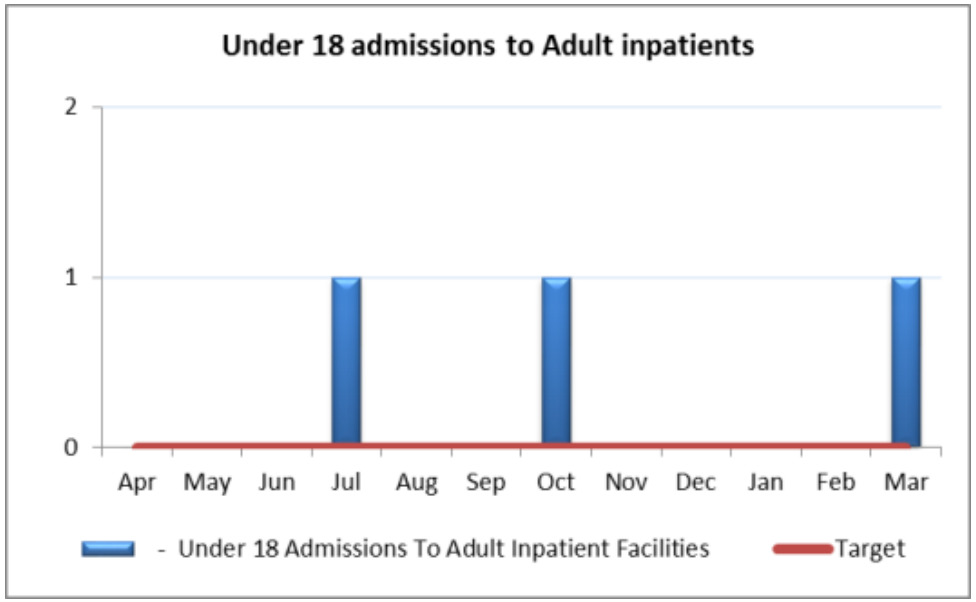
Killamarsh and North Chesterfield medical secretaries now telephone patients to remind them of upcoming appointments and we will have a full month of data around the impact of this intervention in mid-April.

Consultant Outpatient Cancellations linked to DNA's

	DNA		No DNA		Total n	Total %
	n	%	n	%		
2017						
Apr	42	11%	342	89%	384	100%
May	79	14%	501	86%	580	100%
Jun	66	13%	454	87%	520	100%
Jul	70	12%	497	88%	567	100%
Aug	63	13%	437	87%	500	100%
Sep	62	12%	442	88%	504	100%
Oct	53	11%	435	89%	488	100%
Nov	55	12%	396	88%	451	100%
Dec	30	10%	269	90%	299	100%
2018						
Jan	39	10%	350	90%	389	100%
Feb	40	8%	449	92%	489	100%
Mar	66	11%	545	89%	611	100%
Grand Total	665	12%	5117	88%	5782	100%

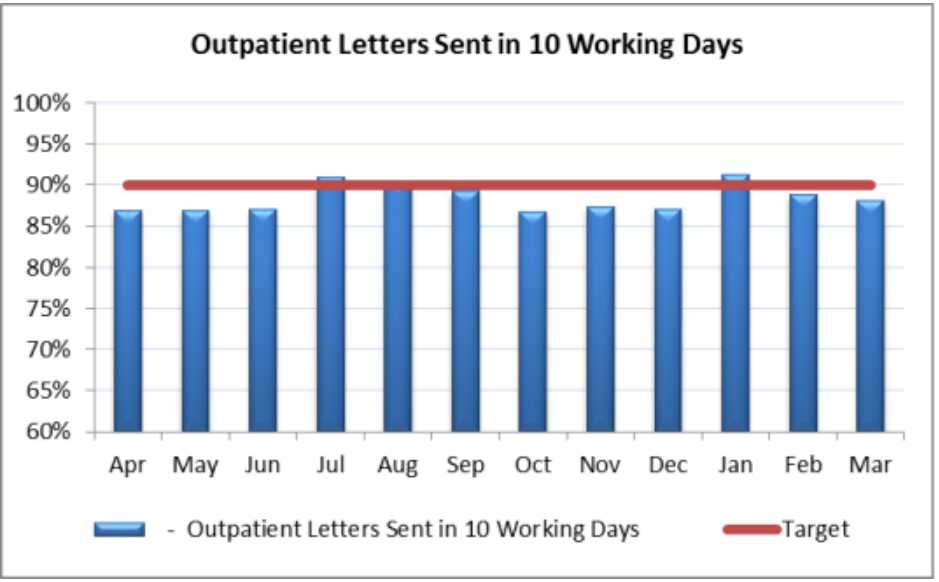
Board members asked for further detail on whether there is any link between cancellation of appointments and future DNA's. Over the last 12 months 12% of the patients who had an outpatient appointment cancelled by the Trust subsequently DNA'd their next outpatient appointment.

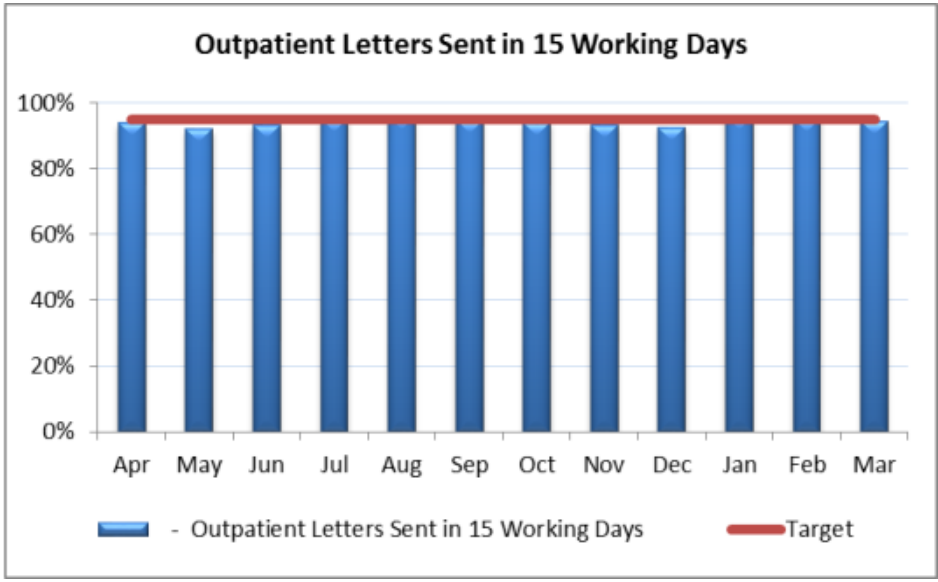
Under 18 admissions to Adult inpatients



A 17 year old male was admitted temporarily to ECW as no CAMHS PICU beds were available at that time.

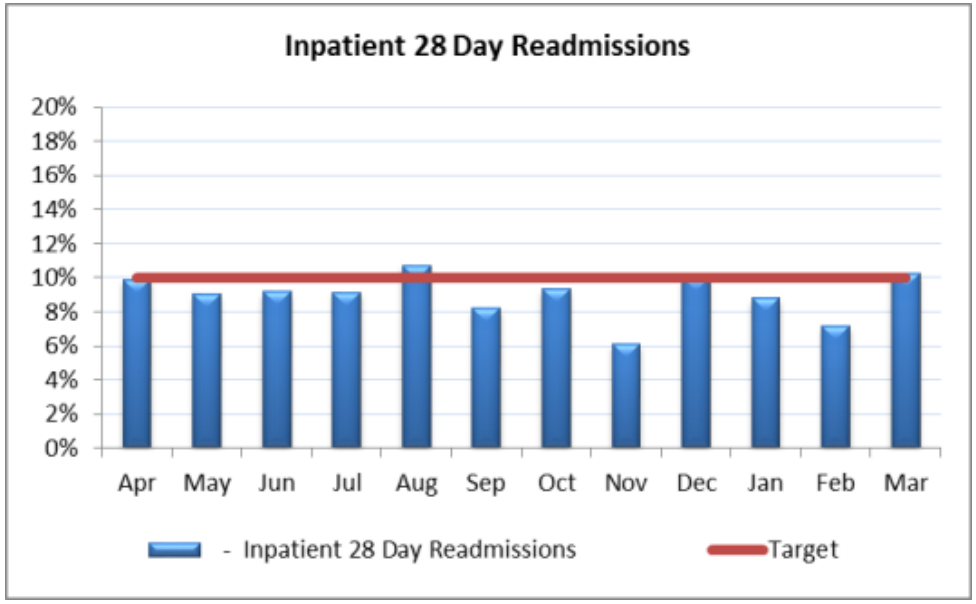
Outpatient letters





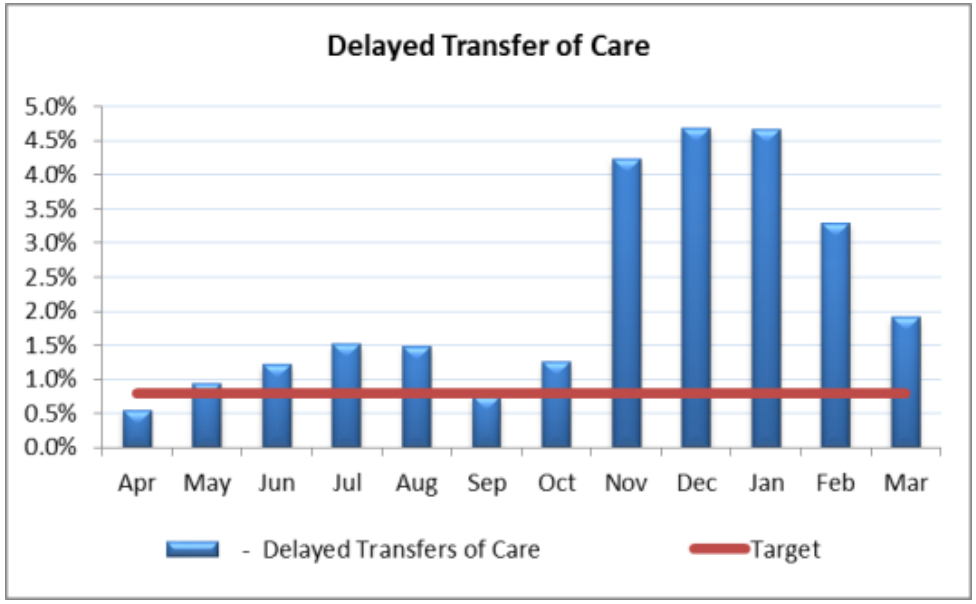
There were a number of dictations uploaded late. There was also an increase in annual leave of Secretaries during March with individuals taking their holiday allocation before year end. In addition there was bereavement leave and sick leave in the support office. This has all impacted on processing speed. April performance (to date) is above target.

Inpatient 28 day readmissions



28 day readmissions exceeded the threshold in March. This is being reviewed by the Clinical Director and Head of Nursing although there is nothing to indicate that this is a trend.

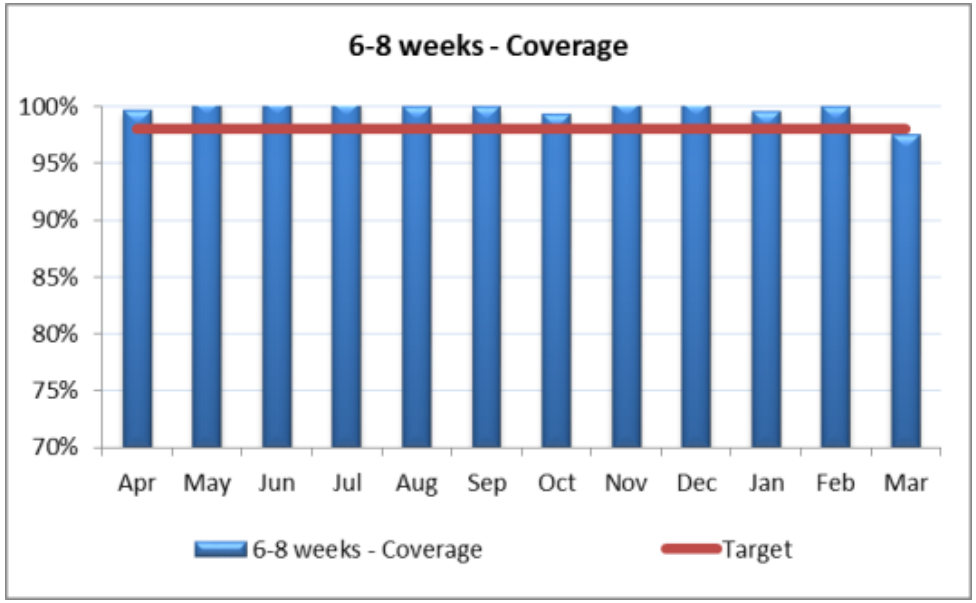
Delayed Transfers of Care



3 discharges were delayed in March, for the following reasons:

Current Ward	Delay Reason	Responsibility
Enhanced Care Ward	K2 - housing - awaiting emergency accommodation from local authority	Health and Social Care
Ward 36	C1 – awaiting further non-acute NHS care	Social Care
Morton Ward	E1 - awaiting care package in own home	Social Care

% 6-8 Week Breastfeeding coverage



Exception reasons:

- 3 have declined visits
- 7 no access visits: these have been followed up
- 5 were late and being carried out on the 12th April

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	80.00%	84.6%	141.6%	66.1%	0.0%	Yes	Audrey House is currently recruiting 3 RN's possible further leavers April 18 1 retired WTE 1 RN transferred to CMHT 0.6 1RN on year secondment to return August WTE 1 RN LTS 0.6 1 RN returned from LTS carrying A/L and phased RTW WTE We are using BN's band 2 to backfill and working creatively
CHILD BEARING INPATIENT	54.84%	61.3%	87.3%	96.8%	129.0%	Yes	We have broken the current fill rate tolerances on days for registered nurse and care staff and night care staff due to : 0.6 WTE Lead Nurse vacancy, 0.8 WTE Registered Nurse vacancy, 0.8WTE Nursery Nurse vacancy, 0.6 WTE maternity leave, 1.0 WTE Registered Nurse long term sickness absence.In addition to this increased staffing to support observation levels
CTC RESIDENTIAL REHABILITATION	66.20%	117.4%	115.1%	109.7%	138.7%	Yes	The ward has broken the current fill rate tolerance due to the following reasons One staff being on long term sickness One staff being on phased return . One staff being on placement One staff retired and took the rest of her shifts as annual leave .
KEDLESTON LOW SECURE UNIT	40.00%	62.9%	55.3%	82.3%	91.9%	Yes	We still have one unit shut which is skewing the figures and where we have one qualified on nights there have been times when the second has been booked onto another ward or we've put the request out to bank and its not been filled so we have back filled the second qual with a nursing assistant.
KINGSWAY CUBLEY COURT - FEMALE	69.18%	70.8%	104.3%	47.3%	116.1%	Yes	We currently have R/N vacancies, R/N long term sickness, and S/N moved to Cubley Male for this period. We are actively looking to recruit into the vacancies.
KINGSWAY CUBLEY COURT - MALE	56.63%	74.7%	121.9%	93.6%	152.7%	Yes	We continue to utilise a high number of bank Nursing assistants due to increased levels of observations on the ward and client group continuing to be more complex and challenging. We aim to have 2 RN at night to support safer staffing. We currently have 2 RN vacancies and RN on maternity leave , we aim to also have a minimum of 2 RN staff in the day shifts. Levels of observations remain high in the day and bank usage continues to remain high with some shifts not being covered by the nurse bank.
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	98.57%	72.0%	115.1%	93.6%	98.4%	Yes	No comment received

WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
HARTINGTON UNIT - MORTON WARD ADULT	93.55%	116.2%	114.8%	67.7%	219.4%	Yes	We have x1 Band 5 who is currently acting into Band 6 role – this individual has now been successful in getting the substantive post and her Band 5 post has been added to the current vacancies at Band 5 level. The others are nearly fully recruited into and we are awaiting start dates for the successful candidates. In addition to that we are waiting for a Band 3 HCA to start pending successful checks, and a Band 5 OT is starting on April 23rd. Once these positions are filled we will be in a position to have x2 Qualified staff on night duty, as currently we are filling the positions with BAND 2/3 HCAs.
HARTINGTON UNIT - PLEASLEY WARD ADULT	84.52%	74.5%	120.7%	41.9%	203.2%	Yes	No comment received
HARTINGTON UNIT - TANSLEY WARD ADULT	91.67%	86.2%	124.7%	59.7%	174.2%	Yes	In the month of March there were 5.6 WTE Band 5 vacancies, 1.0 WTE Band 5 not currently working in clinical duty, 1.0 WTE OT post vacant and 0.6 WTE Band 5 on long term sick. These shifts were partly backfilled by Band 5 Bank cover composed mostly of existing staff working additional hours at Bank rate however a large proportion were covered by Band 2 Bank HCA which is reflected in the staffing fill rates identified below. To try to provide the optimum skill mix to manage the clinical activity on the ward night shifts have run predominantly on 1 registered nurse as opposed to the budgeted 2. On some nights in March clinical activity required an increase in overall staffing to 4 to manage the risk safely. 3 of the WTE Band vacancies are recruited into however the successful applicants have not yet qualified. We have expected qualification dates of September x 2 WTE and December x 1 WTE. The OT vacancy is also recruited into however the successful applicant does not qualify until April. The remaining posts are open to recruitment and hopefully will be recruited into in the next few months. There is an HR process in place for both 1.0 WTE not currently working in clinical duty and the 0.6 WTE currently on long term sickness. It has been noted that there has been a reduction in short term sickness compared to previous months. Although it will not impact on the skill mix we have interviews on 18/04/18 to recruit 2.6 WTE Band 3 nurses on a temporary contract until the new Band 5 nurses come into post later in the year.

WARD STAFFING

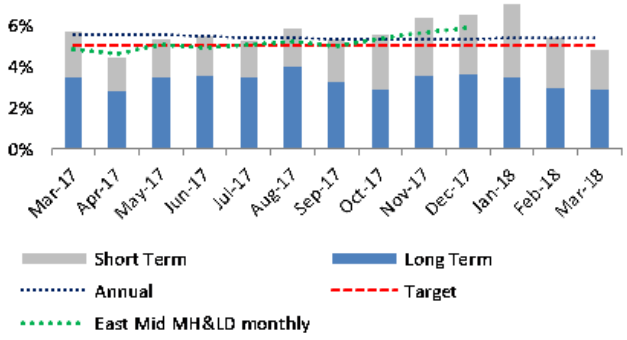
Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
ENHANCED CARE WARD	91.94%	82.9%	125.2%	50.0%	182.3%	Yes	Continue to work with RN deficit. All vacant posts are recruited into with first new starter next week, 1 due back in August from Career break, 1 due back from Maternity leave in June and 3 new starters in early September. Until Vacancies are filled continue to attempt to have trust qualified staff member as NIC pershift. Deficits are often filled with bank NAs we try to use those regularly that are familiar with patients and ward staff to reduce risks.
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	101.94%	85.7%	116.6%	77.4%	216.1%	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	99.03%	75.0%	114.0%	71.0%	193.5%	Yes	Staffing requirements are unable to be fulfilled due to ongoing RN vacancies , recruitment continues
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	99.19%	87.9%	149.2%	58.1%	225.8%	Yes	Ward 35 continue to carry a high number of increased engagement levels hence the increase in the use of care staff specifically at night. There has been an increased amount of sickness also. Vacancies remain which are trying to be addressed with in recruitment.
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	98.23%	93.3%	139.7%	51.6%	312.9%	Yes	No comment received

Workforce Section

WORKFORCE DASHBOARD

Sickness Absence	Jan-18	Feb-18	Mar-18
(Monthly)	7.33%	5.40%	**4.80%**
(Annual)	5.39%	5.41%	**5.38%**

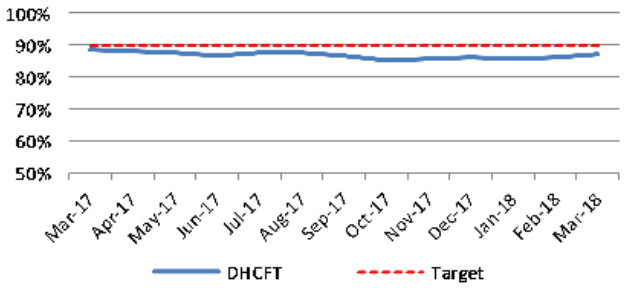
Target 5.04%



The monthly sickness absence rate is 0.60% lower than the previous month and compared to the same period last year (March 2017) it is 0.90% lower. The Trust annual sickness absence rate is running at 5.38%. Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounted for 28.86% of all sickness absence during March 2018, followed by surgery at 12.97% and other musculoskeletal problems at 9.72%. Compared to the previous month short term sickness absence has decreased by 0.55% and long term sickness absence has decreased by 0.05%.

Compulsory Training	Jan-18	Feb-18	Mar-18
(Staff in-date)	85.93%	86.35%	**87.09%**

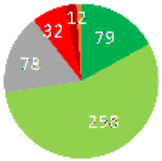
Target 90%

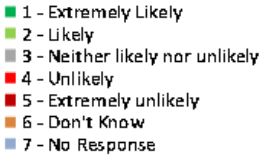


Compulsory training compliance continues to remain high running at 87.09%, an increase of 0.74% compared to the previous month. Compared to the same period last year compliance rates are 1.64% lower.

