Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Board of Directors

Training Rooms 1 and 2, Centre for Research and Development, Kingsway Hospital, Derby
6 November 2018 09:30 - 6 November 2018 12:00

INDEX

Derbyshire Healthcare NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – TUESDAY 6 NOVEMBER 2018
TO COMMENCE AT 9:30am IN TRAINING ROOMS 1 AND 2
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOPMENT, KINGSWAY HOSPITAL, DERBY

AGENDA

	TIME	SUBJECT MATTER	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies for absence and Declarations of Interest Register	Caroline Maley
2.	9:35	Minutes of Board of Directors meeting held on 2 October 2018	Caroline Maley
3.		Matters arising – Actions Matrix	Caroline Maley
4.		Questions from governors or members of the public	Caroline Maley
5.	9:45	Chair's Update	Caroline Maley
6.	9:50	Chief Executive's Update	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY			
7.	10:05	Integrated Performance and Activity Report	Claire Wright/Amanda Rawlings/Carolyn Green/Mark Powell
8.	10:25	Quality Report - Use of Resources	Claire Wright
9.	10:45	Business Plan 2018-19 Monitoring	Gareth Harry
11:00 B R E A K			
10.	11:15	Update report on Deloitte Phase 3 Well Led Recommendations	Sam Harrison
11.	11:25	Board Assurance Framework - Third Issue for 2018/19	Sam
12.	11:35	Board Committee Assurance Summaries and Escalations: Audit & Risk Committee 4 October, Quality Committee 9 October, People & Culture Committee 23 October 2018 *(minutes of these meetings are available upon request)*	Committee Chairs
13.	11:50	2018 Flu Campaign	
CLOSING MATTERS			
14.	12:00	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Board Forward Plan - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Glossary of NHS Acronyms			

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

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

Next meeting will be held at 9.30am on 4 December 2018 in
Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ

Users of the Trust's services and other members of the public are welcome to attend the meetings of the Board.
Participation in meetings is at the Chair's discretion

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.

Declaration of Interests Register 2018/19

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	• Director, Organisation Change Solutions Limited • Non-Executive Director, Derwent Living	(a, b) (a)
Gareth Harry Director of Director of Business Improvement & Transformation	• Chairman, Marehay Cricket Club • Member of the Labour Party	(d) (e)
Geoff Lewins Non-Executive Director	• Director, Woodhouse May Ltd • Director, Arkwright Society Ltd	(a, b) (a)
Ifti Majid Chief Executive	• Board Member NHS Confederation Mental Health Network • Kate Majid (spouse) Chief Executive of the Shaw Mind Foundation which is a global mental health charity	(e) (a, d)
Caroline Maley 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	(e) (e)
Dr Julia Tabreham Deputy Trust Chair and Non-Executive Director	• Non-Executive Director, Parliamentary and Health Service Ombudsman • Director of Research and Ambassador Carers Federation • Member of Sir Alex Allan's Parliamentary and Health Service Ombudsman's Clinical Advice Service Review • Daughter Sophie Elizabeth Barker-Tabreham is a head hunter for Europrojects an organisation that recruits staff from the NHS for private sector companies and special projects	(a) (d) (a) (e)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients.	(e)
Richard Wright Non-Executive Director	• Executive Director, Sheffield Chamber of Commerce • Chair Sheffield UTC Multi Academy Trust • Board Member, National Centre of Sport and Exercise Medicine Sheffield	(a) (a) (d)

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

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

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

Held at the St Thomas Centre, Chatsworth Road, Brampton, Chesterfield, Derbyshire S40 3AW
Tuesday 2 October 2018

MEETING HELD IN PUBLIC

Commenced: 9.30 Closed: 12:00

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
	Richard Wright	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Director of Finance & Deputy Chief Executive
	Dr John Sykes	Medical Director
	Mark Powell	Chief Operating Officer
	Carolyn Green	Director of Nursing & Patient Experience
	Samantha Harrison	Director of Corporate Affairs
	Amanda Rawlings	Director of People Services & Organisational Effectiveness
	Gareth Harry	Director of Business Improvement & Transformation
IN ATTENDANCE	Richard Eaton	Communications Manager
	Sue Turner	Board Secretary
For item DHCFT2018/125	Sean	Service user and volunteer
For item DHCFT2018/125	Katie Keys	Senior Occupational Therapist - High Peak and Dales
For item DHCFT2018/125	Nicola Fletcher	Assistant Director of Clinical Professional Practice
VISITORS	John Morrissey	Lead Governor
	Gemma Stacey	Appointed Governor, University of Nottingham
	Linda Langley	Public Governor, Chesterfield North
	Sandra Austin	Derby City & South Derbyshire Mental Health Carers Forum and Trust volunteer
	Martin Bell	Public Member
	Vanessa Brown	Divisional People Services Lead, Shadowing Amanda Rawlings
	Jose Rodgers	North Derbyshire Mental Health Carers Forum and Trust Volunteer
APOLOGIES	Dr Anne Wright	Non-Executive Director

DHCFT 2018/124	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** The Trust Chair, Caroline Maley, welcomed all to the meeting held within the community that the Trust serves at the St Thomas Centre, Brampton, Chesterfield. Apologies for absence were noted as above.