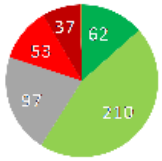
Staff FFT Q2 2017/18 (465 responses, 20.5% response rate) **& Staff Survey** 2017

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.

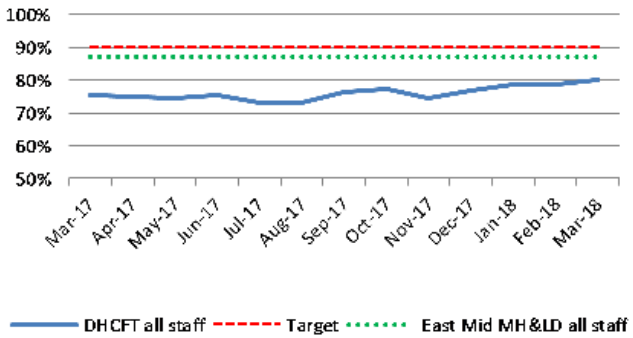


	2017	National average 2017	2016	National average 2016
Overall staff engagement (maximum score 5):	**3.74**	3.79	3.69	3.84

Appraisals (All staff)

Jan-18	Feb-18	Mar-18
78.60%	78.43%	**80.15%**

Target 90%

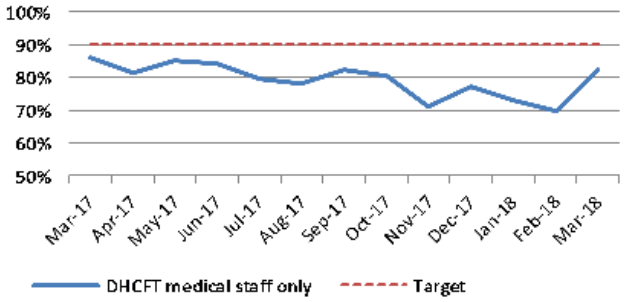


The number of employees who have received an appraisal within the last 12 months has increased by 1.72% during March 2018 to 80.15%. Compared to the same period last year, compliance rates are 5.01% higher. According to the 2017 staff survey results, the national average for combined Mental Health/Learning 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)

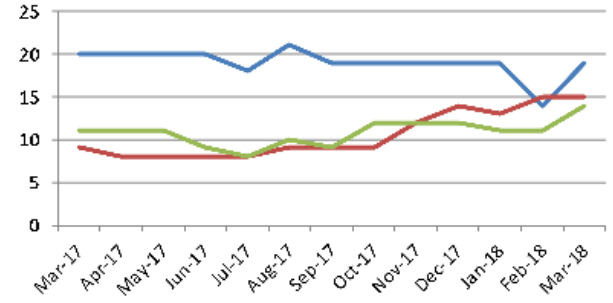
Jan-18	Feb-18	Mar-18
72.89%	69.72%	**82.41%**

Target 90%



The number of Medical staff who have received an appraisal within the last 12 months has increased by 12.69% to 82.41%. Compared to the same period last year, compliance rates are 3.70% lower. Junior Doctors on rotational training are excluded from the figures.

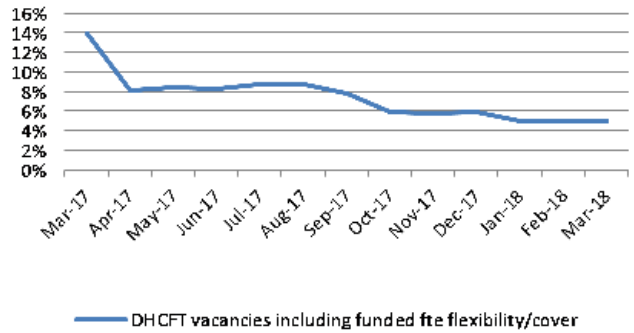
Disciplinaries/Dignity at Work/Grievances as at 31/03/2018



There are 19 Disciplinary cases, 6 new cases have been lodged and 1 case has been resolved. There are 14 Grievance cases lodged at the formal stage with 3 new cases being lodged and none resolved in the period. There are 15 Dignity at Work cases, none have been resolved in the period.

WORKFORCE DASHBOARD

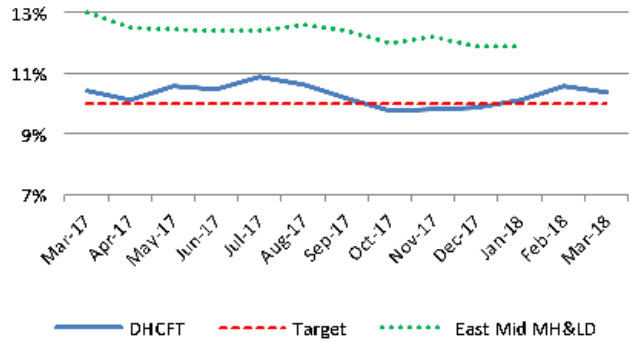
Vacancy	Jan-18	Feb-18	Mar-18
(Funded full time equivalent) Including funded fte flexibility/cover	5.03%	4.95%	**5.00%**



The Trust vacancy rate includes funded Fte surplus for flexibility including sickness and annual leave cover. Funded vacancy rates have increased slightly by 0.05% to 5.00% in March 2018. 2017/18 budget changes included a large reduction in Fte from 2016/17 investment not materialising and Cost Improvement Programmes. During the period April 2017 to March 2018 2018, 260 employees have left the Trust and 350 employees have joined the Trust.

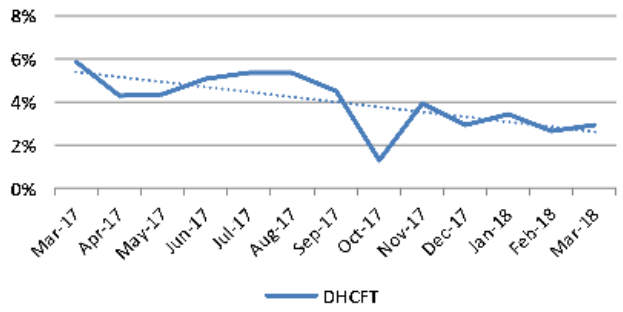
Turnover	Jan-18	Feb-18	Mar-18
(Annual)	10.14%	10.60%	**10.38%**

Target 10%



Annual turnover remains within Trust target parameters at 10.38% 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 21.67 to 21.75. During March 2018 24 employees left the Trust which included 10 retirements.

Agency Usage	Jan-18	Feb-18	Mar-18
(Spend)	3.43%	2.63%	**2.93%**



Total agency spend in March was 2.93% (3.44% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 0.80%, Medical 1.96% and other agency usage 0.17%. Agency Qualified Nursing spend against total Qualified Nursing spend in March was 2.17%. Agency Medical spend against total Medical spend in March was 10.91%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £740k.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors - 1 May 2018

Measuring the Trust Strategy – Year Two (2017/18)

Purpose of Report:

To update the Trust Board on the Strategy Dashboard for 2017/18.

Executive Summary

The Trust Strategy 2016-21 was approved by the Board in May 2016. In November 2016 draft measures were presented to the Trust Board where it was agreed that the integrated performance report would be used for on-going monitoring of the strategy.

The Board were in agreement that we should use one or two key measures for each strategic aim, with a report being produced annually.

Owing to the timing of key information it was agreed that the update would be presented at the May Board each year.

This report gives an update on year 2 of the Trust Strategy 2016-21. This will be the final report in this format as during 2017/18 the Trust Strategy was refreshed to reflect:

- 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.

A new dashboard will be devised to help demonstrate progress towards achieving the revised strategic objectives.

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 information contained on the dashboard has been presented and scrutinised throughout the year • The dashboard is a collation of information to assist in measuring year on year progress.	

Consultation

- The dashboard has been discussed previously by the Trust Board, the Executive Leadership Team and their respective teams.
- Lead Directors have been consulted and have approved their relevant sections.

Governance or Legal Issues

There are no governance or legal issues associated with the actual dashboard.

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

Equality Delivery System

This report has a neutral impact on REGARDS groups.

Recommendations

The Board of Directors is requested to accept the dashboard noting the achievements for Year 2 of the Strategic Plan

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

Measuring the Trust Strategy – Revised Dashboard

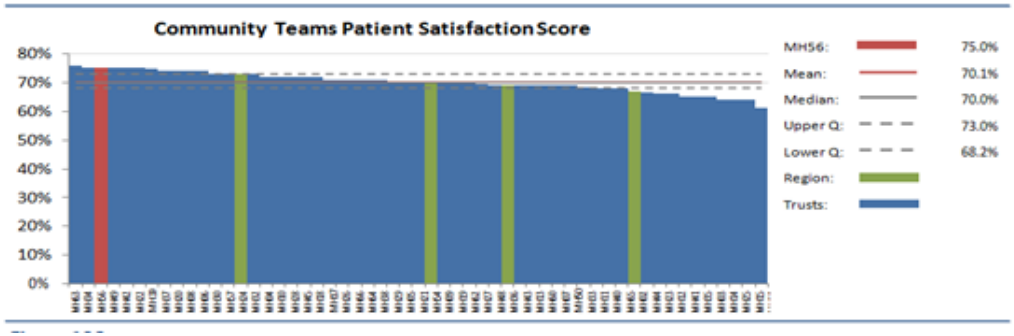
Quality - provide good care to our service receivers and families, developing the use of clinical and patient outcome measures, to test and measure how effective our services are. Work to achieve at least a 'good' rating with the Care Quality Commission (CQC).

Measure

Primary

By 2021 we will be within the top 20% against benchmark organisations for our 'Patient experience of community mental health services'

- 2016/17 – achieved top 50%
- 2017/18 – achieved top 10%



N.B. DHCFT are shown by the red line

- By 2020/21 we will have received at least 'good' in the CQC ratings.
  - 2017/18 – CQC actions plans have been embedded and many changes made as we prepare for a full inspection in 2018/19.
- A 20% year on year increase in the volume of 'Friends and Family' test feedback reporting 'extremely likely/likely' to recommend our services

F&F feedback	Baseline	2016/17	2017/18	2018/19	2019/20	2020/21
Target	856	1027	1233	1479	1775	2130
Actual		1142	800			

People – our people and organisational development strategy will enable us to create the cultural change that is required for the next five years.

Measure

By 2020/21 we will be in the top 20% of NHS organisation as a place to work as measured by the national staff survey engagement score. This will be benchmarked against other Trusts in the MH with LD and Community category:

- 19 Mental Health Trusts – in 2017/18 the top score was 3.94 (5 being the maximum)
- The lowest score was 3.63
- 9 Trusts saw a decrease in their score from 2016/17
- DHcFT was 13th out of the 19 Trusts

	Baseline 2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
			Top 60%	Top 50%	Top 40%	Top 20%
Target Score	3.73		3.79	3.80	3.82	3.85
Actual		3.69	3.74			

<table>
<tr><td>Partnerships – develop partnerships which enhance service delivery and foster a system wide approach in line with the Sustainability and Transformation Plan.</td><td>Transformation – our plans will be both internally and externally focused, aimed at ensuring a sustainable long-term future for the organisation and the health and care economy in which we work.</td></tr>
<tr><td>Measure
Qualitative feedback will be given on an annual basis

• On-going feedback to F&P Committee – tenders won on the basis of partnerships e.g. Substance Mis-use and other examples of partnership working.
• Formal partnership established with Derbyshire Community Health Services NHS FT (Joint Venture) for the provision of People and Organisational Effectiveness services across the two Trusts.
• MH STP Partnership Events – co-production of new models of care</td><td>Measure
Achievement of the organisational control total

<table><tr><th>Control Total</th><th>Baseline</th><th>2016/17</th><th>2017/18</th><th>2018/19</th><th>2019/20</th><th>2020/21</th></tr><tr><td>Target</td><td>£2.530m</td><td>£2.530m</td><td>£2.764m</td><td>£3.022m</td><td>£3.022m</td><td>£3.022m</td></tr><tr><td>Achieved</td><td></td><td>Achieved</td><td>Achieved</td><td></td><td></td><td></td></tr></table></td></tr>
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Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 May 2018

Update on the Joint Shared HR/Workforce Function between DHCFT and DCHS

Purpose of Report

To update the Board on the Joint Shared HR/Workforce function between DHCFT and DCHS.

The Board is aware of the agreement that the Boards of both Trusts reached in 2017 to create a joint function and to confirm that this was enacted formally on 1 April 2018.

To confirm that the governance arrangements are agreed and up and running as a Joint Venture Agreement, under the direction of the Joint Venture Leadership Team.

To confirm that 31 employees from DHCFT were subject to TUPE transfer on 1 April 2018.

To confirm that from1 May 2018 the new service will commence. There are still some final appointments to be made and work hand over to be completed before the service is able to be fully functional.

During the year there are a number of service improvements planned and a programme of work will the discussed and finalised with the Joint Venture Leadership Team.

Executive Summary

This has been a complex and sensitive programme of work. The plans were ambitious and progressive in terms of vision and met the requirements within the Lord Carter reforms for the NHS. The newly created People Services (name as voted on by the staff) will deliver the following services to the Trust and be based across two sites, Derby and Chesterfield. Each team is finalising their name and job titles to align and we will be looking to communicate this to staff at the beginning of May in order that all leaders and staff know who is who in the structure, how to make contact and the services that each team will be providing.

Process

The heads of service undertook a mapping exercise, following one to ones to determine slotting rights to the new structure. This was shared with Partnership/Staff Side and adjustments made where agreed.

All staff in scope were encouraged to seek opportunities for career progression or seek new opportunities even if they had slotting in rights. Interviews were scheduled week beginning 12 March and cognisance was taken of staff and Staff Side / Partnership views in relation to constituency of panels. There was representation from both Trusts and the workforce development and education team invited an external representative to join the panel following request from staff.

Outcome

All staff have permanent roles have roles in the new structure and 2 employees who were on fixed term contracts (one DHCFT and one DCHS) left at the end of March 2018. There are no costs, other than pay in lieu of notice associated with these contracts terminating. One member of staff is subject to pay protection.

There is no expected redundancy costs associated with Phase two of this programme.

It is pleasing that 19 staff have gained promotion in the new structure and 9 have moved team within the Service utilising transferable skills to move in a different direction. The staff are excited to be able to use their transferable skills and learn more about the other elements of People Services, it is always good to see people developing and gaining promotion and seeking opportunity.

Staff are embracing the planning meetings and enjoying seeing the benefits of utilising the systems to deliver to 2 trusts such as TRAC and the Allocate bank system. They are seeing and delivering efficiencies of scale.

Vacancies remain in the Service and all posts are advertised now. Below provides details of the remaining roles:

Employee Relations - 2 x Employee Relations Assistants

Resourcing - 2 x Admin Support

Equality and Diversity and Inclusion - 1 ED&I Advisor

Development & Education - 1 x Specialist Lead Trainer / 2 x Mandatory Trainer (Clinical) / 1x Senior Training Officer / 1 x Training Admin Support / 1x Mandatory Training Support / 1 x Workforce Planning & Development Lead / 1x Wider Workforce Manager

Organisational Development - 1 x Leadership Development Lead / 1 x OD Advisor / 1 x OD Assistant

**Please note that team names and job titles will be changing following consultation with the staff.*

Staff Engagement

Extensive staff engagement has taken, place since1 April. Welcome letters and new contracts issued, opportunities to meet new colleagues and inductions into both Trusts planned to enable the team to deliver services of equal parity to both Trusts. Team meetings have taken place for orientation and familiarisation with new systems, policies and ways of working. Underpinning this will be programmes to enable the team to understand the culture and requirements of each Trust.

Opportunities for one to ones have taken place and the whole team had a very successful launch on 24 April. Identity of the team going forward as a key topic as is meeting the business and service requirements of the Trust. Detailed business

planning to meet the KPIs is underway. The new team introduction to colleagues delivering Services is in the planning stage with communication support to ensure visibility and understanding.

Risks

There is a risk is to recruiting and filling all the positions so we can fully deliver our service specs. Team development will be ongoing for a couple of months so there is a risk of not hitting our KPIs straight away.

There is also risk with the new in-house bank for DHCFT will not deliver KPIs on fill rates as we have work to do to build the temporary staffing supply, action plans are in place and are now agreed with the executive team.

There is risk of to achieving the mandatory training compliance rates. This has been a live risk for some months and the development of the service and increased capacity will support the mitigation.

Finance

The objective of developing this new service was to provide more capacity and resilience in delivery of HR, workforce and OD requirements to the trust. Initial savings to be shared between the two trusts is £461.5k.

There will be an ongoing service improvement and development programme agreed and overseen by the Joint Venture Leadership Team**.**

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

Assurances

All systems are transferred and accessible to the teams that need to ensure we meet our data and reporting obligations.

All existing staff (bar one, who is deciding which role to accept in the new structure) are in post and fulfilling the requirements of their roles as set out in the agreed HR/Workforce structure.

All remaining vacancies have been advertised.

That the Joint Venture Leadership Team has received assurance on the financial envelope agreed and will receive and oversee the delivery of performance on a

monthly basis against the KPIs set out in the service specs. A template report is currently being developed.

Consultation

This was concluded in February 2018, having been delayed from the original start date intended as October 2017. There were 4 briefings held at both Trusts led by either the HRD or Deputy, and two conference calls (due to snow) to which all staff were invited. All staff were offered the opportunity of one to ones. Some new joint teams had away days to consider service re design.

The original structures were amended in response to feedback from staff themselves, Partnership and Staff Side and response from other stakeholders and resource was adjusted accordingly. The ED&I, Staff Wellbeing and Workforce Development team structure were revised to accommodate feedback. The overall structure was not altered significantly with the majority of staff broadly accepting the structures.

We established an Implementation Group with TOR, constituted with management side reps from both Trusts and Heads of Staff Side and Partnership from both Trusts. The raison d'etre being to develop open dialogue, confirm and challenge and transparency of process. This has worked well with good feedback provided by the Trade Unions.

TUPE

Consultation took place by DHCFT with all affected employees prior to the transfer date. All staff with rights to transfer did transfer on 1 April to DCHS. No bases have changed unless at the express request of the individual concerned.

Governance or Legal Issues

- Every effort has been made through the consultation process to mitigate and Equality and Diversity implications with individuals, teams and the Directorate as a whole.
- There are legal claims known in relation to this programme of work.

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 –

An equality impact assessment and mitigation plan was developed by the team overseen by the Head of Equality Diversity and Inclusion and shared with the Staff Side representatives.

Recommendations

The Board of Directors is requested to:

1) Note the progress with the delivery of the new service and the intended launch from 1 May 2018 and that some final appointments to be made.
2) Note that the Joint Venture Leadership Team will oversee the development and delivery of the service
3) Note that the People and Culture Committee will receive updates on the delivery of the key people metrics as identified in our Trust performance report and People Strategy that will be supported and enabled by this new service.

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 May, 2018

Equality and Equality Delivery System (EDS2) & Workforce Race Equality Standard (WRES) Update

Purpose of Report

The purpose of this paper is threefold, firstly to present to the Board of Directors an EDS2 update, key themes and actions following our annual grading against the national performance EDS2 standards for service and workforce. An overall Draft EDS2 Grading Dashboard 2017 for approval is attached at Appendix 1

Secondly, Workforce Race Equality Standard Action Plan 2017: Helping our BME Staff to succeed is at Appendix 2. For reference WRES benchmarking 2017 data comparison against other trusts is attached at Appendix 3 in preparation for WRES 2018 reporting due August 2018.

Finally, forthcoming performance standard - Workforce Disability Equality Standard (WDES) deadline August 2019 and proposal for Disability and Long Term Conditions Board Equality Champion.

Executive Summary

1. The Trust Draft EDS2 Dashboard 2017 across the four goals is presented for consideration and approval. This has been presented at Quality Committee on 8 March, 2018 in line with our intention to embed EDS2 Goals and accountability across our organisation, structures and systems. It will then be published on our external website as part of statutory report duties and also as evidence for Quality Schedule 4 of the Main Contract.

Key themes and actions are also set out below.

<u>Annual EDS2 grading took place in three parts to reflect the four EDS2 goals:</u>

EDS2 Goals Service outcomes and experience: Universal Children's Services (0-19) took place on 23 November, 2017. The Quality committee was presented with Universal Children Services EDS2 ratings and action plan 2017-18 on 14 December, 2017.

EDS2 Goals Representative Workforce and Inclusive Leadership: took place with the BME Staff Network on 3 November, 2017 and wider workforce on the 13 February, 2018.

- The Workforce & Organisation Team presented the evidence on behalf of the organisation to help staff and governors to assess if the Trust is a good and fair employer i.e. fair treatment and effectiveness of our policies and management decisions for all REGARDS (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation) groups.

- The session was promoted internally to encourage wide representation across the Divisions, bands, professions, BME Staff network, staff side and governors (over 80+ people participated across both events). Managers were

asked to invite and empower their team members to get involved and 'have their say'. However, it was noted that we need to build on this and encourage a wider representation of the different bands and professions at future events. Provisional dates for 2018-2019 have been set to enable managers to plan ahead, so that we can maximise engagement and gather relevant evidence.

- Members of senior management team and board members supported the three events and actively listened and participated.

- The events produced a number of insightful conversations which provided rich feedback for further development and improvement for the leadership and also for the wider organisation.

- This grading provided an opportunity to look at the service and workforce through equality impact analysis of data and case studies across the protected characteristics. This process considered and triangulated a variety of intelligence, e.g. staff survey, Family Friends, workforce diversity analysis and Workforce Race Equality Standard.

Draft EDS2 Dashboard 2017-18 :

The grades produced are summarised below and in the attached Draft EDS2 Dashboard 2017. *Please note the 18 outcomes have been locally adjusted to 19 for easy read format and not every stakeholder chose to grade each outcome of the outcomes. **Outcome 4.2 Papers that come before the Board and other major committees identify equality related impacts including risks, and say how these risks are to be managed – grading subject to outcomes from session taking place on the 27 April, 2018 chaired by Director of Nursing and Patient Experience

Is the Trust a good and fair employer for all REGARDS Groups?

Developing/OK but need to do more

EDS2 2017 Grades across the 2018/19*outcomes

	Good/Achieving 6-8 groups Green	Developing/OK, but need to do more 3-5 groups Amber
Service & Experience outcomes	7	3
Workforce outcomes	1	5
Inclusive Leadership outcomes		3**
Total	8	11

Workforce diversity and inclusive culture key messages and actions::

The key themes and actions to take forward were summarised by Chief Executive and Chief Operating Officer as follows:

- Our Trust is committed to ensuring Equality, Diversity & Inclusion are central to the way we deliver healthcare services to our service-users and how we support our staff.
- Continuous engagement and creating an environment where people positively experience our values is fundamental.

- A representative workforce and talent pool supports the delivery of our Trust objectives.
- Good examples of flexible working received and case studies shared.

Challenges to build on and actions to be taken forward.

- Services and workforce equality data – require greater level of data to make informed decisions, so we can understand and address barriers and make reasonable adjustments.
- Communication and continuous engagement so we improve individual confidence in asking questions and build trust in disclosing REGARDS data to help us inform our work and reasonable adjustments.
- Inclusive and compassionate culture and working environment – so people experience our Trust values around putting people first and respect (confidence, being respectful of each other and to each other). Get some good evidence, the way we work with each other and support each other to be the best we can be.
- Workforce Race Equality Standards Indicators - to help us understand the inequalities and root causes:
    - WRES Indicator 2: Relative likelihood of White staff being appointed from shortlisting compared to BME staff - 1.5 times more compared to BME counterparts.
    - WRES Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process compared to White staff: BME 1.6 more likely.

Next Steps - an EDS2 workforce action plan will be developed and linked to People Strategy 2018-2020 setting out how we intend to address the issues raised and close the gap over the next 12 months.

Performance management, accountability and reporting progress :

- The EDS2 Children Services EDS2 action plan and progress will be provided by the accountable officer, Hayley Darn, General Manager, Children's Services. This will be monitored via the Divisional Children's Clinical Operational Assurance Team 2017 and Equalities Forum.
- The Workforce EDS2 action plan will be developed by the new Workforce Team/service leads and Head of Equality. This will be shared and monitored via People & Culture Committee and Equality Forum.
- Feedback to stakeholders and staff will be undertaken via existing communication routes and email.

Forward planning EDS2 2018-19 and provisional dates
Date for your diary :

- EDS2 grading 2018 for service and patient experience standards: **15 November, 2018** at the R & D Centre Kingsway. Operational service for EDS2 review to be agreed.
- EDS2 Workforce and inclusive leadership grading – **12 February, 2019** at the R&D Centre Kingsway.
- Improving services for BME people through reverse commissioning – action planning and grading event date to be agreed with stakeholders and project board.

2. DHCFT Workforce Race Equality Standard Action Plan 2017: Helping our BME Staff to succeed

The WRES action plan was presented at People & Culture Committee on the 19th January, 2018 and progress noted. The WRES action plan (appendix 2) has now been cross referenced with the BME network objectives and includes clear priority areas for completion and closing the gap over the year:

1. Recruitment (WRES 2)
2. Progression (WRES 1 & 2)
3. Equality & Diversity Training (WRES 3, 5- 8 & staff survey results). Review training to improve cultural competency and to reduce bullying and harassment. Inclusive leadership workshop to be delivered as part of suite of Team Derbyshire on 17 July, 2018.

The BME Network Chair, Trust Equality Lead met with the Chief Executive and BME Board Champion to progress the actions. The Chief Operating Officer has also requested that regular updates from the WRES action plan be provided to the Trust Management Team every quarter for review at TMT meetings. These will commence following the annual BME Staff Network conference and the agreed actions going forward to close the gaps in the top three aforementioned issues.

Chief Executive & Board BME Champion has met with BME Network Chair and commissioning audit of recruitment process/journey and appointments to help us understand the root causes and close the gap for the variation in appointment of BME colleagues compared to white counterparts Workforce Information colleague invited to provide data analysis to inform this programme of work (BME Network 25 April 2018).

The annual BME Staff Network meeting once a month (12 meetings). The annual Conference and AGM is taking place on 15 May, 2018 will be taking stock and further refine the WRES action plan to ensure that this year's theme 'recruitment and progression' will be progressed. The agenda is focusing on sharing and analysing the inequalities/ factual evidence and also understanding the root causes, issues and barriers impacting the interview process and progression. A positive action – how do we make change happen and 'coaching yourself to success' session will be facilitated by an external coach.

Reverse Mentoring for Diversity, Equality and Inclusion (ReMeDi) training and preparation has been completed for both BME mentors and Executive mentees. The logistics are now in place to formally implement the process and Professor Johnson will be sending out an introduction email to BME mentor and mentee pairs from the 11 May, 2018. They will then arrange to meet monthly over the next six months. Research interviews will commence November 2018. Top up 1-1 sessions will be available for Execs who have committed to this project but were unable to attend the initial preparatory training.

Sharing learning: our partnership work with University of Nottingham in pioneering reverse mentoring was referenced at a recent NHS Improvement event by Professor Johnson.

Discussions have commenced with the BME Network Chairs to hold DHCFT end of year Reverse Mentoring celebration – December 2018 and invite Yvonne Coghill, Director, and National WRES Team.

WRES Benchmarking 2017– DHCFT is similar to other organisations in the region

as referenced at Appendix 3 2016-2017 and benchmarking against local trusts and two CQC 'outstanding rated' trusts (source: National UNIFY analysis via WRES Team).

The WRES 2018 is due August 2018 and we will continue to track and compare progress to see if gaps are reducing and improving.

Forthcoming performance standards

3. Workforce Disability Equality Standard (WDES) is a set of specific measures (metrics) that enable NHS Organisations to compare the experience of disabled and non-disabled staff. It is partly modelled on the Workforce Race Equality Standard. NHS England has been holding a series of consultation activities and events. The NHS Standard Contract for 2017-2019 (January 2018 edition) set out the NHS Trusts and Foundation Trusts will have to implement the WDES in the first year.

The indicative timetable and the **reporting deadline of August 2019** in line with the WRES deadline.

Time table	Action
Autumn 2018	Publication of the WDES
Autumn/Winter 2018	Trust review their data and reporting against the metrics.
June 2019	Reporting sheet with pre-populated data sent to NHS Trusts
August 2019	First WDES reports to be published in August 2019 based on data from j2018/19 financial year.
April/May 2020	First National WDES annual report published by NHS England

Preparing for WDES :

- Workforce data on ESR to be reviewed by workforce team to ensure we maximise recording across the disability fields and also using the Draft Metrics for WDES (data from the staff survey) to prepare preliminary position and gaps.
- Board champion for disability – we have an identified lead for Accessible Information Standard (reasonable adjustments) but need to consider a named lead to champion disability and long term conditions.
- Disability and Long Term Conditions Colleague Network to be scoped and set up.

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

Assurances

The Equality Forum together with Quality Committee and People and Culture Committees will ensure the Trust meets its statutory duties under the Human Rights Act (1998). Equality Act (2010) and Public Sector Equality Duty. The EDS2 Children Services action plan will be monitored via the Divisional Children's Clinical Operational Assurance Team and was shared on the 12 December, 2017. Equalities Forum – preliminary findings shared 28 November, 2017 and May 2018 (date to be confirmed).

Consultation

A number of key stakeholders including service users, community groups, and Healthwatch Derby and partner organisations, governors, staff including BME Network, staff side and governors joined leaders from corporate, service and workforce team from the organisation to review evidence and produce a final benchmark grade against the national performance EDS2 standards. Feedback to stakeholders has been agreed on a six monthly basis. Stakeholders including governors have been invited to audit our board papers on 27 April, 2018.

Governance or Legal Issues

Undertaking the EDS2 demonstrates progress and commitment to understanding of duties towards protected characteristics or REGARDS groups under the Equality Act 2010 & Human Rights Act 1998.

Quality Schedule 4 of the Main Contract: NHS Equality Delivery System (EDS2) evidence / progress reporting / assessment grades.

The Specific Duties regulations already require all public authorities, listed at the schedules to the regulations, to publish information to demonstrate their compliance under the Public Sector Equality Duty (PSED). There are currently different deadlines for publishing the information that is required:

- All the listed public bodies are required to publish equality objectives by 6 April 2012 and subsequently every four years from the last publication
- All the public bodies listed in Schedule 1 to the regulations are required to publish annual information which demonstrates their compliance with the PSED by 31st January each year – this has changed to 30 March and thereafter.

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).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential gaps/inequalities are outlined below, with the appropriate action to mitigate or minimise those risks.	x

Actions to Mitigate/Minimise Identified Risks

The EDS2 grading methodology involves gathering and analysing REGARDS data and case studies to help external stakeholders grade our performance. The aim is to identify potential inequalities and good practice, to show how groups fare across the service and employment pathway. The EDS2 also serves as barometer for inclusive environment and culture. The presentation and equality data analysis is available if requested.

Workforce Race Equality Standard indicators data was considered to support EDS2 grading, particularly inequalities related to variations between BME staff and white counterparts in shortlisting and appointment and formal disciplinary. An action plan will be developed to close the gap:

- Relative likelihood of White staff being appointed from shortlisting compared to BME staff - 1.5 times more compared to BME counterparts.
- Relative likelihood of BME staff entering the formal disciplinary process compared to White staff: BME 1.6 more likely
- Harassment and bullying data as part of WRE indicators and staff survey.

Recommendations

The Board of Directors is requested to:

1) Discuss and approve draft EDS2 Dashboard prior to sharing with our commissioners, stakeholders and on our external website.
2) Note the EDS2 Implementation Plan 2018-19 and provisional dates 15/11/2018 (operational service) and 12/2/2019 (workforce and inclusive leadership) to enhance planning and attendance.
3) Note the WRES action plan, progress to date, top three areas for action to close the gap.
4) Note the WRES deadline August 2018
5) Note Reverse Mentoring commencement from 11 May 2018 and offer to deliver one-to-one training to remaining Executives Directors.
6) Note the WDES deadline August 2019 and next steps.
7) Discuss the proposal for Disability and Long Term Conditions Board champion.

Report produced by: **Harinder Dhaliwal**
Head of Equality, Diversity & Inclusion

Appendices

- Appendix 1 : Draft EDS2 Grading Dashboard 2017
- Appendix 2: Workforce Race Equality Standard Action Plan 2017: Helping our BME Staff to succeed.
- Appendix 3: WRES benchmarking 2017 data comparison against other Trusts

Equality Delivery System2 Dashboard: Grading Results 2017

Green = Achieving (8) | Amber = Developing (10)

Grading dates: 0-19 Universal Children's Services 23/11/2017 and workforce 3/11/2017 & 13/2/2018

Goal 1: Better health outcomes for everyone (Healthy living & results for all REGARDS groups		**Goal 2: Improved patient access and experience** (REGARDS Group - getting, using and experiencing	
1:3 health service meets needs of local people in their communities	G	2:1 Everyone should be able to get into and use all our services	A
1:2 Each person has their health needs checked and met in the best way	G	2:2 People are told about choices they have in ways they understand	A
1:3 Moves to other services are done smoothly and everyone knows what is happening.	G	2:3 People have the support they need to make the choices they want.	G
1:4 People using service are safe, they are properly treated not abused or mistakes are not made	G	2:4 People say good things about the service they have used.	G
1:5Health promotion and screening – everyone gets a chance to have their checks and the information they need.	G	2:5Complaints are sorted out quickly and properly	A
Goal 3 :A representative and supported workforce (Trust a good and fair employer for all groups)		**Goal 4 : Inclusive Leadership & Governance** (Leaders responding and engaging with the needs of the diverse communities)**.**	
3:1 Do we have fair recruitment & selection processes which lead to a more representative workforce at all levels?	A	4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.	A
3:2 Do equal pay audits show that staff from most REGARDS groups fare well as overall workforce?	G	4.2 Papers that come before the Board and other major committees identify equality –related impacts including risks, and say how these risks are to be managed	TBA
3:3 Are personal development and leadership courses taken up and positively evaluated by all staff?	A	4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.	A
3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source.	A		
3:5 Are flexible working options available to all staff consistent with the needs of the service and the way they live their lives?	A		
3:6 Staff report positive experiences of their membership of the workforce.	A		

Please note EDS2 outcomes have been adapted to easy read. 4:2 audit of papers to be completed 27th April 2018. Outcomes 2.3 to 2.5 have been locally adapted for easy read and grading purposes as suggested by stakeholders.

Appendix 2 : DHCFT Workforce Race Equality Action Plan 2017: Helping our BME Staff to Succeed

WRES 2017 submission http://www.derbyshirehealthcareft.nhs.uk/standards/equality-diversity/wres/

WRES Indicator	Action	Target date	Expected outcomes	By whom (accountable lead)	Update April 2018
Indicator 1 – percentage of staff in each of AfC bands 1-9 and VSM (including executive Board for both white and BME staff groups. The data indicates under-representation but an increase for both white and BME staff groups. Clinical staff increase – white 0.71 percentage points and BME 2.39 percentage points. Non-clinical staff shows a slight increase with white 0.71 percentage point and BME 0.01 percentage point Table1 on page 8 shows under-representation and proportionately	As part of DHCFT Workforce Plan we need to understand what may be happening for each band boundary, talent pool and succession planning. a) Undertake analysis of the ethnic profile of staff for each Agenda for Change/pay band structure and for each of the staff groups. b) Enhance operational accountability in the system to proactively address BME under-representation across the bands and build BME pipeline. c) Teams/neighbourhoods set their own targets perhaps based on the diversity of their local geographical areas as a minimum.	Progress on all actions to be demonstrated by 30th June 2018, in time for the next WRES submission	Ensure that BME staff are equally represented at middle and senior management positions. Address the under-representation of BME staff at middle and senior management positions Create a level playing field for senior management positions.	Head of Education Deputy Director of Operations & Management teams to set targets based local population. Board to seek assurance of that workforce reflects the local neighbourhood population, fair employment and that we are leveraging the talents/assets and community knowledge of our workforce	WRES action plan shared and developed in partnership with BME network 3/11/2017 and approved QC 14/12/17 and PCC 19/1/2018 Workforce EDS2 grading event 13/2/2018 data presented by Head of Education and Workforce Team - key action to understand the data better and to close the gaps in across all our functions/operational services. QC paper 8/3/2018.

lower number of BME staff in the relevant bands April 2017. The highest non-clinical BME percentage is Band 1 (catering, domestic assistants and porters). BME Consultants continue to be over-represented at our senior clinical positons. Linked to: EDS2 Evidence Board Equality Objective BME Staff Network Objectives, People Plan and Workforce Plan (see end of document)	d) To ensure all BME staff have appraisal and PDP. e) Ensure equity of access to external training and development that supports career advancement. f) Positive action to improve team profile. g) Promote and monitor BME access to NHS national programmes, Leadership Academy and ILM programmes that aim to build leadership capacity amongst BME staff. h) Continue to develop and monitor BME access to internal and external* leadership development, coaching and mentoring programmes that aim to build BME leadership capacity and capability in the Trust (build talent pool and pipeline). *East Midlands Leadership Academy.		BME staff have the opportunity to gain practical experience at band 7 & 8a Clearly identified route for anyone requiring education and support. Chief Nurse is able to demonstrate that all BME nursing staff receive their annual appraisal as part of the CPD.	Head of Equality & Diversity BME Network, Network Chair/Deputy Executive Directors	BME Chairs appointed and invited to People & Culture Committee and Staff Forum. BME Network launched by Chief Executive on 3/11/2017. Network terms of reference approved, email and budget allocated to support positive action. BME Network has met 12 times including annual conference. BME Chairs (promote opportunities via BME Network email, including Visible Leaders Programme (evidence available via BME Network email).

	i) Explore and agree potential positive action opportunities with managers and BME network to ensure BME staff from each relevant band/profession are selected for acting up, shadowing, secondments, project leadership, mentoring and coaching opportunities. j) BME access to mentorship programmes with at least two undergoing external mentorship. k) Work with BME Network to host events for BME staff to identify their training and development needs and they would like to progress their careers (various staff groups clinical/non-clinical including facilities and estates staff)				Positive action: Building confidence and career building workshop delivered 3/11/2017. 2nd Annual BME Staff Network conference 23/5/2018 Theme Recruitment & Progression. BME Network Chair invited Head of Education to share BME training and development data at BME Annual Conference 23/5/2018 BME Chair has attended the national WRES conference and regularly meets with the Chief Executive. Top 3 priorities agreed as per WRES gaps Recruitment, Progression and Training.

	l) Drive cultural change through implementing the Reverse Mentoring for Equality, Diversity and Inclusion (ReMeDI Pilot in (action research) in partnership with University Of Nottingham. Developed following BME Network workshop and dialogue with board/senior leaders to enhance cultural competence. m) BME Staff Network championed by CEO - strengthened, resourced and representation at key decision making committees - People & Culture, Equalities Forum and staff engagement forum. Terms of reference and membership enhanced to ensure BME voice. WRES linked to network action plan as baseline. Annual conference				Reverse mentoring implementation plan on track and training completed. BME mentors and Executive Pairs to be formally introduced by Prof Johnson, University of Nottingham from the 11th May 2018 (six meeting over six months). Celebration event to be held in December, inviting Yvonne Coghill, Director National WRES Team, NHS England. Good practice : DHCFT pioneering work around ReMeDi shared at NHS Improvement event by Prof Johnson (April 2018) WRES action plan shared and developed in partnership with BME network 3/11/2017 and approved QC 14/12/17 and PCC 19/1/2018.

	externally facilitated to identify issues, barriers, develop network purpose, mission and goals.				BME Network positive action “Coaching yourself to success” external coach delivering at BME Network annual conference & AGM. 23/5/2018 BME Network Chair invited Head of Education to share BME training and development data at BME Annual Conference 23/5/2018
Indicator 2: White shortlisted job applicants are 1.47 (1.5) times more likely to be appointed from shortlisting than BME shortlisted applicants, who remain noticeably absent from senior grades within Agenda for Change (AfC) pay bands. However, data indicated a decrease from last year by 0.16% points.	a) As part of our Workforce Plan we need to understand what may be happening for each band boundary, talent pool and succession planning. b) Audit shortlisting and appointments by ethnicity and department. Involve BME network in this process.		To achieve a fair and equitable recruitment and selection process. Address the potential bias in the recruitment process To have more diverse recruitment panels. At least one BME nominated by the	Workforce & OD Managers Recruitment & Retention Group multidisciplinary team chaired by Deputy Director of Operations. Co-ordinated by Workforce Team Head of ED&I	Recruitment & Progression is the key theme at BME Network annual conference 23/5/2018. Chief Executive & Board BME Champion has met with BME Network Chair and commissioning audit of recruitment process/journey and appointments to help us understand the root causes and close the gap for the variation in

	c) BME Network - staff to be trained to participate in the recruitment process. d) To monitor the recruitment process. e) The Trust is providing a suite of training for managers to upskill in people management and effective application of policies. f) Inclusive and Leadership Spot light on leaders - unconscious bias and cultural competence training for senior leaders and managers. The aim is to help them to critically reflect on their practices and become better aware of their conscious and unconscious attitudes towards equality and reflect on the impact of organisational culture		BME Network to be on interviews for senior posts.		appointment of BME colleagues compared to white counterparts. BME Network 25/4/2018.Workforce Information colleague invited to provide data analysis. BME Network bespoke coaching and career building delivered 3/11/2017 and follow up 23/5/2018 Chief Executive commissioned Inclusive and Compassionate leadership - Spotlight on leaders 17 July 2018 to build cultural competency and reduction in harassment and bullying (as per staff survey findings).

	on equality outcomes.				
Indicator 3: BME staff 1.6 times more likely to be disciplined than white staff members. This has increased from last year 0.43. This requires further exploration.	a) Disseminate learning from conduct cases to enable organisational learning and processes. b) To ensure Trust policies are applied equally to all staff		Fairness in application of Trust policies irrespective of ethnicity. Procedural justice. Cases resolved fairly. understanding of the consequences of racial discrimination Reduction in racial discrimination and increase knowledge Current leadership is upskilled to effectively deal with issues. Race equality included in annual appraisal.	Senior Workforce Team Assistant Director for Engagement & Inclusion	Data explored as part of EDS2 grading 13/2/2018 and 23/5/2018 BME Annual Conference.
Indicator 4: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff 0.97.	a) Further work needs to be done to explore and understand this data, including career development and progression		Parity	Head of Education	EDS2 grading 13 Feb 2018 – agreed Head of Education will provide further data to understand issues of access and funding for