	The Declaration of Interests register, as included in the Board papers, was noted. No declarations of interest were raised.
DHCFT 2018/125	**PATIENT STORY - HIGH PEAK AND DALES NEIGHBOURHOOD TEAM** Assistant Director of Clinical Professional Practice, Nicola Fletcher, introduced service user Sean and Senior Occupational Health Therapist, Katie Keys from the High Peak and Dales neighbourhood team. Sean gave an overview of the new role he was embarking upon as a volunteer after experiencing a prolonged cycle of mental ill health. After joining the armed forces in 1978 as an officer in the Parachute Regiment, Sean left in 1983 and trained as an accountant and worked for a large transport company. Sean had always wanted to be a nurse when he was in the armed forces. He embarked on a nurse education programme and qualified as a mental health nurse in 2001. Sean chose to work at the high secure Rampton Hospital as he had always wanted to nurse people with complex mental health issues and continued to work mainly in the forensic sector. In 2012 Sean was working in a medium secure hospital in Devon and was severely beaten by a patient. This resulted in him suffering from PTSD (Post Traumatic Stress Disorder) and he also suffered a stroke. After fifteen years as a mental health nurse his career ended when he was dismissed from the NHS through ill health. Following Sean's subsequent return to Derbyshire he entered a deep depression and twice attempted to take his own life. Luckily two friends took him to see a GP, as he had not registered with a GP on return to Derbyshire, and he was referred to the CHRT (Crisis Home Resolution Team) and came under the care of Occupational Therapist, Katie Keys. Sean was keen to tell the Board that the support he received from Katie and the team saved his life. He talked about how hard it was as a registered mental health nurse to engage with health services and that the main reason for him talking to the Board today was to show that mental health treatment works extremely well. He felt his recovery was well underway and his work as a volunteer was aiding his recovery. Sean also highlighted how a lack of joined up information systems within the NHS meant that there was no transfer of information about him from Devon to Derbyshire. He also described the challenges of having to repeat his medical history to a number of service providers and GPs. Sean was informed that the Trust was experiencing a high level of sickness absence with front line staff suffering from poor mental health and was interested to know if he could give an insight into how the Trust could make staff feel more comfortable to speak up if they have concerns about their mental wellbeing. This resonated with Sean as he felt that mental health nurses are more susceptible to stress related sickness and believed that staff should be helped to come forward when they are experiencing problems with their mental wellbeing. On behalf of the Board, Caroline Maley thanked Sean for bringing his story to the attention of the Board and to Katie for the support that she and the High Peak and Dales neighbourhood team provide to service users like Sean. The Board considered Sean was a strong advocate for the reason why the NHS needs to be more connected to a joined up health information system linking all providers and

	thanked him for becoming a volunteer of the Trust. **RESOLVED: The Board of Directors thanked Sean for sharing his story which enabled the Board to focus on the wellbeing of the Trust's staff.**
DHCFT 2018/126	**MINUTES OF BOARD OF DIRECTORS MEETING HELD ON 4 SEPTEMBER 2018** The minutes of the previous meeting, held on Tuesday 4 September 2018, were accepted as a correct record subject to the following amendments to item DHCFT2018/116 Equality Delivery System 2 and Workforce Race Equality Standard Submission: The third paragraph of this item is to be amended to reflect that the WRES action plan has been driven by the BME network. The fourth paragraph and second action would be corrected to reflect that whilst the WRES submission cannot be altered the Board would have sight of reasons why people from a BME or disability background are absent from work.
DHCFT 2018/127	**MATTERS ARISING – ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the actions matrix. All completed 'green' actions were scrutinised to ensure that they were fully complete and actions that were not complete were challenged with Executive Director leads.
DHCFT 2018/128	**QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC** No questions had been received from members of the public or governors in advance of the meeting.
DHCFT 2018/129	**CHAIR'S UPDATE** This report provided the Board with the Trust Chair's reflections on her activity with and for the Trust since the previous Board meeting on 4 September 2018. Caroline drew attention to additional activities she had been involved in. A particular highlight was taking Helen Philips, Chair of Chesterfield Royal Hospital Foundation Trust to the Hartington Unit and seeing how someone external to our organisation recognised the compassion and care that the Trust's staff portrayed. Caroline noted that DCHS (Derbyshire Community Health Services Foundation Trust) were potentially stopping using their locations for delivering medication to patients in the community and she hoped that DCHS would continue to deliver this service. Chief Operating Officer, Mark Powell, responded that he had been involved in discussions with colleagues at DCHS and was assured that plans had been developed to ensure that families can continue to access medication from some of these locations and he expected that contingency plans would reach a good outcome for our service users. Caroline reported that Avtar Johal, who was on the national NeXt director scheme was due to close his placement with the Trust at the end of September. Richard Wright was interested to know what response had been received from

	Sean Duggan, CEO of the NHS Confederation Mental Health Network when he visited the Trust. Caroline was pleased to report that he was engaged in the Trust's activities and enthusiastic about raising the profile of mental health within the network of the NHS Confederation. **RESOLVED: The Board of Directors noted the activities of the Trust Chair since the last meeting held on 4 September 2018**
DHCFT 2018/130	**CHIEF EXECUTIVE'S UPDATE** This report provided the Board of Directors with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within our local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as commissioners and feedback from staff. Chief Executive, Ifti Majid, referred to NHS Resolution's report on learning from suicide. This prompted discussion on how the Trust supports staff when they are involved in Serious Incident (SI) investigations and hearings at coroners' courts. It was agreed that the Quality Committee would take oversight of learning and the quality improvement requirements arising from suicide incidents and would produce a report to the Board on suicide and wider mortality and the specific actions that are in place to support both local and national strategies for learning from deaths in custody. Medical Director, John Sykes undertook to lead the implementation of actions from this report. Director of Nursing and Patient Experience, Carolyn Green confirmed her acceptance of these recommendations with regard to supportive observations to prevent harm. Ifti referred to the report published by the CQC that reviewed sexual safety on acute mental health wards. The Board discussed the provision of single room accommodation rather than dormitories and committed to ensuring that that the Trust's accommodation suits the patients within in its care. It was noted that Carolyn Green had taken on the role of Board lead for sexual safety and would ensure that the Trust continues to create a culture on its wards that promotes sexual wellbeing and supports those affected by incidents. The Board formally noted that the CQC had published its report following the Trust's comprehensive inspection earlier this year. The report could now be accessed through the CQC's website and the Trust's website also contained a link to the report. Ifti was pleased to report that September had been a busy month for staff engagement with events such as the Staff Forum, Staff Conference, Annual Members Meeting and Staff Awards ceremony all taking place within a four week period. There had also been an increased number of CEO and Executive Director visits which showed how Board members have fulfilled their desire to visit community teams and wards to engage with staff. Deputy Trust Chair, Julia Tabreham, recognised the competing demands outlined in Ifti's report and asked if he was confident that the Trust's systems and processes will respond effectively when winter pressures hit. She was assured that despite the Trust operating at high capacity throughout the year significant work is being undertaken to deal with extra requirements particularly with regard to non-bedded care.

	ACTION: Quality Committee to assess the recommendations on learning from suicide and death contained in the NHSI report and consider whether the Trust's processes should be modified in line with the recommendations contained in the report **RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken**
DHCFT 2018/131	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT</u>** Chief Operating Officer, Mark Powell, presented the Integrated Performance Report (IPR) and provided the Board with an integrated overview of performance as at the end of August 2018. The focus of the report is on workforce, finance, operational delivery and quality performance. The report contained similar themes as last month and showed an improved level of assurance around some of the people measures. A key concern highlighted was the increase in the number of patients placed out of area during August although it was understood that this number had decreased during September. Benchmarking data has indicated that several other mental health trusts' figures are much higher in terms of patients placed out of area. Mark drew attention to CPA (Care Programme Approach) reviews and advised the Board that although the Trust has not achieved the key objective of achieving a 95% CPA standard, work is being undertaken by the operational teams to improve the standard of CPA compliance throughout the year. Director of Finance and Deputy Chief Executive, Claire Wright, referred to the financial position and advised that the current focus is on reducing overspend and was pleased to report that Director of Business Improvement and Transformation, Gareth Harry and the operational teams were working to support this. The next forecast will assume that the Trust will not achieve its full CQUIN income but it is hoped that this will be matched with outcomes from the Urgent Care Improvement Plan. Claire made the Board aware that NHS Improvement (NHSI) was in the process of discussing with providers the potential of bonuses that can be realised through overachievement of their control total. While discussing the agency staffing forecast Caroline Maley asked if the agency contingency calculation should be reviewed. She was advised that contingency costs are currently estimated at £350k and while this is not being used the forecast is significantly improved and would be reviewed going forwards. In addition to this the Trust is meeting its position regarding bank fill rates. Director of People Services and Organisational Effectiveness, Amanda Rawlings, drew attention to sickness absence rate which was higher than August 2017. Absence through stress, anxiety and depression is still high and is reflected in the use of bank and agency staff. Non-Executive Directors, Geoff Lewins and Julia Tabreham were both concerned that mental ill health is the biggest contributor of sickness absence. They were advised that this is a national issue and the Trust is not benchmarked as an outlier. This is a challenge for mental health environments rather than physical healthcare organisations and was highlighted during today's patient story. The Board acknowledged that the People and Culture Committee regularly discusses how to improve recruitment and staff retention to support areas of high sickness absence

	and the People Services team is supporting line managers in hot spot areas. Work is also taking place to improve the level of 24 hour occupational health and support to staff and strengthen the support that the Trust provides to staff who have suffered as a result of assault from service users, as well as the stress, anxiety and depression that can be experienced due to the work that they do. Julia also asked for assurance that repatriation of patients is still providing the correct level of support. Mark Powell clarified that adult acute patients are sometimes placed out of area if we do not have adequate bed provision. From a psychiatric care perspective these patients would not be repatriated if they did not meet the care criteria of the Enhanced Care Ward and that this was carefully balanced with bed availability. Julia confirmed that she was assured by Mark's response. Ifti Majid referred to staff absences, vacancies, appraisal rates and compulsory training as these were strong quality indicators and if not improved they would have a direct impact on the quality of care provided on wards. He looked to the People and Culture Committee to assure the Board that preceptorships are continuing and that recruitment is improving. Margaret Gildea the Committee's chair assured Ifti that the Committee has a full oversight of all these issues which are taken extremely seriously. Non-Executive Director, Richard Wright, asked what progress had been made with DNAs (Did Not Attend) as a great deal of work had been carried out to support patients who do not attend appointments. Mark Powell advised that DNAs were running at a rate of 15% which is similar to other organisations. He intends to provide the Finance and Performance Committee with assurance of the support provided to patients who do not attend or if an appointment is cancelled and the timeline for them to attend their next appointment. Caroline Maley asked about neighbourhood wait times and whether CAMHS (Child and Adolescent Mental Health Services) and paediatrics wait times have increased. Mark Powell advised that wait times for CAMHS have risen due to a lack of CAMHS consultants. Their wait times will potentially continue to rise until we have been able to recruit to CAMHS consultant posts. He expected the paediatrics wait time of 18 months to reduce now that two new consultant posts had been recruited to. **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained limited assurance on current performance across the areas presented.**
DHCFT 2018/132	**<u>QUALITY REPORT - SAFETY</u>** This month's Quality Report provided the Board with a focused report on safety and was used to facilitate non-operational discussion linked to the Trust's strategy aspects of quality in the context of national strategy. The report also enabled the Board to review CQC's key line of enquiries (KLOE) regarding safety. Medical Director, John Sykes, provided an overview of the Trust's strategy on safety and the particular focus being paid to physical healthcare on those with mental health problems and the importance of working together with other services and providers to achieve these aims. He referred to the CQC domains, the most important of which is caring and emphasised that nothing good will happen if we are not caring and staff need to see this reflected in the Trust's approach to