This is a 0.12 difference compared to last year 0.85. A figure below '1' would indicate that white staff members are less likely to access non-mandatory training and CPD than BME.	opportunities such as funding/sponsorship, acting up, projects and secondments between different groups				BME & other protected characteristics. This is to be shared at 23/5/2018 BME Network conference and action planning session.
Indicator 5: KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months appears to have decreased by 5.42% white staff and 8.49% for BME staff. White 27% (32.42% 2016) and BME 29% (40.91% 2016).	a) Further exploration is required to understand this difference and triangulated with internal Datix system reporting. b) Monitor all race-related Datix reports occurring at DHCFT and their outcomes. c) The Trust's position on zero tolerance to be regularly communicated on the Trust intranet, via training, induction, mandatory and team meetings by line managers.		Effective reporting and handling of racial abuse incidents and staff supported	Assistant Director of Engagement & Inclusion Workforce Team	As above
Indicator 6: KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months has	As above				Chief Executive commissioned Inclusive and Compassionate leadership - Spotlight on leaders 17/7/2018

increased by 2.2 % points for BME staff 21% (18.8% 2016) compared to white staff decrease by 0.53 percentage points at 22% (22.53% 2016).					(session will include unconscious bias)
Indicator 7: KF 21. The percentage of staff believing the trust provides equal opportunities for career progression or promotion has fallen for both white and BME staff groups compared to last year. The white group 8.57 % points show a greater difference compared to BME staff 7 % points. White BME staff 7 % points. White staff 75% (83.57% 2016) compared to BME 73% (80.0% 2016).	As above				Chief Executive commissioned Inclusive and Compassionate leadership - Spotlight on leaders 17/7/2018 EDS2 event 13/2/2018 Staff survey summary report by REGARDS analysis to be completed May 2018.
Indicator 8: Q17. In the last 12 months have you personally experienced discrimination at work	As above				As above

from any of the following? b) Manager/team leader or other colleagues. This has decreased across both groups - White 6% (6.85 % 2016) and BME 10% (13.64% 2016). The difference is white by 0.5 percentage points and greater drop BME 3.41 percentage points.					
Indicator 9 - compare the difference for white and BME staff: Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce. This data indicates the percentage of BME Voting Board Members is 8.3% compared with the Trust 12.3% (this	a) Aim to build BME talent pipeline, leadership capacity and capability in the Trust. Positive action programmes to support BME staff to progress within the organisation, including increasing representation at the Board. b) Reverse mentoring- the Board has signed up to this to raise the confidence and profile of BME staff in the Trust and consider the		Boards are expected to be broadly representative of the population they serve.	Board to seek assurance of that workforce reflects the local neighbourhood populations, fair employment and that we are leveraging the talents/assets and community knowledge of our workforce	Annual Workforce Diversity Analysis Report to meet our public sector equality duties to be published as part of Equality Act. Executive inclusive leadership programme – Reverse Mentoring for equality and diversity for Executives to prepare for being mentored by BME colleague.13/3/2018 & 11/4/2018 completed. Board shadowing by member of Deaf

includes NEDS voting members of the Board). This is a difference of 4 percentage points. Cross reference to EDS2 Goals and Board Equality Objectives/top 6 priorities.	contribution this might make to increase the diversity of the leadership. This intervention will enable senior leaders (initially Executives as mentees) to gain insight into the lived experience of BME staff and support development of cultural competence, inclusive culture and environment c) Improving board diversity and NExT Director Scheme for Non-Executive Directors - Trust agreed to host NED placement (championed by Chair). NHS Improvement initiative to help people from under-represented groups who have the skills and expertise necessary to make a real contribution to NHS to take that final step into the board room.				community – completed November 2017. BME NED placement commenced- induction was originally planned for January 2018 – candidate has extended and taking place April 2018.

Table 1:

Category	Description	Applications	%	Shortlisted	%	Appointed	%
Ethnicity	White	5,044	73.06%	1,951	79.54%	392	84.12%
	BME	1747	25.30%	461	18.79%	63	13.52%
	Undisclosed	113	1.64%	41	1.67%	11	2.36%
		6,904		2,453		466	

Table 2:

Ethnic Origin	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8 - Range A	Band 8 - Range B	Band 8 - Range C	Band 8 - Range D	Band 9	Executive	Consultant	Medical Other	Medical Trainee	Other	Total
White	39	150	323	173	321	526	218	102	23	20	5	0	4	38	11	16	4	1973
BME	12	28	49	10	47	55	20	8	1	0	0	0	1	34	11	16	2	294
Not Stated	3	12	21	7	23	20	9	4	1	1	0	1	0	7	5	8	0	122
Total	**54**	**190**	**393**	**190**	**391**	**601**	**247**	**114**	**25**	**21**	**5**		**5**	**79**	**27**	**40**	**6**	**2389**

Table 3 indicates under-representation and proportionately lower number of BME staff in the relevant bands. The highest non-clinical BME percentage is Band 1 (catering, domestic assistants and porters). BME Consultants continue to be over-represented at our senior clinical positons.

Consultant	89% BME 34 from 38 staff
Executive	25% BME (1 from 4 staff)
Band 9	0%
Band 8D	0% BME (0 from 5 staff)
Band 8C	0% BME (0 from 20 staff)
Band 8B	4.34% BME (1 from 23 staff)
Band 8A	7.84% BME (8 from 102 staff)

Band 7	9.17% BME (20 staff from 218)
Band 6	10.45% BME (55 from 526 staff)
Band 5	14.64% BME (47 from 321 staff)
Band 4	5.78% BME (10 from 173 staff)
Band 3	15.17 % BME (49 from 323 staff)
Band 2	18.66% BME (28 from 150 staff)

WRES cross referenced to the following:

1. Board Equality Objectives 2017 -2019/Top 6 Priorities Completion of data (across the nine protected characteristics) for services and workforce – target 85% by March 2018. Developing engaging and inclusive leadership. Allocate corporate resources to progress the equality and inclusion agenda within DCHFT. Demonstration of 'due REGARDS' relating to strategy, policy and decision-making. Develop refined community engagement mechanisms. EDS2 assessment – no red (undeveloped) rated by 31st March 2018 and 70% green (achieving grade) by 2019 and 100% by 2020.

2. BME staff network action plan and mission: to achieve open and fair access to opportunities, development and progression to ensure equality in career outcomes. Objectives: Representation, having a voice and visibility (to be heard, seen and listened to). BME staff and wider staff reporting positive working experience and environment. Ensure BME people no longer feel bullied. Diverse, skilled, talented and experienced workforce providing quality service based on individual need. To have a happy and healthy workforce and community. Equality and fairness - recognition by Trust and accessibility.
3. Equality Delivery System national equality performance toolkit and annual grading. EDS2 Goal 3: Empowered, engaged and well supported staff *(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).*
4. Public Sector Equality Duty – aims 1) Eliminate discrimination and harassment 2) Advance Equality of Opportunity, 3) Foster good relations. report April 2017

Appendix 3: WRES Benchmarking 16-2017 against local Trusts and two CQC 'outstanding rated' Trusts (source: National UNIFY analysis via WRES Team).

WRES Indicator 2: Relative likelihood of White staff being appointed from shortlisting compared to BME staff
DHCFT = White staff 1.5 times more likely to be appointed compared to BME counterparts.

		2016				2017		
Trust Type	Org name	Relative likelihood of shortlisting/appointed (White):	Relative likelihood of shortlisting/appointed (BME):	Relative likelihood of White staff being appointed from shortlisting compared to BME staff:		Relative likelihood of shortlisting/appointed (White):	Relative likelihood of shortlisting/appointed (BME):	Relative likelihood of White staff being appointed from shortlisting compared to BME staff:
Acute	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	12%	7%	1.8		11%	8%	1.3
Acute	DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST	15%	9%	1.7		30%	18%	1.6
Community	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	5%	2%	2.6		14%	8%	1.8
Mental Health	**DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST**	**22%**	**14%**	**1.6**		**20%**	**14%**	**1.5**
Mental Health	EAST LONDON NHS FOUNDATION TRUST	13%	10%	1.3		5%	5%	1.1
Mental Health	LEICESTERSHIRE PARTNERSHIP NHS TRUST	14%	9%	1.6		19%	13%	1.5
Mental Health	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	10%	11%	0.9		40%	12%	3.3
Mental Health	NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	15%	10%	1.5		19%	13%	1.5
Mental Health	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	12%	7%	1.7		9%	6%	1.5

WRES Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process compared to White staff: DHCFT = BME 1.6 more likely compared to white counterparts.

		2016				2017		
Trust Type	**Org name**	**Likelihood of White staff entering the formal disciplinary process:**	**Likelihood of BME staff entering the formal disciplinary process:**	**Relative likelihood of BME staff entering the formal disciplinary process compared to White staff:**		**Likelihood of White staff entering the formal disciplinary process:**	**Likelihood of BME staff entering the formal disciplinary process:**	**Relative likelihood of BME staff entering the formal disciplinary process compared to White staff:**
Acute	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	1.1%	1.7%	1.55		1.0%	0.8%	0.8
Acute	DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST	0.4%	0.6%	1.35		0.6%	0.4%	0.7
Community	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	0.7%	0.0%	0.00		0.3%	0.0%	0.0
Mental Health	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	1.5%	1.8%	1.17		1.1%	1.7%	1.6
Mental Health	EAST LONDON NHS FOUNDATION TRUST	1.5%	4.0%	2.74		0.8%	2.6%	3.2
Mental Health	LEICESTERSHIRE PARTNERSHIP NHS TRUST	1.7%	2.0%	1.20		0.8%	1.0%	1.2
Mental Health	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	4.2%	4.4%	1.05		3.0%	4.4%	1.5
Mental Health	NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	1.3%	1.0%	0.76		1.7%	3.4%	2.1
Mental Health	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	0.5%	0.5%	1.00		0.7%	0.9%	1.3

WRES Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD.

		2016				2017		
Trust Type	**Org name**	**Likelihood of White staff accessing non-mandatory training and CPD:**	**Likelihood of BME staff accessing non-mandatory training and CPD:**	**Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff:**		**Likelihood of White staff accessing non-mandatory training and CPD:**	**Likelihood of BME staff accessing non-mandatory training and CPD:**	**Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff:**
Acute	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	-	-	-		84.0%	69.0%	1.2
Acute	DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST	90.4%	93.9%	0.96		98.5%	97.4%	1.0
Community Provider Trust	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	-	-	-		-	-	-
Mental Health	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	-	-	-		83.2%	85.7%	1.0
Mental Health	EAST LONDON NHS FOUNDATION TRUST	45.6%	53.0%	0.86		67.6%	72.2%	0.9
Mental Health	LEICESTERSHIRE PARTNERSHIP NHS TRUST	55.1%	47.2%	1.17		51.6%	45.6%	1.1
Mental Health	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	-	-	-		50.5%	29.2%	1.7
Mental Health	NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	1.5%	3.9%	0.40		2.4%	2.2%	1.1
Mental Health	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	89.8%	73.4%	1.22		47.6%	34.9%	1.4

Derbyshire Healthcare NHS Foundation Trust

Board Committee Summary Report to Trust Board
Quality Committee - meeting held 10 April 2018

Key items discussed

- **Risk Assurance and Escalation quarterly report-** how we oversee quality risks. Triangulation and monitoring risks to inform the BAF
- **Oversight of Deloitte Well Led Phase 3 Recommendations-** are we progressing and implementing feedback
- **Accessible Information Standard (AIS) Report-** do we remain compliant
- **Analysis of Inquest Activity-** benchmarking and assurance
- **Quality Dashboard –** Monitoring, triangulation and assurance
- **Quality Priorities –** setting the strategy and incentivising and encouraging continuous quality improvement
- **Quality Account (first draft)-** Public, Regulatory and Board assurance
- **Serious Incidents bi-monthly report-** Public, Regulatory and Board assurance. Ensuring we have effective systems and processes to learn.
- **Dementia Strategy Review (mid-year review report) –** clinical strategy and improvement
- **Report on Safe Working Hours: Doctors in Training 2017-2018-** Safety monitoring and assurance of compliance
- **Quality Assurance Group Summary-** Triangulation and monitoring risks to inform the BAF
- **Quality Committee Annual Effectiveness Report-** Board governance, reflection and ensuring we are learning
- **Healthwatch Report -** Triangulation and monitoring risks to inform the BAF on Patient and Carer experience

Assurance/lack of assurance obtained

Board assurance framework - Review of incidents and the potential future horizon risks. This was reviewed and significantly reflective.

Clinical risk register- was offered to ensure the Quality Committee had oversight of all of the clinical and operational risks that impact upon quality. A new model will be redeveloped.

Deloitte Well led required recommendations - Quality impact assessment new policy. Review will take place in May 2018 - on target.

Deloitte phase 3 - Learn the lessons, issues and how we learn, John Sykes, explained lots of positive mitigating actions including how do we measure and ensure our staff know? Additional evidence was offered, signposting, eLearning and induction. Measure and plans to add assurance. Exploration of internal audit, smart survey, and or improvement in staff survey results. Exploration of improvement.

Accessible information standard - This information and assurance was provided. A review of the accessible information, and on-going staff training and assurance/ recommendations provided the Committee with significant assurance.

Inquest activity - A full report and benchmarking was provided covering staff health and wellbeing and support and the dialogue through ELT, with additional pressure. Communications and briefing to the Board and to wider stakeholders on the changing process in our inquests**.**

Quality dashboard – improved performance on complaints, limited assurance due to remaining CQC actions. Concerns regarding non-completion of mitigating CQC actions. The summary appears to show managerial improvement and some concerns regarding competing priorities and pace of progress in these residual actions. Discussion took place on regulatory outcome if actions are not mitigated and how we continually maintain our improvements.

Quality priorities - Approved

Quality Account 2017/18 - thanks extended to the author. Concerns noted with death data and information, communication strategy regarding death charts, readability of small charts and break up the charts. On target for completion of the formal process. Quality Account is currently subject to consultation.

Serious incident reports - the recommendations issues continue to carry a number of risks, and some recommendations then remain outstanding. Assurance obtained from the report and completions rates. Exploration of actions and learning of the management. Substantial improvement in investigations and substantial reduction in overdue investigations to STIES (Department of. Health Strategic Executive Information System).

Healthwatch reports and learning lessons - Agreed action plans and issues were confirmed. This report provided triangulation of evidence**.**

Dementia strategy - The report and performance was presented. Further equalities data was provided which confirmed accessibility, both in relation to access to service and to interpreters. Challenge on joint working with individuals with dementia and the risks and the issues surrounding an ageing workforce. This will be further explored by the Dementia Board.

Challenge of dementia training in teams, to have a wider skill set, has been explored and requires further assessment to assist all patients in our pathway.

Focus on the implementation on the north based dementia rapid response, how this is rolling out and exception reporting on these risks in a future report to be scheduled on the forward plan. Significant assurance on progress.

Safer working hours - Report of the guardian of safe working, Dr Saxena is now in post as the new guardian due to promotion of the former guardian. The report outlines the potential risk issues related to safer working. Compliance is in place. Significant assurance on the process, we continue to manage operational issues in the delivery arm.

Quality assurance group and plan - Accepted the report. CQUIN- issues - quality improvements and the wider financial plan is that we will achieve all CQUINs, there is sustained challenge.

Quality committee end of year report - Accepted and reviewed. The Committee confirmed the recommended improvement plan.

Emergency plan - Approved

Assessment of safety needs assessment - Policy changed to include a stepped approach and ratified.

Key risks identified

- Executive Director attendance and suitably briefed deputy
- Risks regarding older adults crisis commissioning equalities gap- confirmation of action
- Our acute pathway is now in out of area bed use, with four patients out of area. Consider on the risk register for the plan as part of Trust strategy in delivery of Red to Green
- We have 15 patients in out of area Psychiatric intensive care, monitoring of risks associated with this significant change in operational activity and whether this is sustained and a review in clinical strategy is required.
- Transition and risk register for the bank transition.
- Assurance and analysis, risk based report at the sub groups and escalation to People and Culture committee on the Bank risk issues
- Risk and audit to the Quality committee by exception inform if any concerns re risks, of reduction in performance in this area.
- The inquest activity is on the increase, due to the Derby Coroner's inquest backlog, teams may be under significant pressure as the coroner's office, as it clears its backlog of cases.This may require further communication.

Decisions made

- Quality risk highlight reports on risk issues for quarterly reporting.
- Exploration of the impact and allocation for some key monies and reinvestment into key areas to be provided by Executive leadership team with assurances that the investment will be targeted to the greatest risk areas as evidence in BAF risk 1a.
- Further assurance and scrutiny on equalities issues in the accessible information standards
- Exploring executive membership with the addition of a new director, to review the representation of Directors forward plan
- Scheduling and amendments to forward plan on clinical strategies to enable completion
- Recommendations to the Board development session on quality
- Implementing the Quality committee evaluation recommendations was confirmed
- Changes to the forward plan on revised quality priorities.
- Revisions to the BAF based upon evidence and papers occurred.

Meeting effectiveness

Benefit of having fewer members has shown improvement. Improved discussion on issues and team working within the Committee. Future work on seminars. Positive experience as Chair.

Escalations to Board or other committee

None to Board

Escalation to other committees: Escalation to ELT- staff support, Bank escalation already in replace, Audit & Risk Committee: Risk escalation report confirmed – full transfer. Changes to the BAF: We are reviewing three proposed changes, investment in community forensic team, neighbourhoods and crisis teams.	
Committee Chair: Julia Tabreham	**Executive Lead: Carolyn Green, Director of Nursing & Patient Experience**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors –1 May 2018

Board Assurance Framework (BAF)
First issue for 2018/19

Purpose of Report

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

Executive Summary

- The initial headline risks for the 2018/19 BAF were considered by the Audit and Risk Committee and Board in March 2018 who agreed the initial eleven risks, with a plan for these to be fully worked up in in relation to assurances and controls, gaps and actions

- Seven risks from the 2017/18 BAF have been refreshed and carried forward into 2018/19 and four new risks have been added.

  Risks carried forward into 2018/19 relate to:

  - Achieving standards for safety and quality
  - Compliance with Mental Health and Mental Capacity Acts
  - Engagement with workforce
  - Delivery of financial plans
  - Influence on system wide change
  - Recruitment and retention of staff
  - Improving the flow of patients through or services

  New risks for 2018/19 relate to:

  - Delivery of physical healthcare agenda
  - Redesign of the Care Programme Approach processes
  - Confidence in the electronic patient record
  - Reskilling of staff to meet requirements for new workforce models

- Two risks are initially rated as extreme in terms of risk to achievement of the Trust strategic objectives. These are: delivery of financial plan; and recruitment and retention of staff. The remaining nine are currently rated as high risks.

- Further work will be completed for the second issue of the BAF, to clearly define key controls and assurances, and associated actions to reduce gaps. As this is the first issue for 2018/19 progress on actions are not identified, apart from for risk 3a, delivery of financial plan, where the continuation of existing actions is described.

- The Deep Dive programme for review of risks by board committees is being developed. A draft programme is included for information.

- 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.