	management as well as clinical care. This is why Quality Improvement Cycles have been developed to improve safety to ensure work takes place in a compassionate work environment. The Board recognised that a number of people had contributed to producing the report, particularly the KLOEs that were appended to the report and commended the thoroughness of their work. In addition to this the Quality Committee has oversight of safety issues and exceptions against the strategy are escalated to the Board when necessary. The Quality Committee will also take a strategic overview of safety and quality risks and will monitor the progress and pace made with safety and care planning being driven by the Clinical Operational Assurance Teams (COATs) to ensure the five KLOEs are driven and embedded within the wider organisation. This will be achieved through an integrated workforce using people with different skills and would be taken forward by Gareth Harry. The Board agreed that significant assurance had been obtained from the report and was also assured that high level risks had been included in the Board Assurance Framework that would be received by the Board at the next meeting. The Quality Report on Responsiveness was received by the Board in September 2018. The next Quality Report will focus on the use of resources under the lead of Claire Wright. Reports covering the domains of Well Led, Caring and Effectiveness are to follow. **RESOLVED: The Board of Directors:** **1) Discussed the strategic issues associated with the Trust's services** **2) Received significant assurance on the level of performance across the areas presented** **3) Obtained assurance that the Board Assurance Framework would be updated to reflect the risks discussed**
DHCFT 2018/133	**<u>MORTALITY REPORT</u>** This report presented to the Board by John Sykes was produced to meet requirements set out in the 'National Guidance on Learning from Deaths' that the Trust is required to collect and publish on a quarterly basis specified information on deaths. The report had previously been received by the Quality Committee on 11 September. Chair of the Committee, Julia Tabreham asked that the report be corrected to show that it was the Board and not the Quality Committee that agreed the proportionate use of clinical and administrative resources before it is published on the Trust's website. **ACTION: Mortality Report to be corrected to show that the Board agreed the proportionate use of clinical and administrative resources and not the Quality Committee.** **RESOLVED: The Board of Directors accepted this Mortality Report as assurance of the Trust's approach, and agreed for it to be published on the Trust website prior to end of October 2018, as per national guidance, subject to the above amendment.**

DHCFT 2018/134	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) SELF-ASSESSMENT AND ANNUAL REPORT** The Trust is required to self-assess against EPRR Core Standards every year. This report provided the Trust Board with this year's assessment. Mark Powell gave an overview of the work undertaken within the self-assessment process attached to the report. The Board commended the level of compliance that was evidenced within the report and was assured of the plans to increase the amount of resource to lead the EPPR for next year. **RESOLVED: The Board of Directors:** **1) Received and accepted the core standards self-assessment (pending CCG confirmation and challenge process)** **2) Received significant assurance from the sustained level of improvement in compliance with EPRR core standards.**
DHCFT 2018/135	**RECEIPT OF ANNUAL REPORTS** These Annual reports were presented to the Trust's Safeguarding Committee on 11 September 2018 and were reviewed, information was scrutinised, feedback was received on style, content and adjustments were made to the descriptive content, language, assurance and SMART actions were adjusted based upon feedback. The Safeguarding Children and Adults at Risk Annual Report and the Looked After Children Report provided the Trust Board with an overview of the issues, initiatives and themes within safeguarding and provided assurance on the quality of the services and the quality governance systems and processes to ensure the Trust has robust quality management of the safeguarding required to provide safe services for children and adults. The Board recognised its statutory duty in receiving these reports in the public domain and noted that the Safeguarding Committee had scrutinised both reports and had not escalated any concerns. Thanks were extended to the Safeguarding Adults and Children teams for the quality of work performed and the reports were formally endorsed and accepted. **RESOLVED: The Board of Directors:** **1) Received this formal set of annual reports in the Public Board** **2) Noted the Trust Safeguarding Committee's scrutiny, level of assurance and recommendations** **3) Noted that two other mental health trust annual reports have been published this year. These have been included in the knowledge section on Board Pack and give a comparator of the level and standard of governance that they provide for Children's services to allow fair comparison of quality and completeness** **4) Endorsed and accepted these annual reports and their recommendations in the public domain.**
DHCFT 2018/136	**REPORT ON TRUST SEALINGS** Reporting on use of the seal for the 2017/18 financial year was made to the Board on 1 May 2018. This report provided the Trust Board with a six monthly update of