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

Assurances

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

Consultation

Board Development session – 14 February 2018

Individual Executive Directors – during March/April 2018

Members of the Audit and Risk Committee – 18 April 2018

Executive Leadership Team – 23 April 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).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience	x

and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Actions to Mitigate/Minimise Identified Risks

Specific reference to equality impact will be identified in the second issue of the BAF, due July 2018

Recommendations

The Board of Directors is requested to:

1. Agree and approve this first issue BAF for 2018/19 and the significant assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2. Agree the draft plan for completion of 'Deep Dives'
3. Agree for further work to be completed for the second issue of the BAF, due July 2018, to clearly define key controls and assurances, and associated actions to reduce gaps

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

Report prepared by: **Samantha Harrison**
Director of Corporate Affairs and
Rachel Kempster
Risk and Assurance Manager

Board Assurance Framework

First issue 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 first formal presentation of the Board Assurance Framework to the Board of Directors for 2018/19

1) Overview and movement of risks 2018/19

A summary of all risks currently identified in the 2018/19 BAF is shown below. Movement of these risks will be added as the year progresses

BAF ID	Risk title	Director Lead	Risk rating Q1	Risk rating Q2	Risk rating Q3	Risk rating Q4	Direction of movement
18_19 1a	Failure to provide safety and quality standards	Director of Nursing and Patient Experience	HIGH (4x4)				
18_19 1b	Failure to provide full compliance with the Mental Health Act (MHA) and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)				
18_19 1c	Failure to develop systems and processes to deliver physical health care for patients	Medical Director	HIGH (4x4)				
18_19 1d	Failure to redesign the Care Programme Approach processes	Director of Nursing and Patient Experience	HIGH (4x4)				
18_19 2a	Risk that we don't engage our workforce to experience aims and values of the Trust	Director of People and Organisational Effectiveness	HIGH (4x4)				
18_19 3a	Delivery of financial plan	Director of Finance	EXT (4x5)				
18_19 3b	Failure to influence Joined Up Care Derbyshire	Director of Business Improvement and Transformation	HIGH (4x4)				
18_19 4a	Unable to retain, develop and attract staff in specific teams	Director of People and Organisational Effectiveness	EXT (4x5)				
18_19 4b	Failure to gain confidence of staff re the electronic patient record	Chief Operating Officer	HIGH (4x4)				
18_19 4c	Unable to introduce new workforce models and provide training to reskill staff	Director of People and Organisational Effectiveness	HIGH (4x4)				
18_19 4d	There is a risk that the Trust will not improve the flow of patients through our services	Chief Operating Officer	HIGH (4x4)				

2) Deep dives 2018/19

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

The draft plan for Deep Dives for 2018/19 is shown below:

Risk ID	Subject of risk	Director Lead	Committee
18_19 1a	Safety and quality standards	Carolyn Green	Quality Committee Jul 2018
18_19 1b	MHA/MCA Compliance	Dr John Sykes	Mental Health Act Committee: Sept 2018
18_19 1c	Physical healthcare compliance	Dr John Sykes	Quality Committee Sept 2018
18_19 1d	CPA approach	Carolyn Green	Quality Committee Oct 2018
18_19 2a	Staff engagement	Amanda Rawlings	People and Culture Committee Oct 2018
18_19 3a	Financial plan	Claire Wright	Audit and Risk Committee (Finance and Performance Committee) Jan 2019
18_19 3b	Influence 'Joined Up Care Derbyshire'	Gareth Harry	Finance and Performance Committee Sept 2018
18_19 4a	Staff retension, recruitment and development	Amanda Rawlings	Audit and Risk Committee (People and Culture Committee) Jul 2018
18_19 4b	Electronic Patient Record	Mark Powell	Quality Committee Dec 2018
18_19 4c	Workforce model and training to reskill staff	Amanda Rawlings	People and Culture Committee Dec 2018
18_19 4d	Improve flow of patients	Mark Powell	Finance and Performance Committee Jan 2019

Summary Board Assurance Framework Risks 2018/19. Issue 1.2

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)
Strategic Objective 1. Quality Improvement			
18_19 1a	There is a risk that the Trust will fail to provide standards for safety and quality required by our Board, as set out in the Health and Social Care Act 2009 and measured through the CQC's regulatory process	Executive Director of Nursing and Patient Experience	HIGH (4x4)
18_19 1b	There is a risk that the Trust will fail to provide full compliance with the Mental Health Act (1983) and Mental Capacity Act (2005)	Medical Director	HIGH (4x4)
18_19 1c	There is a risk that the Trust will fail to develop systems and processes to deliver safe and effective physical health care for patients	Medical Director	HIGH (4x4)
18_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 patients 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 Business Improvement and Transformation	HIGH (4x4)
Strategic Objective 4.Operational Delivery			
18_19 4a	There is a risk that the Trust will not be able to retain, develop and attract enough staff in specific teams to deliver high quality care	Director of People and Organisational Effectiveness	EXTREME (4x5)
18_19 4b	There is a risk that the Trust will fail to gain the confidence of staff to maintain a modern and effective electronic patient record system	Chief Operating Officer	HIGH (4x4)
18_19 4c	There is a risk that the Trust will be unable to meet the needs of patients by not introducing new workforce models and provide sufficient training to reskill staff.	Director of People and Organisational Effectiveness	HIGH (4x4)
18_19 4d	There is a risk that the Trust will not improve the flow of patients through our services	Chief Operating Officer	HIGH (4x4)

Board Assurance Framework Risks 2018/19 v1.2

Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

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

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):

Board Assurance Framework Risks 2018/19 v1.2

- Quality dashboard - Scrutiny of Quality Account (pre-submission) by committees and governors	- National enquiry into suicide and homicide - NHLSA Scorecard demonstrating low levels of claims - Safety Thermometer identifies positive position against national benchmark - Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards and 12/58 for effectiveness - CQC comprehensive review 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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Fully implemented quality priorities and Quality Improvement Strategy	Roll out of actions in relation to the current quality priorities and Quality Improvement Strategy including a training needs analysis and full implementation plan [ACTION OWNER DON]	31/08/2018		Medium
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]	31/07/2018		Medium
Lack of effective forensic clinical service pathway following prison release. Release of IPP prisoners (indeterminate imprisonment for public protection) increases risks..	Recruit to and operationalise community forensic team, following funding settlement [ACTION OWNER:COO] Recruit to and operationalize additional investment in Neighbourhoods and Crisis service [ACTION OWNER:COO]	30/09/2018		Medium
Non commissioned services for Derbyshire based PICU beds and CAMHS Tier 4 beds	Improvement plan with commissioners in place for CAMHS rise and HTT model [ACTION OWNER COO]	31/07/2018		High
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]	31/07/2018		Medium
Full compliance with medicines management code, including medicines storage	Improvement plan in place to deliver, including implementation of the medicines reconciliation strategy [ACTION OWNER DON]	30/09/2018		Medium
Fully embedded Clinical and Operational Assurance Teams	Embed CPD and complete development work [ACTION OWNER COO]	31/07/2018		Medium
Gap in knowledge and competence in relation to treatment of autism and support in complex cases	Implement clinical quality improvements as identified in Schedules 4 and 6 in autism treatment during 2018/19	31/07/2018		High
Clinical buy in to review NICE	To be evidenced through compliance with quality	31/07/2018		Medium

guidelines	priorities assessed during Quality Visit programme			
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Effective plan for comprehensive re-inspection 2018 and embedding any learning and findings	Lead Trust wide plan and fully implement CQC actions plan established in 2018, with subsequent plan to raise all services identified as requires improvement [ACTION OWNER DON]	31/07/2018		Medium
Effective plan to ensure ability to achieve quality priorities, CQUIN and Non CQUIN targets including 'Sign Up to Safety' and 'Always Events' campaigns	Implement CQUIN action plan for 2018/19, and action plans for 'Sign up to safety' and 'Always Event' campaigns [ACTION OWNER DON]	31/07/2018		Medium
Develop new clinical strategies with Divisional areas.	Recovery and enablement, substance misuse and Co- existing substance misuse and then Eating Disorders [ACTION OWNER DON]	30/09/2018		Medium
Evidence to support sexual safety of patients is maintained across inpatient areas	Identify issues re sexual safety of patients in inpatient areas and develop a plan to improve where gaps are identified	31/08/2019		Medium

Related operational high/extreme risks:

Organisational level	ID	Directorate	Risk Subtype	Title
Trust wide Risk Assessment (Clinical)	21068	Pharmacy	Clinical - Medication/	Medicines Management - providing effective care
Team Risk Assessment	21204	Campus - Radbourne Unit	Clinical - Points of Ligature	Ligature risk assessment
Divisional Risk Assessment (Clinical)	3385		Clinical - Staffing levels	Waiting Times for Psychological Assessment
Divisional Risk Assessment (Clinical)	21221	Children's Services	Clinical risk - Other	Resuscitation training
Team Risk Assessment	21189	Psychological Therapies, Perinatal & Performance/Training/Admin	Commissioning Risk	Admission criteria to Eating Disorders Service
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
Team Risk Assessment	21171	Children's Therapies & Complex Needs	Environmental risk - Other	medicines fridge in a room too hot/cold
Team Risk Assessment	2944	Neighbourhood Services - City	H&S - Workplace Health, Safety and Welfare	H&S - Workplace Health, Safety and Welfare

Board Assurance Framework Risks 2018/19 v1.2

Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

Preventative – Comprehensive training plan supported by MCA Training Manual developed by trust clinicians; Good compliance with MCA training; Increased general awareness of issues amongst clinicians with multidisciplinary team approach; Junior doctor training; Single place created in PARIS to record MCA assessments

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

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

Corrective – MHA Committee assurance on MHA/MCA processes with clear lines of responsibility and accountability

Assurances on Controls (internal):	Positive assurances on Controls (external):
- Reporting of training compliance against plan to MHA Operational Group and relevant managers. Good levels of compliance - Range of compliance checks and audits agreed by MHA Operational Group with assurance provided to MHA Committee - Campus General Manager oversight and reporting to MHA Operational Group on progress against CQC(MHA) unannounced visits to wards and teams	KMPG audit of Mental Capacity Act 2017/18

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Improvement in practice and recording	Focused workplan for improving compliance in	31/07/2018		High

made in inpatient areas yet to be made in community settings	community team with development of relevant guidance and documentation [ACTION OWNER MD]			
Comprehensive training to support application of MHA and DoLs	Develop and implement comprehensive training plan to support application of MHA and DoLs. [ACTION OWNER MD]	30/09/2018		High
Real time feedback to clinicians following rapid tranquilisation	FSR to be developed to enable pharmacists to give clinicians 'real time' feedback following rapid tranquilisation to their patient. Pilot operation now on Enhanced Care Ward [ACTION OWNER MD]	31/07/2018		Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Evidence of actions taken and embedded following CQC mental health act focused related visits	Action matrix to cover all actions from all units, and to highlight those overdue, to be in place by September 2018 as per KPMG recommendation [ACTION OWNER MD]	30/09/2018		Medium
Related operational high/extreme risks: None specifically identified				

Board Assurance Framework Risks 2018/19 v1.2

Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

Preventative – Range of physical health related training in place i.e. physical health care screening and monitoring , ILS/BLS, infection control, ,
Detective – Physical health care monitoring clinics pilots in various trust services
Directive – Physical Health Care Strategy; Physical Care Committee; Trust Infection Control Committee; Drugs and Therapeutics Committee; infection control and tissue viability link nurses; Policies and procedures support a range of physical health interventions and monitoring; 'Smoke Free' Trust
Corrective – Practice Development and Compliance Lead for physical health care, to support ward/team based best practice

Assurances on Controls (internal):	Positive assurances on Controls (external):
Programme of physical health care related audits and associated action plans	CQC (Cubley Court) feedback report Feb 2018 Safety Thermometer

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of single location on PARIS for recording and monitoring of physical health care	Development of a physical health care tile on PARIS to record in a single place all physical health care related information [ACTION OWNER MD]	31/07/2018		Medium
Consistent implementation of the LESTER tool	Scope the implementation an E-prescribing module to support the FSR to enable local teams to receive early notification of patients	31/07/2018		High

	commencing medication to enable monitoring to be put in place [ACTION OWNER MD]			
Trust led physical healthcare monitoring following initiation of medications	Expand Derby pilot of physical health care monitoring clinics to Chesterfield [ACTION OWNER MD]	31/07/2018		Medium
Increase uptake of intervention focused training re physical healthcare	Compliance reporting and monitoring of hotspots, to target in specific areas, including resuscitation training [ACTION OWNER MD/COO]	31/07/2018		Medium
Gaps in communication with GP practices re awareness of SMI cohort leading to potential gaps in physical healthcare monitoring	Continue to work with GP practices to ensure SMI databases are maintained and kept up to date [ACTION OWNER MD]	31/07/2018		Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Access to NHS Digital information relating to deceased patients to support learning from deaths agenda	Agree and submit application for access to NHS Digital. Build dashboard to monitor learning from deaths	30/06/2018		Low

Related operational high/extreme risks:

Organisational level	ID	Directorate	Risk Subtype	Title
Trust wide Risk Assessment (Clinical)	21068	Pharmacy	Clinical - Medication/ Pharmaceutical	Medicines Management - providing effective care for patients
Divisional Risk Assessment (Clinical)	21221	Children's Services - Management Team	Clinical risk - Other	Resuscitation training
Team Risk Assessment	21189	Psychological Therapies, Perinatal & Performance/Training/Admin	Commissioning Risk	Admission criteria to Eating Disorders Service

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Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

a) Homicide investigation identifying failure to implement effective CPA policy and resulting no adherence

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

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

Key controls:

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Current policy not fit for purpose	Redesign CPA Policy and approach [ACTION OWNER DON]	31/07/2018		Medium
	Engage and consult with social care colleagues and develop collaboratively.[ACTION OWNER DON]	30/06/2018		
	Engage and consult with colleagues around best approach for implementation [ACTION OWNER DON]	30/06/2018		
	Design and redesign training methodology using experts by experience and carers[ACTION OWNER DON]	30/06/2018		

	Continual audit of compliance and outcomes., connecting to recovery and enablement strategy.[ACTION OWNER DON] Adopting a learning and scrutiny culture in supervision that reviews the adequacy and meaningfulness of CPA in supervision[ACTION OWNER DON] Embed CPA monitoring into COAT practice and include routinely on compliance and clinical audit programme.[ACTION OWNER DON]	30/06/2018 31/12/2018 31/12/2018		
Compliance with revised policy	Develop and implement audit of compliance over an 18 month period[ACTION OWNER DON]	31/12/2018		Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Related operational high/extreme risks: None specifically identified				

Board Assurance Framework Risks 2018/19 v1.2

Strategic Outcome 2. Engagement

Principal risk:

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

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

Root causes:

a. Engaging and participative leaders and managers in an inclusive way
b. Clear leadership expectations
c. Lack of management and leadership development
d. Robust recruitment processes ensuring suitability for role
e. Lack of mentoring and coaching to develop leaders

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

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

Key controls:

Preventative – Team Derbyshire leaders events to engage leaders. Ongoing wider engagement activities for all staff
Detective – Management and leadership questions from staff survey
Directive – Leadership development training supporting managers
Corrective – Appraisal and supervision processes

Assurances on Controls (internal):	Positive assurances on Controls (external):
Improvement from staff survey to pulse check evident during 2018 Report in Chief Executive report to Board and Weekend Note to staff highlighting staff engagement and feedback Staff forum feedback Planned oversight of implementation of leadership development strategy to People and Culture Committee (as part of People Plan)	Staff Survey (limited) Pulse Checks Friends and Family Test

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of leadership development strategy	Develop leadership development strategy to include: management development; leadership development; coaching and mentoring, reverse	31/07/2018		High

	mentoring.			
Required further development to embed and coordinate wider engagement activity	Range of activities are in place including Staff Forum, Team Derbyshire Healthcare Leaders events, team briefing, raising concerns, director/CE visits etc to provide opportunity to engage with staff. Continuing implementation and evaluation of effectiveness to be undertaken including review of feedback captured from all engagement activities. [ACTION OWNER DPOE/DCA]	31/7/2018		Medium
Lack of response/analysis of feedback from staff	Broad oversight of feedback from all staff engagement to be coordinated and themes identified in order to address these. Ensure response to issues staff raise and promoting 'you said, we did' to encourage further engagement and feedback. [ACTION OWNER DPOE/DCA]	31/07/2018		Medium
Staff awareness and ownership of Trust vision and values	Refreshed Trust strategy, vision and values to be cascaded through Trust and reinforced by staff communication, branding and role modelling from senior leaders. Promotion of examples of positive behaviours in practice to be disseminated and example of this happening in practice celebrated. Ensure staff are aware of what behaviours/practice is not acceptable and how to report this. [ACTION OWNER DPOE/DCA]	31/05/2018		Medium
Required further development to embed and coordinate wider engagement activity	Range of activities are in place including Staff Forum, Team Derbyshire Healthcare Leaders events, team briefing, raising concerns, director/CE visits etc to provide opportunity to engage with staff. Continuing implementation and evaluation of effectiveness to be undertaken including review of feedback captured from all engagement activities. [ACTION OWNER DPOE/DCA]	31/7/2018		Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Staff survey identifying issues with leadership and management.	Identify resources to implement leadership and management development programme [ACTION OWNER DPOE]	31/07/2018		High
Staff responses on morale and health and wellbeing questions in staff survey	Address hotspot areas and wider trust actions to address [ACTION OWNER DPOE]	31/07/2018		Medium
Related operational high/extreme risks: None specifically identified				

Strategic Outcome 3. Financial sustainability

Principal risk:

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

Impact: Trust becomes financially unsustainable.

Root causes:

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

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction 1st Issue	Rating 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, Programme Assurance Board for CIP delivery

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

performance evidencing whether we deliver services within our resources		- Deloitte Well Led review – positive affirmation of the effectiveness of the Finance and Performance Committee		
Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Agency approvals controls are failing to reduce agency expenditure to under the NHSI ceiling level	Executives continue to have regular meetings and take appropriate actions.[ACTION OWNER: COO] AIM: achieve average £250k per month agency spend (or less)	31/08/2018	Agency controls have led to reduced total agency expenditure and better adherence to capped hourly rates, but ceiling not achieved. Agency spend reduced from c£5m in 1617 to c£4m in 17/18 Trust vision/priorities: Financial sustainability – the leading indicators chosen are achieving agency ceiling and recurrent CIP	Medium
Cost control/Cost improvement – requirement for firm plans for full 18/19 CIP programme (and longer term pipeline of cost and quality improvement)	QIPP and CIP incorporated into the mental health STP workstream [ACTION OWNER DBI] Increased CIP meetings and project scrutiny, management action via PAB {ACTION OWNER – CEO] AIM: full CIP programme, quality assured. Updated PMO and associated structures with new Director Business Improvement and Transformation in place	31/08/2018	CIP and QIPP continue to be part of Mental Health STP Workstream. New Programme Delivery approach planned. Gap remains: full assured programme for 18/19 required. Further action: Additional F&P oversight and scrutiny of continuous improvement/longer term plans for 18/19 and beyond. PAB re-instated chaired by CEO. Continuous cost and quality improvement is a key deliverable in the new Director of Business Improvement and Transformation role Trust vision/priorities: Financial sustainability – the leading indicators chosen are agency ceiling and recurrent CIP	High
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery.
Related operational high/extreme risks: None specifically identified				

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Strategic Outcome 3. Financial sustainability

Principal risk:

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

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

Root causes:

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

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

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

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

Corrective- Ongoing discussions with key stakeholders on proposed changes, progress, establishment of partnerships etc. ; Engagement and consultation with patients, carers, public and staff as appropriate; Interrelationships with other STP workstreams

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

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Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Level of influence on system wide QIPP schemes	Develop new clinical models for service delivery via Mental health System Board (external focus) [ACTION OWNER DSD]	31/07/2018		High
Lack of capacity and cohesion across clinical pathways	Transform clinical pathways to provide more joined up care (internal focus)[ACTION OWNER DSD]	31/07/2018		High
Delivery of 'Five Year Forward View'	Work with commissioners to deliver Mental Health Investment Standard in developing new pathways and services [ACTION OWNER DSD]	31/07/2018		High
Gaps in assurances:	**Actions to close gaps in assurances:**	**Review due:**	**Progress on action:**	**Risk to delivery.**
Compliance with Mental Health Investment Standard	Audit of CCG's compliance with investment standard [ACTION OWNER DSD]	31/12/2018		High

Related operational high/extreme risks:

Organisational level	ID	Directorate	Risk Subtype	Title
Divisional Risk Assessment (Corporate)	867		Clinical - Staffing levels	Commissioned Care Co-ordination Capacity within Neighbourhood Teams
Divisional Risk Assessment (Clinical)	21223	Learning Disabilities Services	Clinical - Staffing levels	Exceeded waiting times for dysphagia referrals
Team Risk Assessment	21238	Neighbourhood Services - City	Clinical - Staffing levels	Inability to allocate urgent referrals
Divisional Risk Assessment (Clinical)	2772	Child and Adolescent Mental Health Services (CAMHS)	Clinical - Staffing levels	Insufficient resources CAMHS workforce
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
Team Risk Assessment	21189	Psychological Therapies, Perinatal & Performance/Training/Admin	Commissioning Risk	Admission criteria to Eating Disorders Service
Divisional Risk Assessment (Clinical)	21209	Children's Services - Management Team	Financial risk - other	Contracting and financial risk

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Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

Preventative – Only targeted recruitment campaigns, including through social media
Detective – Performance report identifying specific hotspots and interventions to increase recruitment
Directive – Implementation of actions to deliver People Strategy, with focus on attracting and retaining staff
Corrective – Recruitment campaign delivered through targeted mobile display and implementation of mobile phone 'pop ups'

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Workforce plan to include alternative workforce models	Implement Year 2 of workforce plan [ACTION OWNER DPOE]	31/07/2018	Plan approved by ELT and People and Culture Committee	High
Appeal of the trust as a place to work	Further develop multigenerational offer to attract	31/07/2018		Medium

	staff for key national occupational shortages, and for development and retention of staff in key areas [ACTION OWNER DPOE]			
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]	31/07/2018		High

Related operational high/extreme risks:

Organisational level	ID	Directorate	Risk Subtype	Title
Divisional Risk Assessment (Corporate)	867		Clinical - Staffing levels	Commissioned Care Co-ordination Capacity within Neighbourhood Teams
Divisional Risk Assessment (Clinical)	21223	Learning Disabilities Services	Clinical - Staffing levels	Exceeded waiting times for dysphagia referrals
Team Risk Assessment	21238	Neighbourhood Services - City	Clinical - Staffing levels	Inability to allocate urgent referrals
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
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
Trust wide Risk Assessment (Clinical)	21106	Children's Therapies & Complex Needs	Commissioning Risk	Sexual Abuse Referrals

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Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

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

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

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

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

Assurances on Controls (internal):	Positive assurances on Controls (external):

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Clear specification for improvements required	Develop clear specification of improvements required to PARIS, with project plan, and timeline to meet agreed scope. CRG to develop plan and report back to the finance and Performance Committee [ACTION OWNER COO]	31/08/2018		Moderate
Confidence of staff in using the FSR to enhance patient care	Ongoing support and review from Clinical systems lead Involve clinicians in the FSR CRG to seek opinion and advice. Ensure focus is maintained on reducing complexity and number of templates and time taken to complete by staff) [ACTION OWNER COO] Identify medical clinical information officer to develop clinical involvement in PARIS [ACTION:MD]	31/07/2018 31/08/2018		High
Fragmented recording of physical healthcare information on PARIS	Remapping of physical healthcare health care recording and monitoring on PARIS) [ACTION OWNER MD]	31/07/2018		Moderate
Limited staff engagement with safety planning process	Developing the safety plan framework in on PARIS in line with commissioner feedback to include a stepped approach to safety planning and review of the existing form [ACTION OWNER MD]	31/07/2018		Moderate
Too many locations on PARIS to record same information	Rationalisation and reduction of clinical documents held on PARIS Conversation of 'forms' to 'locations' to centralise similar clinical information in one place.	31/07/2018		High