	the authorised use of the Foundation Trust Seal since 1 April 2018. An end of year report on the use of the seal for the 2018/19 financial year is scheduled to be submitted to the Board in May 2019. **RESOLVED: The Board of Directors noted the authorised use of the Foundation Trust Seal since April 2018 and received full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.**
DHCFT 2018/137	**BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS** Assurance summaries were received from the Board Committees below, and highlights provided by the respective Non-Executive Chair. **Mental Health Act Committee 7 September:** In the absence of the Committee chair, Anne Wright, Margaret Gildea reported that an effective meeting had been held and no escalations had been raised. Discussions were held on ethnicity during the Reverse Commissioning item. The issue of care pathway needs for personality disorder being a predominantly female issue is to be raised with the Executive Leadership Team (ELT) and reported to the Quality Committee. **Safeguarding Committee 11 September:** Julia Tabreham updated the Board on behalf of Anne Wright on key risks identified during the meeting. The level of compliance of Safeguarding training was still a concern but was seen to be on trajectory. Professional issues resulting from the revisions to DBS (Disclosure and Barring Service) checks for Safeguarding Adults and Children's Doctors were a concern and would be prioritised at the next meeting in November. The implementation of the CPA policy and clinical model continues to be a pressurised area. This has now been reviewed by ELT and will be discussed at the October meeting of the Quality Committee to ensure delivery. **Quality Committee 11 September:** Chair of the Committee, Julia Tabreham, reported that the Physical Healthcare Strategy was an area of focus. The Committee remains concerned that full CQUIN compliance has not been achieved and this was escalated to ELT. The Committee will be looking to improve the level of report writing for the Committee as well as focussing Committee business on the five emerging themes that were highlighted in the Quality Report received by the Board today. **Finance & Performance Committee 18 September:** Chair of the Committee, Richard Wright reported that many issues discussed had also been raised with the Board at today's meeting. Discussions had focussed on the delivery of the Cost Improvement and Continuous Quality Improvement Delivery Programmes and how investment will be concentrated. The strategy for recording and monitoring equality through the Information Management and Technology strategy had been escalated to ELT to obtain an understanding of how this can be achieved. Caroline Maley had observed that staff had questioned how charitable funds could be used and requested that the Finance & Performance Committee consider communicating to staff how spending can be utilised. **ACTION: Finance and Performance Committee to consider how staff can obtain a better understanding of the use of charitable funds** The Board noted the escalations raised and requested that reports be more

	standardised across the Committees. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries**
DHCFT 2018/138	**REPORT FROM COUNCIL OF GOVERNORS MEETING HELD 4 SEPTEMBER 2018** The Board noted the report from the Council of Governors meeting held on 4 September 2018 that was provided for information. **RESOLVED: The Board of Directors received and noted the report from the Council of Governors meeting held 4 September 2018**
DHCFT 2018/139	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** No additional issues were raised in the meeting for updating or including in the Board Assurance Framework.
DHCFT 2018/140	**2018/19 BOARD FORWARD PLAN** The forward plan was noted by the Board along with upcoming reports to be received at subsequent meetings. The 2019/20 forward plan is under development and dates of meetings are to be published.
DHCFT 2018/141	**MEETING EFFECTIVENESS** Attendees and visitors were thanked for their attendance at today's meeting held in the community away from the Trust's headquarters in Derby. The Board considered that the IPR and Quality Report on Safety had both driven strategic discussions and consideration of risks that impact the people who use the Trust's services.

The next meeting of the Board to be held in public session will take place at 9.30 on Tuesday 6 November 2018.

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

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - NOVEMBER 2018			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
28.3.2018	DHCFT 2018/042	Board Assurance Summaries and Escalations	John Sykes Ifti Majid	**Transferred to Quality Committee Actions Matrix** Age discrimination breach within the Equalities Act to be raised with commissioners on behalf of the Quality Committee	~~1.5.2018~~ ~~3.7.2018~~ ~~4.9.2018~~ 6.11.2018	Letter regarding age discrimination breach within the Equalities Act was sent to commissioners. John Sykes fed back to Trust Board on 3 July that commissioners have confirmed that they will invest in crisis teams this year and that an ageless service is essential to comply with the law. Commissioners wish to engage with the Trust to determine the priority of this development against others that have been identified. Board requested at 4 September meeting that this action be closed from the Board's perspective and that the Quality Committee confirm when the action is complete. The Quality Committee agreed on 9 October to inform the Board that this action is now complete. Age discrimination breach with the Qualities Act is a residual risk and is included on the Risk Register and forms part of BAF Risk 1a on safety and quality standards. ACTION COMPLETE	Green
2.10.2018	DHCFT 2018/133	Mortality Report	John Sykes	Mortality Report to be corrected to show that the Board agreed the proportionate use of clinical and administrative resources and not the Quality Committee	6.11.2018	Report corrected and included in October Board papers uploaded to Trust website as per national guidance	Green
2.10.2018	DHCFT 2018/137	Board Committee Assurance Summaries and Escalations	Claire Wright	Finance and Performance Committee to consider how staff can obtain a better understanding of the use of charitable funds	4.12.2018	Following on from discussions within the Finance & Performance Committee earlier this year the Executive Leadership Team gave the go ahead to the approach that staff have developed for the use of charitable funds.	Green
2.10.2018	DHCFT 2018/130	Chief Executive's Update	John Sykes	Quality Committee to produce a report to the Board on suicide and wider mortality. Medical Director to lead the implementation of actions arising from the report	4.12.2018	Report on NHS Resolution Recommendations on learning from suicide and death to be received at December Board meeting after submission to November Quality Committee meeting	Yellow

Resolved	**GREEN**	**3**	**75%**
Action Ongoing/Update Required	**AMBER**	**0**	**0%**
Action Overdue	**RED**	**0**	**0%**
Agenda item for future meeting	**YELLOW**	**1**	**25%**
		4	**100%**

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 6 November 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 my activity with and for the Trust since the previous Board meeting on 2 October 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 26 September I took part in a quality visit to the Memory Assessment Service team. This was held at the Ilkeston Day Hospital, but they operate all over the county. The visit was chaired by Director of Business Improvement and Transformation, Gareth Harry, and included April Saunders, staff governor and Nicola Fletcher, Assistant Director of Clinical Professional Practice. The visit was supported by a service user who was very helpful in demonstrating the value of the service to her but also the challenge experienced by younger adults diagnosed with dementia. For me it also helped to link a visit I made in July to the service at the Dovedale Hospital.

3. On 27 September I attended a clinic at the Ronnie MacKeith Centre at the Derby Children's Hospital. This clinic was run by Dr Hayley Griffin and attended by Dr Wolff, a community Paediatrician. This is a part of our Children's Services. We saw two young patients and their families and I was so struck by the care and compassion of our team and the ability to work across the system (in the wider geographic sense as well) for the benefit of patients. One of the young patients was Max and his mother, who had attended our Board meeting in 2016 when our patient story focussed on the Lighthouse and the work that they did.

4. On 2 October, following the Board meeting held in Chesterfield, the Non-Executive Directors (NEDs) visited a number of the Children's services across the county: Health visiting at Sinfin Health Centre; Eating disorders at Temple House; the Children in Care Team at Long Eaton; Healthy Schools / settings team; and CAMHS Assist in Long Eaton. I met with the senior managers of the service. Observations from the visits have been captured and shared with the team.

5. On 3 October I took part in a Quality Visit to the Southern Community Learning Disabilities Team in Swadlincote. The visit was chaired by Sam Harrison and was attended by Kelly Simms as staff governor and Rachel Williams. Again it was an opportunity for me to relate back to a visit that I undertook in the summer to this team. We had a patient story from a carer and family member for a

service user which brought to life the issues around care in the community where provider changes have caused issues, and also the challenge of admission to the acute sector for patients with learning disabilities.

6. My next report will cover further team visits to CAMHS (Child and Adolescent Mental Health Services) eating disorders and Killamarsh.

Council of Governors

7. On 11 October I met with John Morrissey to review the 360° feedback from Executive Directors, Non-Executive Directors and Governors as part of the appraisal process for two NEDs. This is an important part of the appraisal process for our NEDs and will be reported to the Nomination and Remuneration Committee of the Governors on 1 November.

8. On 17 October, I attended the Governors' Governance Committee which was chaired by Carole Riley, Deputy Lead Governor. Carole has stepped in as chair of this committee until the end of the calendar year when hopefully a new chair will be appointed. I am grateful to Carole for her support in this matter, and encourage Governors to consider this opportunity. This committee performs an important role in giving Governors time to consider various topics in advance of the full Council of Governors meetings.

9. On 17 October, the Council of Governors and Board met jointly to discuss the Trust strategy and direction of travel. I was particularly pleased at how well this meeting was attended by Governors. The dialogue and discussion was very useful in forming how we develop our strategy for the future.

10. On 23 October I met with Carole Riley as part of a regular series of meetings with her and Lead Governor John Morrissey. These are important meetings in terms of my relationship with the Council of Governors ensuring that there is open and transparent sharing of views and information.

11. The next meeting of the Council of Governors will be on 6 November following the public Board meeting. The next Governance Committee takes place on 11 December.

Board of Directors

12. A core Board activity this month has been the review of our Trust Strategy and the direction of travel as described under item 8 above. This work is being led by Gareth Harry, Director of Business Improvement and Transformation. I look forward to receiving the next iterations of the strategy at future meetings.

13. I have carried out the performance appraisal of Margaret Gildea, our Senior Independent Director and Chair of the People and Culture Committee. This will be reported the Council of Governors' Nomination and Remuneration Committee on 1 November. Julia Tabreham's appraisal will be concluded in the next month, having been delayed following a road traffic accident. We wish Julia well in her recovery from this accident.

14. The placement of Avtar Johal, our NeXT director, has been brought to an end. I have requested that we seek another placement from the scheme, run by NHSI, with a focus on BAME participants. I await further information and news. Sam Harrison, Director of Corporate Affairs, and I will be working with NHSI to report back on the experience that we have had under the scheme so far and to provide feedback to Avtar himself.

15. I continue to meet with NEDs on a one to one basis quarterly. I met with Anne Wright this month. NED appraisals for Margaret Gildea and me are complete and will be reported to the Council of Governors' Nomination and Remuneration Committee on 1 November 2018. Julia Tabreham's will be completed in the next month; and the process will commence for the gathering of 360° feedback on Richard Wright over the course of the next month.

System Collaboration

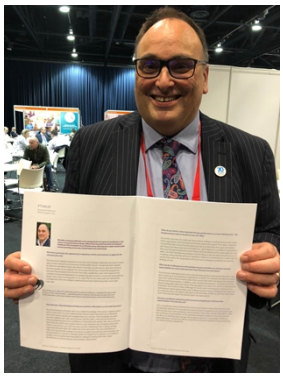
16. The JUCD (Joined Up Care Derbyshire) Board meeting took place on 18 October and was attended on my behalf by NED, Geoff Lewins. More detail will be included in the CEO report to this Board.

Regulators: NHS Providers and NHS Confederation and others

17. On 9 and 10 October I attended the NHS Providers annual conference in Manchester with Geoff Lewins, Ifti Majid and Gareth Harry. This was a useful time to listen to some key note speakers, breakout sessions and networking with other providers in the NHS. The first session was on lessons learned from mental health services – a good reminder of how far we have come, but also how much more we still can do.