	Increasing auto population of forms where relevant Development of tiles to improve access to key information (Care planning/ physical health care/ safety planning. [ACTION OWNER COO]			
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Oversight of other Trust development of FSR's	Continue to develop supporting arrangements with other Trusts using PARIS and other EPR's to support learning and development [ACTION OWNER COO]	31/07/2018		Moderate
Related operational high/extreme risks: None specifically identified				

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Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

Assurances on Controls (internal):	Positive assurances on Controls (external):

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Workforce plan: Oversight of delivery via fully functioning strategic workforce groups. Leadership ownership of the plan with sponsors for introducing new roles	Reshape the strategic workforce group and education group membership. Identify leaders for each new role [ACTION OWNER DPOE]	31/07/2018		Medium
Funding: Ownership across the leadership team to transform current	Executive oversight at ELT to delivery and transformation. HEEM funding – bid for every	30/09/2018		High

gaps in supply to new posts. Trust and HEEM funding availability	available work stream [ACTION OWNER DPOE]			
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Lack of regular review at ELT and strategic workforce group of workforce plan delivery	Increase the focus on the ELT and Strategic workforce groups quarterly [ACTION OWNER DPOE]	31/07/2018		Medium
Related operational high/extreme risks: None specifically identified				

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Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

Preventative - Project Vision project management system; project management structure including stakeholder engagement; Move away from cost improvement to continuous quality improvement model

Detective – Programme Assurance Board reporting to TMT/ELT and F&P Committee

Directive – 'LEAN' based approaches to service change; Coaching support by Programme Assurance Office and Head of Programme Delivery

Corrective – Project Assurance Office processes and reporting to Project Assurance Board; Board reporting on Trust Strategy

Assurances on Controls (internal):	Positive assurances on Controls (external):
Update reports to Quality Committee and TMT on Neighbourhood Review progress Bed status dashboard Red2reen weekly tracker Community Caseload health tracker	CMHT Community Service Survey

Gaps in control:	Actions to close gaps in control:	Review due	Progress on action:	Risk to delivery:
Increased use of health services by some high risk individuals	Improving packages for high intensity users of health services through projects supporting the acute care pathway	31/07/2018		Moderate
Delayed discharges above specified lengths of stay	Bed optimisation project, including 'red to green' project implementation to increase flow in inpatient areas	31/12/2018		High

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High caseloads and long waiting lists in community based mental health teams	Neighbourhood review to be completed, to ensure services are meeting commissioned needs in line with 'Joined Up Care Derbyshire' approach	31/10/2018		High
Lack of clear Urgent and Emergency Care clinical model	Review of Urgent and Emergency Care clinical model to be undertaken to introduce a single inpatient clinical model	31/10/2018		High
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery

Related operational high/extreme risks:

Organisational level	ID	Directorate	Risk Subtype	Title
Divisional Risk Assessment (Corporate)	867		Clinical - Staffing levels	Commissioned Care Co-ordination Capacity within Neighbourhood Teams
Team Risk Assessment	21238	Neighbourhood Services - City	Clinical - Staffing levels	Inability to allocate urgent referrals
Divisional Risk Assessment (Clinical)	3385		Clinical - Staffing levels	Waiting Times for Psychological Assessment and Intervention

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors –1 May 2018

2017/18 Data Security Protection Requirements

Purpose of Report

NHS Improvement require every Trust to make a submission demonstrating their level of compliance with 10 cyber security standards. Before the submission can be made NHS Improvement mandate that the submission has been ratified by the Trusts Board. This paper outlines the proposed content of the submission and seeks Trust Board approval to proceed.

Executive Summary

The 2017/18 Data Security Protection Requirements submission must be made by 11 May. The submission defines 10 requirements under three obligations.

1. Leadership obligation 1: People
2. Leadership Obligation 2: Processes
3. Leadership obligation 3: Technology

Each of ten requirements has been assessed and rated.

The Trust is compliant with all 10 requirements and the proposed submission reflects that level of compliance.

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

Assurances

This paper provides full assurance that the Trust complies with the NHSi 2017/18 Data Security Protection Requirements.

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

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) (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 proposed content of the submission to NHS Improvement
2. If they are prepared to ratify the proposed submission as mandated by NHSi.

Report presented by:	**Mark Powell, Chief Operating Officer** **Samantha Harrison, Director of Corporate Affairs and Trust Secretary**
Report prepared by:	**Peter Charlton, General Manager, Information Management**

2017/18 Data Security Protection Requirements

April 2018

Background

In January 2018, to improve data security and protection for health and care organisations the Department of Health and Social Care, NHS England and NHS Improvement published a set of 10 data and cyber security standards – the 17/18 Data Security Protection Requirements (2017/18 DSPR) – that all providers of health and care must comply with.

The 2017/18 DSPR standards are based on those recommended by Dame Fiona Caldicott, the National Data Guardian (NDG) for health and care, and confirmed by government in July 2017.

All providers are being asked to confirm to NHSi whether or not they are complying with the 2017/18 DSPR standards. To do this, we must submit a response using a web form.

The questions set out below are the same as those found in the web form. They are designed to test whether we have implemented (fully, partially or not) the 10 standards outlined in the 2017/18 DSPR.

As part of the assurance process, the board must sign off our response before it is submitted.

Leadership obligation 1: People

1. Senior level responsibility

There must be a named senior executive responsible for data and cyber security in your organisation.

Ideally this person will also be your senior information risk owner (SIRO), and where applicable a member of your organisation's board.

Fully implemented	Partially implemented	Not implemented
The organisation has a named senior executive who reports to the board who is responsible for data and cyber security and this person is also the SIRO	The organisation has a named senior executive who reports to the board who is responsible for data and cyber security but this person is not the SIRO	The organisation does not have a named senior executive who is responsible for data and cyber security

Please provide the contact details of the named senior executive responsible for data and cyber security if they are in place.

Name	Sam Harrison
Job title	Director of Corporate Affairs and Trust Secretary
Name of organisation	Derbyshire Healthcare NHS Foundation Trust
Email	Samantha.Harrison@derbyshcft.nhs.uk
Telephone number	01332 – 623700 extension 31212

2. Completing the Information Governance toolkit v14.1

By 31 March 2018 organisations are required to achieve at least level 2 on the Information Governance (IG) toolkit. More information about the IG toolkit v14.1 can be found here: www.igt.hscic.gov.uk/help.aspx

For more information on how to complete the toolkit, please refer to the guidance:

- NHS foundation trusts: acute trusts, mental health trusts, ambulance trusts, community health providers, commissioning support units, NHS England
- independent providers: nhs business partners, commercial third parties, secondary use organisations, hosted secondary use teams, any qualified providers − clinical and any qualified providers − non clinical.

NOTE: the new Data Security and Protection toolkit is being introduced for 2018/19. This will replace the current IG toolkit.

Fully implemented	Partially implemented	Not implemented
The organisation has completed the IG toolkit, submitted its results to NHS Digital and obtained either level 2 or 3.	The organisation has completed the IG toolkit and submitted its results to NHS Digital but has not attained level 2.	The organisation has not completed the IG toolkit and submitted the results to NHS Digital

3. Preparing for the introduction of the General Data Protection Regulation in May 2018

The beta version of the Data Security and Protection toolkit was released in February 2018 and will help organisations understand what actions they need to take to implement the General Data Protection Regulation (GDPR) which comes into effect in May 2018.

Detailed information about the implementation of the GDPR can be found in the implementation checklist produced by the Information Governance Alliance (https://digital.nhs.uk/information-governance- alliance/General-Data-Protection-Regulation-guidance)

Fully Implemented	Partially Implemented	Not Implemented
By May 2018, the organisation will have an approved plan to detail how it will achieve compliance with the GDPR. This will have board-level sponsorship and approval.	By May 2018, the organisation will have a plan that has been developed but not yet sponsored and approved at board level on how it will achieve compliance with the GDPR.	A plan has not been yet been developed.

4. Training staff

All staff must complete appropriate annual data security and protection training.

As per the IG toolkit, staff are defined as: all staff, including new starters, locums, temporary, students and staff contracted to work in the organisation.

A new training programme has been introduced: https://www.e-lfh.org.uk/programmes/data-security-awareness/. This programme replaces the previous IG training whilst retaining key elements of it. More information about the previous IG training resources can be found at

https://www.igt.hscic.gov.uk/NewsArticle.aspx?tk=431663506918390&lnv=1&cb=6fa0a573- a4df-45f3-8af1-5c5ff58cce87&artid=170&web=yes

Providers must ensure staff have completed either the new IG training tool or the previous IG training tool.

Fully implemented	Partially implemented	Not implemented
At least 95% of staff have completed either the previous IG training or the new training in the last twelve months.	At least 85% of staff have completed either the previous IG training or the new training in the last twelve months.	Less than 85% of staff have completed either the previous IG training or the new training

Leadership Obligation 2: Processes

5. Acting on CareCERT advisories

Organisations must:

- Identify a primary point of contact for your organisation to receive and co-ordinate your organisation's response to CareCERT advisories, and provide this information through CareCERT Collect
- act on CareCERT advisories where relevant to your organisation
- confirm within 48 hours that plans are in place to act on High Severity CareCERT advisories, and evidence this through CareCERT Collect

Fully implemented	Not implemented
The organisation has registered for CareCERT Collect	The organisation has not registered for CareCERT Collect

Yes	No	Not applicable
The organisation has plans in place for all CareCERT advisories up to 31/3/2018 that are applicable to the organization (**Note**: the plan could be that the board accepts the residual risk)	The organisation does not have plans in place for all CareCERT advisories up to 31/3/2018 that are applicable to the organisation	The organisation has not registered for CareCERT Collect

Fully implemented	Partially implemented	Not implemented
The organisation has clear processes in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place.	The organisation does not have clear processes in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place, but is developing these processes	The organisation does not have clear processes in place that allow it to confirm within 48 hours of a High Severity CareCERT advisory being issued that a plan is in place, and these processes are not under development

Fully implemented	Partially implemented	Not implemented
The organisation has in post a primary point of contact who is responsible for receiving and co-ordinating CareCERT advisories.	The organisation does not have in post a primary point of contact who is responsible for receiving and co-ordinating CareCERT advisories, but is in the process of filling that role.	The organisation does not have in post a primary point of contact who is responsible for receiving and co-ordinating CareCERT advisories, and no plans are in place to fill that role.

6. Business continuity planning

Comprehensive business continuity plans must be in place to support the organisation's response to data and cyber security incidents.

Fully implemented	Partially implemented	Not implemented
The organisation has an agreed business continuity plan(s) for cyber security incidents in place. The plan(s) take into account the potential impact of any loss of services on external organisations in the health and care system.	The organisation is developing a business continuity plan(s) for data and cyber security incidents. The plan(s) will take into account the potential impact of any loss of services on external organisations in the health and care system.	The organisation does not have a continuity plan for data and cyber security incidents in place

If there is a business continuity plan in place has it been tested in 2017/18?

Yes	No
The business continuity plan for cyber security incidents in has been tested in 2017/18.	The business continuity plan for data and cyber security incidents has not been tested in 2017/18.

7. Reporting incidents

Staff across the organisation must report data security incidents and near misses, and incidents should be reported to CareCERT in line with reporting guidelines.

Incidents should be reported to CareCERT via carecert@nhsdigital.nhs.uk or 03003035222 if part of a national cyber incident response.

Fully implemented	Partially implemented	Not implemented
The organisation has a process or working procedure in place for staff to report data security incidents and near misses	The organisation is developing a process or working procedure for staff to report data security incidents and near misses	The organisation does not have a process or working procedure in place for staff to report data security incidents and near misses

Leadership obligation 3: Technology

8. Unsupported systems

Your organisation must:

- identify unsupported systems (including software, hardware and applications)
- have a plan in place by April 2018 to remove, replace or actively mitigate or manage the risks associated with unsupported systems.

NHS Digital's good practice guide on the management of unsupported systems is at: https://digital.nhs.uk/cyber-security/policy-and-good-practice-in-health-care.

Other guidance and general documents are on the main CareCERT website.

Fully implemented	Partially implemented	Not implemented
The organisation has reviewed all its systems and any unsupported systems have been identified and logged on the organisation's relevant risk register	The organisation has reviewed all its systems and any unsupported systems have been identified but not logged on the organisation's relevant risk register	The organisation has not reviewed its systems to identify any that are unsupported

For any unsupported systems identified, has the organisation developed a plan for how it will remove, replace or actively mitigate or manage the risks of unsupported systems. Organisations are not required to submit a plan as part of this data collection process but should be prepared to submit their plan to NHS Digital if requested.

Fully implemented	Not implemented
By May 2018 the organisation will have developed a plan to remove, replace or actively mitigate or manage the risks associated with unsupported systems	By May 2018 the organisation will not have a plan in place to remove, replace or actively mitigate or manage the risks associated with unsupported systems

9. On-site cyber and data security assessments

Your organisation must:

- have undertaken or have signed up to an on-site cyber and data security assessment by NHS Digital
- act on the outcome of that assessment, including any recommendations, and share the outcome of the assessment with your commissioner.

Fully implemented	Partially implemented	Not implemented
The organisation has undergone an NHS Digital on-site cyber and data security assessment	Prior to 31 March 2018 the organisation signed up to undergo an NHS Digital on-site cyber and data security assessment but has not yet	Prior to 30 March 2018 the organisation has not signed up to an NHS Digital on-site cyber and data security assessment

For organisations who have undergone an NHS Digital on-site cyber and data security assessment:

Fully implemented	Partially implemented	Not implemented
The organisation has an improvement plan in place on the basis of the findings of the assessment, and has shared the outcome with the relevant commissioner(s)	The organisation has an improvement plan in place on the basis of the findings of the assessment, but has not yet shared the outcome with the relevant commissioner(s)	The organisation does not yet have an improvement plan in place on the basis of the findings of the assessment, and has not yet shared the outcome with the relevant commissioner(s)

Please tell us if the organisation has used an external organisation to audit the organisation's data and cyber security risks. Please note there is no requirement to use an external organisation to audit data and cybersecurity risks.

Yes	No
The organisation has used an external vendor to audit the organisation's data and cyber security risks	The organisation has not used an external vendor to audit the organisation's data and cyber security risks

10. Checking Supplier Certification

Organisation should ensure that any supplier of critical IT systems that could impact on the delivery of care, or process personal identifiable data, has the appropriate certification (suppliers may include other health and care organisations).

Depending on the nature and criticality of the service provided, certification might include:

- ISO/IEC 27001:2013 certification: supplier holds a current ISO/IEC27001:2013 certificate issued by a United Kingdom Accreditation Service (UKAS)-accredited certifying body and scoped to include all core activities required to support delivery of services to the organisation.
- Cyber Essentials (CE) certification: supplier holds a current CE certificate from an accredited CE certification body.
- Cyber Essentials Plus (CE+) certification: supplier holds a current CE+ certificate from an accredited CE+ Certification Body.

- Digital Marketplace: supplier services are available through the UK Government Digital Marketplace under a current framework agreement.
- Other types of certification may also be applicable. Please refer to Cyber Security Services 2 Framework via Crown Commercial (https://ccs-agreements.cabinetoffice.gov.uk/contracts/rm3764ii)

NHS Digital contracts for/supplies a number of IT systems and solutions in use by multiple NHS organisations. Please note that NHS Digital ensures in each of its system procurements that appropriate data security certifications are in place from its suppliers.

Fully implemented	Partially implemented	Not implemented
The organisation has checked that the suppliers of all its IT systems have appropriate certification, and can evidence that all suppliers have such certification.	The organisation has checked that the suppliers of IT systems that relate to patient data, involve clinical care or identifiable data have appropriate certification, and can evidence that all suppliers have such certification.	The organisation has not checked whether its suppliers of IT systems have appropriate certification.

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 1 May 2018

NHS Improvement Year-End Self-Certification

Purpose of Report

The aim of self-certification is for the Trust to assure itself it is in compliance with NHS Provider conditions. The report presents the proposed relevant declarations to the Trust Board.

Executive Summary

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. This follows on from similar requirements in previous years to submit self-declarations to NHSI on these areas.

The Trust must publish the declarations within one month of the declaration by the Trust Board. Boards must sign off by 31 May for GS 6/7 and FT4 by 30 June 2017.

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 is in compliance with the conditions set by NHS Improvement, as outlined in the report.

Consultation

This report has been scrutinised by the Trust Chair and Chief Executive.

Governance or Legal Issues
The Trust has met the requirements of the self-certification.

Public Sector Equality Duty & Equality Impact Risk Analysis The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people).	
There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	
Actions to Mitigate/Minimise Identified Risks – not applicable	

Recommendations

The Board of Directors is requested to:

1. Confirm agreement with the proposed declarations for signature by the Chair and Chief Executive.
2. To agree to publication of the self-declarations.

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

NHS Improvement Year-end Self-Certification

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. This follows on from similar requirements in previous years to submit self-declarations to NHSI on these areas.

Providers need to self-certify the following after the financial year end:

NHS provider licence conditions

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))
- The provider has complied with required governance arrangements (Condition FT4(8))
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3)

The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions and providers may carry out this process as they see fit. DHCFT proposes to present the proposed relevant declarations to the Trust Board highlighting key evidence and narrative to support the declarations.

1. General Condition G6

Condition G6(2) requires NHS foundation trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring

Providers must annually review whether these processes and systems are effective must publish their G6 self-certification within one month following the deadline for sign-off (as set out in Condition G6(4)).

Proposed declaration:

The Board declares that the Licensee continues to meet the criteria for holding a licence (condition G6)

This declaration is supported by evidence as outlined in the Trust's Annual Governance Statement, Board Assurance Framework and through the work of the Board assurance Committees in ensuring management of risks and ongoing compliance. This has been supported through external independent assurance carried out in year.

2. Continuation of Services Condition 7

Commissioner requested services (CRS) are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and which will

be subject to regulation by NHS Improvement. Providers can be designated as providing CRS because:

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable.

Primary evidence is contained in the Going Concern assessment. In addition the significantly improved liquidity and cash reserves evidences high short term financial resilience. Successful delivery of control total - ongoing contract management process and project management office arrangements, overseen by Finance and Performance Committee. This is described in full along with mitigating actions in the 18/19 Board Assurance Framework (3a Delivery of financial plan).

Proposed Declaration:

The Board declares that the licensee has a reasonable expectation that the licensee will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

3. Condition FT4 Declaration

NHS foundation trusts must self-certify under Condition FT4 (8) whether the governance systems achieve the objectives set out in the licence condition.

The Trust has during the year undertaken significant work to sustain and embed actions undertaken to improve governance areas. This has involved ensuring effective Board and committee structures, reporting lines and performance and risk management systems. See attached NHSI template for further information against each item. Completion of an external well-led framework review provided assurance on satisfactory policies and practice in place.

Proposed declaration:

The Board confirms that it complies with all elements of the Corporate Governance Statement (condition FT4)

4. Certification on Training of governors

Providers must review whether their governors have received enough training and guidance to carry out their roles.

Governor training has been carried out on a regular basis throughout the year and includes sessions led by Trust Directors, senior staff, external parties and structured training programmes. This has been monitored, evaluated and reviewed by the Council of Governors and been evidenced as part of review of embedding GIAP actions. Governors have confirmed that they are satisfied with the training provided, through their governor effectiveness survey, and through their input to the on-going training and development programme via the governor Governance Committee.

Proposed declaration:

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the

Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Declaration process

The Trust must publish the declarations within one month of the declaration by the Trust Board. Boards must sign off by the 31 May for GS 6/7 and FT4.

From July 2018, NHS Improvement will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified. This can either be through providing the templates if they have used them, or by providing relevant Board minutes and papers recording sign-off.

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Primary evidence is contained in the Going Concern assessment. In addition the significantly improved liquidity and cash reserves evidences high short term financial resilience. Successful delivery of control total - ongoing contract management process and project management office arrangements, overseen by Finance and Performance Committee. This is described in full along with mitigating actions in the 18/19 Board Assurance Framework (3a Delivery of financial plan)

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Ifti Majid	**Name**	Caroline Maley
Capacity	Chief Executive	**Capacity**	Chair
Date	01 May 2018	**Date**	01 May 2018

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Following consideration of an external independent assurance review of governance arrangements at the Trust, NHS improvement issued a certificate of compliance on 24 May 2017. The Trust has continued to sustain and embed the actions undertaken as part of the governance improvement action plan, which have been overseen by Board Committees. Assurance reporting has been presented to the Board in November 2017 and March 2018 to confirm ongoing sustained good practice.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Trust has embedded the actions taken to address the comprehensive Governance Improvement Action Plan completed in 2017 which ensures continued focus on good governance practice.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Trust corporate governance framework has been reviewed in year and implemented successfully. There is a process for review of all Board Committees to reflect on effectiveness. External assurance has been received in year following completion of an independent external Well Led Framework Review.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Board, via its Committees where relevant, overseas the Trust duties as listed. Items are esclated to the Trust Board from Committees to ensure key risks are addressed.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Quality Leadership is overseen by the Trust Board and assurance on quality of care is provided through the Quality Committee. Issues and risks are escalated to the Board as required. We have continued to progress and complete actions arising following the CQC comprehensive inspection in June 2016 and subsequent visits.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Remuneration and Appointments Committee consider the composition of the Board to ensure that this is appropriate in terms of skill mix and qualifications. Fit and Proper Persons Test policy has been fully implemented and embedded. Wider workforce issues are considered by the People & Culture Committee with risks and issues escalated to the Board as required.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name Ifti Majid, Chief Executive **Name** Caroline Maley, Chair

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 1 May 2018

Fit and Proper Persons Test Chair's Declaration

Purpose of Report

To present the Chair's declaration that all Trust Board Directors meet the fitness test and do not meet any of the 'unfit' criteria as per the Fit and Person's Test regulations (Health and Social Care Act 2008 Regulation 2014).