18. On 24 October, I attended the quarterly NHSI Midlands and East Chairs meeting held in London. At this meeting we were able to hear from Dido Harding, Chair of NHS Improvement, on the ten year plan, but most importantly on her emphasis on the importance of the workforce, including leadership development, improving morale and making the NHS a great place to work. Peter Wyman, Chair of the CQC also attended for a session, and gave us his views on how CQC has worked to improve its regulatory role, noting improvements that have taken place in trusts over the past years, including an improvement in mental health services, where 70% of core services are now rated as good, compared to 68% in 2017. We also heard from a Deputy Director from the National Cyber Security on the latest cyber threats and the risks for the NHS.

19. On 10 October, NHS Providers launched a publication, Clinician to Chief Executive. I am pleased to note that Ifti Majid is featured in this publication which recognises those who have worked their way from the front line of service provision to leadership position within the NHS.



Beyond our Boundaries

20. I am taking part in the assessment panels for the Regional Talent Board (Aspire Together). The vision of Aspire Together is to move talent management from individual organisations to a place where it is owned and valued by the whole system. To date I have attended training sessions with other chairs prior to being a part of the first assessment centre on 3 December 2018. I look forward to seeing this collaboration deliver a diverse pool of talent, move talent management to a collaborative place and raise the visibility of talent management in the NHS.

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work – such as children with complex medical needs, dementia, and learning disabilities in our adult community services.

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

Demonstrating inclusive leadership at Board level

Through the Trust's involvement in the NeXT Director scheme, hosting a placement for Avtar Johal, we supported development of those who may find it more difficult to be appointed as a NED in the NHS. This placement ended at the end of September. We will review the effectiveness of our support for Avtar and the scheme, but have already started to think about the next placement.

Recommendations

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 6 November 2018

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. During October the CQC published their report into *The State of Healthcare and Adult Social Care in England 2017/18.* This report is the CQC's annual assessment of quality performance, trends and themes from regulatory activity. This year's report builds on the CQC report into 20 systems released in July 2018

   The four overarching key themes were:

   - Overall the quality of health and care has been maintained and in some places improved despite increasing demand, funding pressures and workforce shortages. The CQC do note an 'integration lottery' with access to services and quality heavily linked to good system working.
   - The fragility of the adult social care market is having an impact on collaboration in local areas and through their inspections the CQC have noted the long term NHS funding settlement could be undermined by lack of longer term funding solutions aimed at social care. They note particularly community based services are impacted by this co dependence.
   - The proportion of Acute and Mental Health providers rated good or outstanding has increased slightly compared to the previous year. However it is noted that capacity and demand pressures are most often noted for their impact on safety.
   - The CQC notes that the complex commissioning environment can make co-ordinating collaborative system working to enhance quality difficult and the CQC urges sustainable reform that enables flexible opportunities for maximising outcomes for populations.

   The report also makes some helpful and relevant comments on the workforce challenges the NHS is facing:

   - In mental health services low staffing levels was the most common reason for delays in accessing and responsiveness in CAMHS (Child and Adolescent Mental Health Services)
   - Staffing shortages continue to drive high bank and agency usage in mental health in-patient areas and Acute emergency departments.
   - Brexit seems to be having a negative impact on European Economic Area (EEA) staffing. 9,389 EEA nurses applied to join the register in 2015/16 compared with compared with just 805 in 2017/18. This is compounded by 1981 EEA nurses leaving the register in 2015/16 compared with 3962 in 2017/18.

There are some specific comments about what the CQC have noted in relation to Mental Health Services:

- 70% of Mental Health Trusts are rated as good and 8% as outstanding
- Safety remains the main concern particularly on adult mental health wards 37% of core mental health services were rated as requires improvement and 2% were rated as inadequate for safety.
- 25% of people spoken to felt they couldn't access NHS Mental Health Services often enough or with enough choice.
- It was noted that the decision commissioners make in the sector have a direct impact on quality with under investment impacting negatively on both access to and quality of mental health services.

The report also makes it clear on the focus of the CQC going forward with updates on policies around out of area placements, physical restraint, sexual safety and dormitories, high secure staffing levels, Children and Young People's services and residential substance misuse services.

2. During October there have been three Brexit related announcements that impact on delivery of health services:

   I. *Technical notice on recognition of professional qualifications.* The latest batch of technical notices outlining the government's preparations for a no deal Brexit scenario was released on Friday 12 October. It included guidance on providing services as a qualified professional. The notice states that, in the event of no deal, the Mutual Recognition of Professional Qualifications (MRPQ) Directive will no longer apply to the UK. The government will develop a new recognition procedure for EEA professionals which will differ from existing arrangements (for example, automatic recognition and temporary access to regulated activities on the basis of a declaration will no longer be applicable). The government will work with the devolved nations and the regulatory bodies to ensure a UK-wide system of recognition. The notice makes it clear that:

      - EEA professionals (including UK nationals holding EEA qualifications) who are already established and have received a recognition decision in the UK, will not be affected and their existing recognition decision will remain valid.
      - EEA professionals (including UK nationals holding EEA qualifications) who have not started an application for a recognition decision in the UK before exit will be subject to future arrangements, which will be published before exit day.
      - EEA professionals (including UK nationals holding EEA qualifications) who have applied for a recognition decision and are awaiting a decision on exit day will, as far as possible, be able to conclude their applications in line with the provisions of the MRPQ Directive.

   II. *EU Settlement Scheme pilot: applicant eligibility.* A new phase of the EU Settlement Scheme pilot will open on 1 November 2018 and will run until 21 December 2018. Those working in the health and social care sectors are eligible to take part, if they are either a resident EU citizens or a non-EU citizen family member of an EU citizen with a biometric residence card.