Executive Summary

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduced a 'Fit and Proper Person Test' for NHS bodies. At its meeting on 30 March 2016 the Trust Board approved a Fit and Proper Persons Test policy which outlines how the Trust will meet the requirements placed on NHS providers.

Under the regulations, all provider organisations must ensure that Director level appointments meet the 'Fit and Proper Persons Test' and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent or Non-Executive Director under given circumstances. The regulations have been integrated into the Care Quality Commission's (CQC's) registration requirements, and fall within the remit of their regulatory inspection approach.

It is the responsibility of the Chair to discharge the requirement placed on the Trust to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria. The Trust has processes in place to ensure that the appropriate checks are made on appointment of Director level posts, that relevant checks and supporting information relating to existing post holders have been provided and there are proactive processes set in place to ensure the ongoing review and monitoring the filing system for all Directors. These have been carried out at appointment for all Director and Non-Executive Director appointments made during 2017/18. In addition, self-declarations have been made by all Directors as at 31 March 2018. Comprehensive files containing evidence to support the elements of the fitness test are retained and regularly reviewed to ensure contents are updated as required.

This declaration evidences the embeddedness of processes set in place as part of the Governance Improvement Action Plan (recommendations FF1(4) and FF(5)) relating to compliance with the Fit and Proper Persons Test.

During the year there has been debate within the NHS regarding the requirement to carry out Disclosure and Barring Service (DBS) checks for Directors. Legislation outlines that DBS checks should only be carried out for individuals who meet specified eligibility criteria. Although Non-Executive Director roles, and Executive Director roles (with the exception of the Director of Nursing and Patient Experience and the Medical Director) do not meet the criteria of carrying out eligible roles, it has been noted by the CQC in recent inspections that enhanced DBS checks are expected for all Directors. The Trust's current policy outlines that new appointments should have DBS checks where appropriate to the role. Prior to the appointment of Geoff Lewins (Non Executive Director from 1 December), the available guidance was reviewed and the Chair decided that a basic check only was required. In the light of recent further feedback from the

CQC to provider Trusts, an application has now been made to undertake an enhanced check. Enhanced checks have previously been carried out for all other Board members roles.

Amanda Rawlings, Director of People and Organisational Effectiveness, carries out a joint Executive Director role with Derbyshire Community Health Services NHS Trust and we have requested an enhanced DBS check to be carried out relating to her role within Derbyshire Healthcare NHS FT. This is in addition to the DBS check carried out on the joint role by DCHS.

Gareth Harry is undergoing pre-employment checks prior to commencing his role as Director of Transformation and Business Improvement on 1 June. An enhanced DBS check has been requested and is underway.

The Fit and Proper Persons Test policy has been reviewed following guidance issued by the CQC in January 2018 (Guidance for providers and CQC Inspectors). This focusses on providing guidance about the meaning of misconduct and mismanagement. We have updated the policy (see separate agenda item) but this has not materially affected the robust and comprehensive test undertaken as established practice by the Trust.

We have however continued to develop our records to encompass wider social media checks (now including Facebook, Twitter, LinkedIn). We have also included details reflecting the values based interview and selection process which has included stakeholder evaluation of all candidates for Board member appointments since April 2016 and for appointments prior to this where information is available.

Appointments from acting roles to substantive roles were each reviewed and it was confirmed that all relevant fit and proper persons test were in place and satisfactory. Additional references were sought on appointment to these roles as part of pre-employment checks.

DECLARATION:

I hereby declare that appropriate checks have been undertaken in reaching my judgment that I am satisfied that all Directors of the Trust, including Non-Executive Directors, and Executive Directors (including voting, non-voting and Acting) are deemed to be fit and that none meet any of the 'unfit' criteria. Specified information about Board Directors is available to regulators on request.

Strategic considerations

- This declaration confirms that the Trust meets the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 'fit and proper person test' for NHS bodies.
- It is an element of NHS Improvement's Code of Conduct for NHS Trusts (Reference B.2.2) for which the Trust must 'comply or explain' within the Annual Report and Accounts

Board Assurances

- The Board can receive assurance that due process has been followed to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria.
- That comprehensive files have been established and maintained for each relevant post, evidencing compliance and that proactive processes have been set in place to monitor the filing system.

Consultation

This report has not been considered by other groups/committees. However confirmation of Fit and Proper Person Test compliance for Non-Executive roles have been received by the governor Nomination and Remuneration Committee on their appointment.

Governance or Legal Issues

- It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that NHS bodies undertake a 'fit and proper person test'.
- The regulations have been integrated into the CQC's registration requirements, and falls within the remit of their regulatory inspection approach.

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) and Public Sector Equality Duty & Equality Impact Risk Analysis.

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

Actions to Mitigate/Minimise Identified Risks

No risks have been identified at this stage.

Recommendations

The Board of Directors is requested to:

1) Receive full assurance from the Chair's declaration that that all Directors meet the fitness test and do not meet any of the 'unfit' criteria

Report presented by: **Caroline Maley, Acting Chair**

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors - 1 May 2018

Fit and Proper Persons Regulations (FPPR)
Update to the Trust's Fit and Proper Persons Policy and Procedures

Purpose of Report

To present the updated Fit and Proper Persons Policy and procedures for approval.

Executive Summary

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduced a 'Fit and Proper Person Test' for NHS bodies. At its meeting on 30 March 2016 the Trust Board approved a Fit and Proper Persons policy and procedures which outlines how the Trust will meet the requirements placed on NHS providers. Although not due for formal review until 2019, the policy has been reviewed in the light of guidance recently issued by both the CQC and NHS Providers.

CQC guidance on FPPR

In January 2018 the CQC published guidance on Regulation 5: Fit and Proper Persons: Directors: 'Guidance for providers and CQC inspectors' which followed extensive consultation during 2017. This includes setting out the procedure for when CQC 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.

Trusts have to decide whether any concerns reach the threshold of being "serious" in nature and determine the appropriate response. For example, CQC's national guidance states that while minor breaches of security or failure to follow agreed policies and processes with limited repercussions would not amount to serious misconduct or mismanagement, incidences such as fraud, theft, assault, sexual harassment and bullying would breach this threshold.

While a single incident of misconduct may amount to serious misconduct, an isolated incident is unlikely to constitute serious mismanagement unless it threatens public confidence in the organisation and individual concerned. Serious mismanagement is rather a "course of conduct over time" and its seriousness can be assessed through the impact on quality and safety of care for service users, the safety and wellbeing of staff, and the organisation's viability.

When assessing whether a director's action(s) or omission(s) amount to "serious misconduct or mismanagement", trusts should consider whether the director played a central or peripheral role, and this will determine how "seriously" it should be taken. Trusts should also consider any mitigating factors.

NHS Providers guidance on FPPR

The CQC guidance was supported by information published by NHS Providers in January 201; Fit and Proper Persons Regulations – What do providers need to know'. This guidance also provides a ten step guide for investigations, which has been developed in response to experience within the NHS and which the Trust will consider and utilise should a situation arise.

We have reviewed our established policy in the light of both these publications to ensure the policy continues to be fit for purpose and reflects best practice and guidance which will support the Board to accurately interpret and effectively apply Fit and Proper Persons Regulations.

Furthermore there has been recent media coverage of comments by Baroness Dido Harding, chair of NHS Improvement, who has demanded tougher action to exclude those who do not deserve to work in the health service again and who have crossed a moral line. However, she said that those who had simply done a bad job must be

given help to get better. Regulators continue to focus on implementation of the Fit and Proper Personal Regulation and we will work to ensure that we take on board guidance and good practice in this area and contribute to ongoing debate to make implementation of the regulations effective.

Role of the Care Quality Commission

The CQC on their forthcoming inspection will wish to ensure that we have a robust process 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 which has been externally assured by the CQC following their comprehensive inspection in June 2016.

As part of the FPP policy the Chair is required to make an annual declaration relating to the compliance with FPPR (see separate agenda item). Although the policy has been refreshed and is presented for approval this does not materially affect the FPPR test applied and as such the declaration, although made against the existing policy is still valid under the revised policy.

Summary of Changes

- Latest policy template used (including addition of information in Summary of and Aim of Policy boxes)
- Trust logo updated throughout
- Addition of other policies, procedures and information that are related to/of interest/subject to the Fit and Proper Persons Policy
- Person amended to Persons
- Director of Corporate and Legal Affairs amended to Director of Corporate Affairs
- Features normally associated with ‘Good character’ added to the policy
- Interpretation of misconduct and mismanagement and advice regarding definition of ‘serious’ added to the policy.
- Reference to process to follow in the case of an appeal

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

Assurances

The policy and its indexes have been updated to reflect latest guidance issued by NHS Providers and also to reflect updated guidance from CQC.

Although the policy has been refreshed and is presented for approval this does not materially affect the FPPR test applied and as such the declaration although made against the existing policy is still valid under the revised policy.

Consultation

The policy was previously approved by the Trust Board in January 2016.

Governance or Legal Issues

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.

It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that NHS bodies undertake a ‘fit and proper person test’.

The regulations have been integrated into the CQC’s registration requirements, and falls within the remit of their regulatory inspection approach.

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 Trust Board is requested to:

1. Note the updates to the policy and approve the policy for publication.
2. Receive full assurance that implementation of the policy will ensure compliance with the Fit and Proper Persons Regulations (2014).

Report presented by:	**Sam Harrison, Director of Corporate Affairs & Trust Secretary**
Report prepared by:	**Sam Harrison, Director of Corporate Affairs & Trust Secretary and Donna Cameron, Assistant Trust Secretary**

Derbyshire Healthcare
NHS Foundation Trust

Fit and Proper Persons Policy and Procedure

See also:	Located in the following policy folder on the Trust Intranet
Disciplinary Procedure for Medical Staff Policy and Procedures	Workforce & OD Policies and Procedures
Disciplinary Policy & Procedure	Workforce & OD Policies and Procedures
Disclosure and Barring Service (DBS) Policy and Procedures	Workforce & OD Policies and Procedures
Recruitment and Selection Policy and Procedures	Workforce & OD Policies and Procedures
Raising Concerns at Work Whistleblowing Policy and Procedure	Workforce & OD Policies and Procedures

Service area	Issue date	Issue no.	Review date	
Trust wide	May 2016	1	May 2019	
Ratified by	**Ratification date**	**Committee/Group responsible for review:**		
Board of Directors	March 2016	Director of Corporate Affairs		

Document published on the Trust Intranet under:

Did you print this document?
Please be advised that the Trust discourages retention of hard copies of policies and can only guarantee that the Policy on the Trust Intranet site is the most up-to date version

ACCESSIBLE INFORMATION STANDARD
The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Ensure you have considered an agreed process for: sending out correspondence in alternative formats and appointments for patients / service users with communication needs, where this is applicable.

Checklist for Fit and Proper Persons Policy

Summary (Plain English) Summarise the main points of the policy below in a style that is clear and easy to understand. Ensure the whole policy is written in plain English, using simple language where possible and avoiding convoluted sentences and obscure words. The resulting policy should be easy to read, understand and use,
The purpose of the Fit and Proper Persons Policy is to hold Trust Board members to account in relation to their conduct and performance and also to instil confidence in the public that the individuals leading the Trust are suitable to hold their position, in line with the requirements of the Fit and Proper Persons Regulations introduced in November 2014.

Name / Title of policy/procedure	Fit and Proper Persons Policy	
Aim of Policy	To ensure all Executive and Non-Executive Director posts (or anyone performing equivalent/similar functions) are filled by people that meet the requirements of the Fit and Proper Persons Regulations.	
Sponsor (Director lead)	Director of Corporate Affairs	
Author(s)	Director of Corporate Affairs Director of Nursing & Patient Experience	
Name of policy being replaced	Not applicable	**Version No of previous policy:**

Reason for document production:	Required policy
Commissioning individual or group:	Trust Board

Individuals or groups who have been consulted:	**Date:**	**Response**
Executive Leadership Team		Agreed

Version control (for minor amendments)

Date	Author	Comment
February 2017	*Sam Harrison*	Amendment to Appendix 1
March 2018	Sam Harrison	Amendments to appendices 2 & 3, list of other relevant policies and associated documents added, additional information added to update the policy following the issue of NHS Providers Guidance on What Providers Need to Know. Updated with amended guidance regarding

		enhanced DBS checks.

Fit and Proper Persons Policy

Table of Contents

Fit and Proper Persons Policy

1. Introduction

1.1 Purpose

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduced a 'fit and proper persons test' for all NHS bodies. This policy outlines how the Trust will meet the requirements placed on the NHS which came into force on 1 October 2014 for all NHS bodies and for all providers on 1 April 2015.

Under the regulations, all provider organisations must ensure that Director level appointments meet the Fit and Proper Persons Test and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent or Non-Executive Director under given circumstances.

The regulations have been integrated into the Care Quality Commission's (CQC's) registration requirements, and falls within the remit of their regulatory inspection approach.

1.2 Scope

This policy applies to all Board appointments, ie Executive and Non-Executive Directors and those senior managers which are formally recognized as part of the Trust's Executive Leadership Team (ELT). This includes permanent, interim and associate positions. It also includes those individuals who are acting up in Board level positions.

2. Requirements

The introduction of the Fit and Proper Persons Requirements (FPPR) requires the Trust Chair to:

- Confirm to the CQC that the fitness of all new Directors has been assessed in line with the regulations; and
- Declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role both on appointment and an ongoing basis and do not meet any of the 'unfit' criteria.

The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about board Directors available to the CQC on request.

Individuals who fall into the categories above must satisfy the Trust Chair they:

- Are of good character

- Hold the required qualifications and have the competence, skills and experience required for the relevant office for which they're employed
- Are able, by reason of their physical and mental health, after any required reasonable adjustments if required, capable of properly performing their work
- Can supply relevant information as required by schedule 3 of the act, i.e. documentation to support the FPPR
- Not have been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

In accordance with schedule 4 part 1 of the act a person is deemed "unfit" if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment

2.1 Good character

In accordance with part 2 of the Act a person will fail the good character test if they:

- Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence
- Have been erased, removed, struck off a register of professionals maintained by a regulator of health care of social work professionals.

Whilst there is no statutory guidance on what constitutes 'good character', the CQC 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 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.

2.2 Serious mismanagement or misconduct

In consideration of any instances of misconduct or mismanagement, consideration will be given to relevant guidance issued by the CQC, as set out below. Providers will have to reach their own decision as to whether any facts that are alleged reach the threshold of being "serious misconduct or mismanagement".

- "Misconduct" means conduct that breaches a legal or contractual obligation imposed on the director. It could mean acting in breach of an employment contract, breaching relevant regulatory requirements (such as mandatory health and safety rules), breaching the criminal law or engaging in activities that are morally reprehensible or likely to undermine public trust and confidence.

- "Mismanagement" means being involved in the management of an organisation or part 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

3. Trust Procedure

3.1 Pre-Employment

The CQC expects senior leaders to set a tone and culture of the organisation that leads to staff adopting a caring and compassionate attitude. Therefore, it is important that in making appointments boards take into account the values of the organisation and the extent to which candidates provide good fit with those values. Values-based interviews, or values-based questions in other interviews, will be used.

All new appointments to the applicable posts will have the following recruitment checks in accordance with NHS Employment Check Standards issued by NHS employers, including:

- Proof of identity and right to work in the UK
- Proof of qualifications
- Professional registration and qualification check
- Full employment history and at least two detailed reference checks, one of which must be the most recent employer. Specifically this includes validating a minimum of three years continuous employment
- Occupational health assessment
- Disclosure and Barring Scheme (DBS) check (where appropriate to the role)
- Search of registers e.g. disqualified directors, bankruptcy and insolvency
- Google, news and social media searches

The standards that the Trust will follow at the recruitment stage, the assurance process to follow and evidence required is outlined in Appendix 2.

3.2 Declaration

Appointees will be asked to complete a declaration to include:

- Confirmation of their reasonable health after reasonable adjustments are made of properly performing tasks related to their role (subject to the relevant provisions of the Equality Act 2010)
- Any criminal and/or regulatory investigations
- Any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out regulated activity
- Any undischarged bankruptcy, disqualification, debt relief orders etc
- Any inclusion on the Children's or Adults barred lists
- Any prohibition from holding relevant position or office under any law

3.3 External Recruitment Consultancy

Where the Trust engages recruitment consultants to asset with appointments, it may ask the consultants to carry to out some or all of the process, but the Trust will gain all necessary documentation to evidence that the checks have been carried out.

3.4 Ongoing Assurance

On an annual basis all relevant office holders will be asked to complete the fit and proper persons declaration (See Appendix 1).

The Trust will review the checks carried out on appointment every three years or annually as appropriate (See Appendix 3).

With regard to the requirement for the Trust to be satisfied as to the post-holders, competence, skills and knowledge necessary for the post in which they are employed the following will be relied upon:

- Documented 360 Appraisals
- Provision of adequate training opportunities to include both individual and collective development.

3.5 Process to be followed on an issue or concern being raised

3.5.1 As set out above, some criteria are pass/fail, i.e. the Trust cannot appoint or have in place an individual in a relevant position if they do not satisfy the specific test. Other, particularly the tests of good character and any association with serious misconduct or responsibility for failure in a previous role, require the Trust to make a reasonable assessment as to fitness.

3.5.2 If, either at the time of appointment or later, it becomes apparent that circumstances exist or have arisen whereby a person may not be considered to meet all the requirements of a fit and proper person, the Director of Corporate Affairs shall inform the Chair (or if the person is the Chair, the Senior Independent Director). The Trust must take appropriate action to investigation and rectify the matter.

3.5.3 The Chair (SID) shall, acting reasonably and having regard to guidance issued by the CQC or Monitor, determine whether the person meets the said requirements.

The Chair leads on addressing these concerns on a case by case basis and will need to consider whether an investigation is necessary or appropriate given the allegation. The Chair may choose to consult with the Senior Independent Director and the Director of People and Organisational Effectiveness to determine the appropriate process to follow and action to take.

The Chair will consider the guidance as issued by NHS Providers, Fit and Proper Persons Regulations in the NHS, namely the Fit and Proper Persons Investigation Ten Step Guide, which covers:

Step 1	Receiving concerns in relation to a director
Step 2	Deciding whether an investigation is necessary
Step 3	Choosing who should carry out the investigation
Step 4	Deciding the remit of the investigation
Step 5	Deciding who to engage in the investigation
Step 6	Agreeing any interim action
Step 7	Gathering evidence
Step 8	Managing competing factors in the investigation
Step 9	Making a final decision
Step 10	Managing the effects of the outcome

3.5.4 Should the Chair consider the individual to be suitable, despite existence of information relevant to issues identified in Schedule 4, Part 2, the Chair's reasons should be recorded for future reference and made available.

3.5.5 If the Chair (SID) determines that the person does not or no longer meets the said requirements, that person may not be appointed, or appropriate disciplinary action be followed in line their tenure of office shall be terminated and that person shall cease to act as a Director.

3.5.6 The Chair should keep the Council of Governors informed throughout any investigation into a Non-Executive Director. However, the tension between confidentiality and transparency may lead to the Chair involving only the Lead Governor.

3.5.7 If action is taken against an Executive Director as an outcome of the hearing because of the failure to comply with Fit and Proper Persons Policy then the right to appeal will apply in accordance with existing Trust Policy & Procedures. In relation to Non-Executive Directors any appeal will be overseen by the Council of Governors. The criteria for removing Non-Executive Directors/Chairman are set out in the Trust's Constitution.

3.6 Implementation

It is the ultimate responsibility of the Trust Chair to discharge the requirement placed on the Trust, to ensure that all Directors meet the fitness test and do not meet any of the 'unfit criteria'. The Director of Corporate Affairs is responsible for ensuring consistent application of the policy during the appointment process and for ensuring that all appropriate documentation is complete, retained and available. The Director of Corporate Affairs will support the Trust Chair in preparing the annual declaration for the Trust Board. The PA to the Chief Executive is responsible for maintaining the records of completed Fit and Proper Persons declarations.

The Council of Governors' Nominations & Remuneration Committee will receive a report to confirm the outcome of the Fit and Proper Person Checks regarding new Non-Executive Director appointments. The Trust Board's Remuneration & Appointments Committee will receive a report to confirm the outcome of the Fit and Proper Person Checks regarding Executive Director/Board appointments.

4. Associated Documents and References

Care Quality Commission, (2018). Regulation 5: Fit and proper persons: directors, Guidance for providers and CQC inspectors.
Available at: https://www.cqc.org.uk/sites/default/files/20180119_FPPR_guidance.pdf

Care Quality Commission, Regulation 5: Fit and proper persons: directors.
https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-5-fit-proper-persons-directors

NHS Employment Standards.
http://www.nhsemployers.org/your-workforce/recruit/employment-checks

NHS Improvement (2017), Fit and proper persons requirements.
https://improvement.nhs.uk/resources/fit-and-proper-persons-requirements

NHS Improvement (2017), Guidance on senior appointments in NHS trusts.
https://improvement.nhs.uk/uploads/documents/senior_appointments_guidance_final.pdf

NHS Providers, NHS Confederation and NHS Employers (2014), Fit and proper persons test guidance.
http://nhsproviders.org/resource-library/briefings/fit-and-proper-persons-test-guidance

NHS Providers (2018), Fit and Proper Persons Regulations in the NHS: What do providers need to know?
http://nhsproviders.org/fit-and-proper-persons-regulations-in-the-nhs

5. Dissemination and Implementation

This policy will be made available on the intranet.

Awareness of this policy will be raised in the Statement of Main Terms and Conditions of Employment and local induction for relevant posts and a summary will be published on the HR section on the intranet.

6. Consultation and Approval

The Joint Consultative Committee (JCC) reviewed the policy and the Executive Leadership Team (ELT) agreed the policy, which was ratified by the Trust Board.

7. Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we treat staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

8. Monitoring Compliance with this Policy

Standard/ Process	Monitoring & Audit		
	By	Committee	Frequency
Instances of non-compliance with policy	Director of Corporate Affairs	Remuneration & Appointments Committee and the Governors Nominations &	Annually

		Remuneration Committee	
Pre-employment checks	Director of Corporate Affairs	Remuneration & Appointments Committee and the Governors Nominations & Remuneration Committee	Upon completion of process
Annual Review	Director of Corporate Affairs	Trust Board	Annually

Appendix 1 - Pre-employment and annual declaration for Executive Directors, Non-Executive Directors and Director Equivalent Posts

Fit and Proper Persons Declaration

1 It is a condition of employment that those holding Director and Director equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Trust's provider licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 ("the Regulated Activities Regulations") and the Trust's Constitution.

2 By signing the declaration below, you are confirming that you do not fall within the definition of an "unfit person" or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

Provider Licence

3 Condition of Derbyshire Health NHS Foundation Trust's Provider Licence ("The Licence") provides that the Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of NHS Improvement.

4 The Licence condition requires the Licensee to ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licence also requires the Licensee to enforce that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of NHS Improvement.

5 An "unfit person" is defined within the Licence as:

(a) An individual:

(i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

(ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

(iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was

imposed on him; or

(iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act appointed for the whole or any material part of its assets or undertaking; or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act; or

(v) which passes any resolution for winding up; or

(vi) Which becomes subject to an order of a Court for winding up.

Regulated Activities Regulations

6 Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a Director, or performing the functions of or equivalent or similar to the functions of, such a Director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation.

7 The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:

(a) The individual is of good character.

(b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed.

(c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed.

(d) The individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

(e) That none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

8 The grounds of unfitness specified in Paragraph 1 of Schedule 4 to the Registered Activities Regulations are:

(a) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.

(b) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.

(c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.

(d) The person has made a composition or arrangement with, or granted a Trust deed for creditors and not been discharged in respect of it.

(e) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

(f) The person is prohibited from holding the relevant office or position, or in the case of an individual carrying on the regulated activity, by or under any enactment.

Trust's Constitution

9 The Trust's constitution places a number of restrictions on an individual's ability to become or continue as a Director. A person may not become or continue as a Director of the Trust if:

(a) They have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged.

(b) They have made a composition or arrangement with, or granted a

Trust deed for their creditors and have not been discharged in respect of it.

(c) They have within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them.

(d) In the case of a Non-Executive Director they no longer satisfy the relevant requirements for appointment

(e) They are a person whose tenure of office as a Chairman or as a Member or Director of a Health Service body has been terminated on the grounds that his/her appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary/non-pecuniary interest.

(f) They have within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a health service body;

information revealed by a Criminal Records Bureau check is such that it would be inappropriate for him to become or continue as a Director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

(g) They have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of that Act, and has not subsequently had their name included in such a list.

(h) They have been placed on the registers of Schedule 1 offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Acts 1933 to 1969 (as amended) and his or her conviction is not spent under the Rehabilitation of Offenders Act 1974;.

(i) They fail to abide by the Constitution.

(j) They are under 16 years of age.

I acknowledge the extracts from the provider licence, Regulated Activities Regulations and the Trust's constitution above. I confirm that I do not fit within the definition of an "unfit person" as listed above and that there are no other grounds under which I would be ineligible to continue in post. I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a "fit and proper person" or other grounds which I would be ineligible to continue in post come to my attention.

Name: _____ Signed: _____

Position: _____ Date: _____

Appendix 2 - Table of requirements for complying with the regulations at the recruitment stage

Below are standards that the Trust will follow at the recruitment stage, the assurance process to follow and evidence required.

	Standard	Assurance Process	Evidence
1.	The Trust should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4, Part 2 of the regulations. The fit and proper persons 'test' must be applied before an individual is appointed to a position.	Recruitment checks in accordance with NHS Employment Check Standards issued by NHS Employers, including: • Proof of identity and right to work in the UK • Proof of qualifications • Professional registration and qualification check • Full employment history and at least two detailed reference checks, one of which must be the most recent employer. Specifically this includes validating a minimum of three years continuous employment • Occupational health assessment • Disclosure and Barring Scheme (DBS) check (where appropriate to the role) • Search of registers e.g. disqualified directors, bankruptcy and insolvency • Google, news and social media searches	• References • Outcome of other pre-employment checks • DBS check certificate where appropriate • Register and internet search results • List of referees and sources of assurance for Freedom of Information Act (FOIA) purposes
2.	Where the Trust deems the individual suitable despite not meeting the characteristics outlined in Schedule 4,	• Report and debate at the nominations committee(s)	• Record that due process was followed for FOIA purposes

	Part 2 of these regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware.	• Report and recommendation at the council of governors (for NEDs) or the board of directors (for executive directors) for foundation trusts, reports to the board for NHS trusts • Decisions and reasons for decisions recorded in minutes • External advice sought as necessary	
3.	Where specific qualifications are deemed by the Trust as necessary for a role, the Trust must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator.	• Requirements included within the job description for all relevant posts • Proof of qualifications checked as part of the pre-employment checks	• Person specification • Recruitment policy and procedure
4.	The Trust should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, to undertake the role; these should be followed in all cases and relevant records kept. N.B. While this provision most obviously applies to executive director appointments in terms of qualifications, skills and experience will be relevant to	• Recruitment checks including a candidate's qualifications and employment references • Recruitment processes including qualitative assessment and values-based questions • Decisions and reasons for decisions recorded in minutes	• Recruitment policy and procedure • Values-based questions • Minutes of council of governors • Minutes of board of directors

	NED appointments.		
5.	In addition to 4. above, the Trust may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe.	• Discussions and recommendations by the nominations committee(s) • Discussion and decision at board of directors or council of governors meeting • Reports, discussion and recommendations recorded in minutes of meetings • Follow-up as part of continuing review and appraisal	• Minutes of committee, board and or council meetings. • NED appraisal framework • NED competence framework • Notes of executive director appraisals
6.	When appointing relevant individuals the Trust has processes for considering a person's physical and mental health in line with the requirements of the role, all subject to equalities and employment legislation and to due process.	• Self-declaration of past health issues subject to clearance by occupational health as part of the pre-employment process • Offer of appointment should be subject to this health screening • If a health issue is raised, should consider if it falls within definition of disability and if it does, consider whether reasonable adjustments in compliance with the Equality Act 2010 can be made.	• Occupational health clearance
7.	Wherever possible, reasonable adjustments are made in order that an individual can carry out the role.	• Self-declaration of adjustments required • Check steps taken are in line with requirements to make reasonable adjustments for employees under the Equality Act 2010 • NHS Employment Check Standards • Board/council of governors decision.	• Minutes of board meeting/council of governors meeting

8.	The Trust has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour and making independent enquiries. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.	• Same checks set out in 1, ie. past employment history in accordance with NHS Employers pre-employment check standards including a self-declaration of fitness in which candidates provide an explanation of past conduct/character issues where appropriate • Clear consequences of false, inaccurate or incomplete information included in recruitment packs	• NED Recruitment Information pack • Reference request for executive directors and NEDs
9.	The Trust must not appoint any individual who has been responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases. N.B. CQC accepts that trusts will use reasonable endeavours in this instance. The existence of a compromise	• Clear consequences of false, inaccurate or incomplete information included in recruitment packs • Core HR policies for appointments and remuneration • Checks set out in 1 above • Included in reference requests • Check publicly available information including serious case reviews	• Executive and non-executive Recruitment Information packs • Core HR policies • Reference request for executive directors and NEDs

	agreement does not indemnify the new employer and trusts will need to ensure that their Core HR policies address their approach to compromise agreements.		
10.	A person who will be acting in a role that falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 must be subject to an enhanced DBS check. N.B. CQC recognises that it may not always be possible for trusts to access a DBS check as an individual may not be eligible.	• Where an executive director or NED meets the eligibility criteria, trusts should apply for an enhanced DBS check • If the director's role falls within the definition of a "regulated activity", the DBS check will establish whether the person is on the children's and/or adults' safeguarding barred list and whether they are prohibited from holding the office in question under other laws such as the Companies Act or Charities Act.	• DBS policy • Enhanced DBS checks for eligible post-holders
11.	As part of the recruitment/appointment process, trusts should establish whether the Individual is eligible for the relevant DBS check.	• Eligibility for DBS checks will be assessed for each vacancy arising • OR • All postholders will undergo an enhanced DBS check	• DBS policy

Appendix 3 – Complying with the regulations on an ongoing basis

Below are standards that the Trust will follow throughout the course of an individual's employment, the assurance process to be followed and the evidence to be produced.

	Standard	Assurance Process	Evidence
1.	The Trust should regularly review the fitness of directors to ensure that they remain fit for the role they are in; the trust should determine how often fitness should be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role.	• Assessment of continued fitness to be undertaken each year as part of the appraisal process • Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process • Board/Council of Governors to review, checks and agree the outcome • Regular DBS checks • Regular checks of relevant	• Continued assessment as part of appraisal process • Register checks if necessary • Board/council minutes record that process has been followed

		• professional regulator's register • Ensure there is an ongoing • obligation in employment contracts to declare any criminal and/or regulatory investigations as soon as reasonably practicable	
2.	If the Trust discovers information that suggests an individual is not of good character after they have been appointed to a role, the trust must take appropriate and timely action to investigate and rectify the matter. The Trust has arrangements in place to respond to concerns about a person's fitness in relation to Regulation 5(3) and (4) after they are appointed to a role whether identified by the trust itself or others – and these are adhered to.	• Core HR policies provide for such investigations • Revised contracts allow for termination in the event of non-compliance with regulations and • other requirements • Contracts (for executive directors , and director-level equivalents) and agreements (for NEDs) incorporate • maintenance of fitness as a contractual requirement	• Core HR polices • Contracts of employment (for executive directors and director-level equivalents) • Service agreements or equivalent (for NEDs)
3.	The Trust investigates, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken; the trust must demonstrate due diligence in all actions.	• Core HR policies include the necessary provisions • Action taken and recorded as required	• Core HR policies

4.	Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users.	• Core HR policies	• Managerial action taken to backfill posts as necessary
5.	The Trust informs others as appropriate about concerns/findings relating to a person's fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/ investigations carried out by others.	• Core HR policies	• Referrals made to other agencies if necessary

Equality Impact Analysis form for Fit and Proper Persons Policy

REGARDS EIRA: Assessing Equality Relevance (Stage 1)

1. Name of the service / policy / project or proposal (give a brief description):

2. Answer the questions in the table below to determine equality relevance:

	Yes	No	Insufficient data / info to determine
Does the project / proposal affect service users, employees or the wider community, and potentially have a significant effect in terms of equality?			
Is it a major project / proposal, significantly affecting how functions are delivered in terms of equality?			
Will the project / proposal have a significant effect on how other organisations operate in terms of equality?			
Does the decision/ proposal relate to functions that previous engagement has identified as being important to particular protected groups?			
Does or could the decision / proposal affect different protected groups differently?			
Does it relate to an area with known inequalities?			
Does it relate to an area where equality objectives have been set by our organisation?			

3. On a scale of high, medium or low assess the policy in terms of equality relevance.

	Tick below:	Notes:
High		If ticked all 'Yes' or 'Insufficient data'
Medium		If ticked some 'Yes' and / or 'Insufficient data' and some 'No'
Low		If ticked all 'No'

EIRA completed by: *Insert job title, not individuals name*
Date:

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 1 May 2018

Register of Trust Sealings 2017/18

Purpose of Report

This report provides the Trust Board with an update of the authorised use of the Foundation Trust Seal since 1 January 2018 and completes reporting on use of the seal for the 2017/18 financial year.

Executive Summary

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

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

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

There have been ten entries made to the Register of Trust Sealings for 2017/18 up until December 2017 and these were reported to the Board on 31 January. Since January the Trust Seal was affixed in March 2018 as follows:

1. DHCFT51 Lease of office number 20 Stoveley Hall (15 March)
2. DHCFT52 Collateral agreement between the Trust, NIBC Bank, FES FM Limited, Arden Partnership (19 March)
3. DHCFT53 Transfer Deed TR5 Bramble House (20 March)
4. DHCFT54 Overage Deed Bramble House (20 March)

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

3) We will develop our **people** to allow them to be innovative, empowered, engaged and motivated. We will retain and attract the best staff.	
4) We will **transform** services to achieve long-term financial sustainability.	X

Governance or Legal issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks – not applicable

Recommendations

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

Report presented by: **Sam Harrison**
Director of Corporate Affairs

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors 1 May 2018

Update on oversight of recommendations from Deloitte Well-Led Framework Review Phase 3

Purpose of Report

To present a summary of the governance process for recommendations arising from the phase 3 Deloitte Review of the Trust's Governance arrangements including progress form relating to recommendations for direct Board oversight.

Executive Summary

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

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

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

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

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

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

Deloitte assessed the areas above and rated each as 'amber–green' which is broadly in line with our own self-assessment. The definition of this score is **'partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe'** and that evidence presented shows

'some evidence of good practice, no major omissions and robust action plans to address perceived gaps with proven track record of delivery'. This is the second highest criterion in the NHS Improvement scoring used for assessing the Well-Led Framework and this is a very positive position for the Trust, evidencing a significant achievement of progress and embedding good governance practice over the past two years.

The Trust Board reviewed the full report at the Board Development Session held on 17 January and formally received the Executive Summary at its public meeting on 3 January 2018. The Board acknowledged the significant progress made by the Trust and noted that recommendations aligned with work we have recognised require further progress and in many areas, where we have already taken action.

There are a total of ten recommendations and following discussion with Board members these were assigned to Board Committees to take oversight and to receive assurance on progress with the recommendations.

Following this, each Board Committee received worked up 'blue forms' which outlined the for each recommendation and comment:

- Board Committee for oversight
- Executive Director lead
- Operational Committee (and operational oversight Committee if appropriate)
- Proposed timeframe for delivery
- Brief description of scope and proposals to address
- Outline of proposed assurances to be presented to the Committee
- Details of how changes/actions are to be sustained.
-

Following review by each Committee, the blue forms were either agreed or updated and summary of the timescale, Board Committee, Executive Lead and current RAG rating is outlined below:

Rec/Com.	Executive Lead	Board Committee	Timescale	RAG rating
1. Strategy	Lynn Wilmott-Shepherd	Board	Apr 2018	Green Complete
2. Annual Planning	Lynn Wilmott-Shepherd	Finance & Performance	Apr 2018	Green Complete
3. Risk assurance / Escalation report	Sam Harrison	Audit & Risk	Jul 2018	Green On track
3. Risk management training	Carolyn Green	Audit & Risk	Apr 2018	Green Complete
4. QIA process	Carolyn Green	Quality	Jun 2018	Green On track
6. Staff objectives	Amanda Rawlings	People & Culture	Jul 2018	Amber
7. Sharing Learning	John Sykes	Quality	Sep 2018	Green On track
8. DATIX training	Carolyn Green	Audit & Risk / People & Culture	May 2018	Green On track
9. IPR	Mark Powell	Board	Oct 2018	Green On track

10. Data Quality	Mark Powell	Audit & Risk	Oct 2018	Green On track
11. Improvement Methodology	Director of Business Improvement and Transformation	Finance & Performance	Dec 2018	Red
12. Staff views on data	Mark Powell	Finance & Performance	Jun 2018	Red

All Board Committees have confirmed agreement with reviewing progress or receiving confirmation of sustained activity in six months' time. In the meantime, Committees and operational groups are encouraged to address the recommendations as part of business as usual wherever possible. Work is ongoing to ensure that interim reporting timeframes are robustly mapped out in Committee forward plans.

Recommendation for direct oversight by the Board

For the recommendations which fall directly to the Board, the blue forms are appended for consideration by the Board for review in six months' time. These relate to recommendations 1 and 9. Recommendation 9 was formerly assigned to Finance & Performance Committee but following consideration by both ELT and the Committee it is proposed that this is oversee by the Board directly.

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

Assurances

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

Consultation

The report was considered at the Board Development Session held on 17 January 2018. On 12 February 2018 the Executive summary, recommendations and action plan from the Deloitte Review of the Trust's Governance Arrangements – Phase 3 were presented to the Executive Leadership Team with further review in March 2018.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics of REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation) and Public Sector Equality Duty & Equality Impact Risk Analysis.

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

Actions to Mitigate/Minimise Identified Risks – not applicable

Recommendations

The Board is requested to:

1) Receive assurance from the update on progress with the recommendations following review and scrutiny by Board Committees.

2) Consider the scope, assurance and proposed timeframe and governance structures outlined for the two recommendations falling under the direct remit of the Board.

3) Agree that a review of progress against all recommendations be reviewed by the Trust Board in November 2018 with assurance/escalations from Board Committees as appropriate via summary reporting from Committees in the interim.

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

Deloitte Phase 3 recommendation/comment

Recommendation 1

RAG rate whether progress is on track for delivery to agreed timescales.	**Red**	**Amber**	**Green Complete**
Timescale:	**April 2018**		

Vision, strategy and planning
Recommendation 1
With the planned refresh of the Trust strategy, the Board needs to ensure that: clear links are made to system-wide plans; SMART goals are defined; sufficient detail is included to facilitate implementation planning with teams; and that there is a clear process to ensure ongoing measurement of success.

Board Committee	**Lead director**	**Operational committee (if applicable)**	**Operational oversight committee (TMT/ELT)**
Board	Lynn Wilmott Shepherd	N/A	ELT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

The strategy has undergone a refresh to reflect Trust priorities and refreshed vision, and values. This has been reviewed by ELT and presented to the Board in March 2018. Measures of success have been identified and agreed to be reported to the Board annually. Ongoing measures of success are reported via the Integrated Performance Report and the six monthly 'Plan on a Page' report – now renamed the Business Plan 2018/19.

Outline of proposed assurances to be presented to the Committee: ('to include timing and nature of proposed reports, any proposals for external or internal assurance, audit or other review')

The Integrated Performance Report provides the Board with ongoing assurance that the strategy is being delivered. In addition the reports regarding the Business Plan 2018/19 will provide assurance that the in-year actions are being completed.

Details of how changes/actions are to be sustained:

Bi monthly performance reviews at TMT and ownership of actions by the Divisional Teams will ensure that actions are reported and where off-track, mitigations put in place. Concerns are escalated to ELT through routine escalation reporting.

Deloitte phase 3 recommendation/comment

Recommendation 9

RAG rate whether progress is on track for delivery to agreed timescales.	Red	Amber	Green On track
Timescale:	October 2018		

Recommendation 9
Further develop the IPR with a focus on:
a) reviewing and rationalising the number of metrics included,
b) aligning the metrics to the Trust's refreshed strategic objectives once these have been defined, and
c) including clear trajectories where performance is off-track.

Board Committee	Lead director	Operational committee (if applicable)	Operational oversight committee (TMT/ELT)
Board	Mark Powell	N/A	ELT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

The IPR has been developed over the last 18 months and is an effective tool for oversight of performance. During this time there have been significant further amendments to enhance the report, provide triangulation and increase effectiveness as an assurance report. Deloitte found a number of areas of good practice in their review. To address the recommendations as outlined it is proposed that the IPR is reviewed fully in 6 months' time as part of a Board Development Session (planned for July 2018) where proposals to rationalise metrics can be outlined and debated, the Trust's refreshed strategic objectives will be known and can been aligned to the metrics and the potential impact of the QUESTT model can be considered in terms of improvement trajectories.

Outline of proposed assurances to be presented to the Committee: ('to include timing and nature of proposed reports, any proposals for external or internal assurance, audit or other review')

Assurance reporting to the Board will focus on effectiveness of IPRs to provide oversight of performance. Improvement trajectories, triangulation and data quality best practice will be incorporated.

Details of how changes/actions are to be sustained:

Monthly report to Board with constituent dashboards to be scrutinised by relevant committees. The IPR is reviewed on an ongoing basis and will be reviewed as part of Board Development Session on an annual basis.