III. *Secretary of State's letter regarding EU Exit NHS Trust Contract Review.* The Secretary of State has written to all trust chief executives to advise of the requirements to ensure continuity of supply of goods and services in the event of a no deal Brexit. As a trust we have now received a pack of materials including a self-assessment methodology to use to identify contracts that may be impacted by EU exit. As required by the letter Director of Business Improvement and Transformation, Gareth Harry, will act as our board-linked Senior Responsible Officer to oversee this work and produce a summary of contracts deemed highly impacted, with mitigating activities, by 30 November. The pack will also will include a list of categories and suppliers that are being managed by Department of Health and Social Care (DHSC), such as the supply of medicines.

3. Health minister Stephen Barclay will announce a new goal for black, Asian and minority ethnic (BAME) representation in senior leadership to "match that across the rest of the NHS by 2028". It follows recent analysis of NHS ethnicity pay levels, which was commissioned by the DHSC and confirmed ethnicity pay gaps within the health service.

   The DHSC said the gap was at its "most stark" among senior, non-clinical managers, where BAME men earnt 11% less than white male managers and similarly, 9% less for BAME female managers. Diversity across the NHS is above the national average, with BAME staff making up 17% of the non-medical workforce. But only 11% of senior managers are BAME, falling to 6.4% at very senior levels.

   The government has today set a goal of ensuring BAME representation at very senior management levels – such as chief executive – matches that across the rest of the NHS workforce within ten years.

   In addition, government arms'-length bodies have also signed up to a new Race at Work Charter also announced today. These include NHS England, Public Health England and Health Education England. The Charter is intended to recognise organisations and business leaders who are taking action to tackle barriers to recruitment or career progression for staff from ethnic minority backgrounds. It recognises organisations that sign up to the five calls to action. These include appointing an executive sponsor for race, capturing data and publicising progress, and committing at board level to zero tolerance of harassment and bullying. I am very keen that as a Board we sign up to this same Charter as it is in line with the work already underway within our Trust. We have subscribed as an organisation and will bring a further update and formal paper to December's meeting.

Local Context

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

- The Chair gave updates about the JUCD submission as part of the ten year plan consultation and updated the Board on the public meeting in Ilkeston
- The financial position was discussed in detail and at month 5 as a system we are forecasting a drift from the combined control total for all organisations with significant risk associated with QIPP (Quality, Innovation, Productivity Programme) and CIP (Cost Improvement Programme) to come further on in the year.
- In terms of system governance the Board agreed various reviews of terms of

reference for system meetings and agreed the need for an independent chair for Joined up Care Derbyshire agreeing said process.

- We received an update on 'outcome based accountability' and agreed a preferred framework that included the following core outcomes, Everyone in Derbyshire will have the best start in life, stay healthy and age well. We agreed that these most closely matched the expected outcomes associated with the coming ten year plan.
- From a performance perspective we heard that Derbyshire continues to improve against constitutional standards and providers benchmark well against peers. Main areas of concern include A&E four hour compliance is at 88.4% and Referral to Treatment has slightly worsened across the system this month.

Within our Trust

5. I was invited to attend a training session for Health Visitors looking at how to use some great tools associated with listening visits. This included training around mental health awareness as well as the use of outcome tools for assessment of depression in particular. It was very helpful to hear the complex challenges our Health Visitors deal with on a daily basis and to hear first hand some of the innovative tools they are using to help them.

6. I was privileged to be asked to present at the Department of Health's BAME Network drawing together some of the key themes from the Workforce Race Equality data and my personal experience as a senior leader in the NHS. As part of this I was able to hear Tracie Joliff the Director for Inclusion at NHS leadership Academy speaking about their development programme for leaders and how inclusion and equality have been built in throughout. We also heard about the experience of a recipient of a kidney transplant and associated extended waits for those from BAME backgrounds, hard to listen to in places but her story was truly inspiring.

7. During the month I have attended various briefing and engagement sessions by NHS England (NHSE) and NHS Improvement (NHSI) as well as the NHS Providers annual conference:

    - Midlands and East CEO Session (NHSI)
    - Moving to Good and Beyond (NHSI)
    - NHS Providers Conference
    - Long Term Planning Event for CEO's MD's and Chief Nurses (NHSI & E)

    Some of the key messages that relate to our Trust include

    - Workforce pressures remain the highest risk facing safety and performance in the provider sector
    - First call expectations on the financial uplift for 2019/20 are likely to be around funding the pay award, sorting out issues with acute tariff and supporting systems/organisations to meet financial expectations. I have heard expectations that the mental health investment standard will remain in place discussed.
    - The Secretary of State has made his interest in effective and efficient IT clear announcing a new framework for the NHS, he has also signalled a clear intent to further reduce agency and that there will not be any direct 'Health' winter funding.
    - It is noticeable that those organisations who have gone from Requires Improvement to Outstanding from a CQC perspective have all had a clear focus

on safety/risk at all organisational levels as well as clear mechanisms for 'telling the story' of their journey to colleagues in their trust. Clarity of expectations for all staff coupled with a focus on engagement and visibility of the senior team but not just the Board also featured heavily in their success.

8. In July 2018 the Board signed up to the 'Treat Me Well Campaign'. On 1 October the Executive Leadership Team received clarity on the areas for priority actions which include:

    - To develop some way of finding resources. Building upon some existing work by a colleague of Charmian who has been developing these in autism services. The Executive Leadership Team (ELT) agreed to find some start-up funding to develop materials and or videos for key sites.
    - To review our Estates Strategy PLACE inspection model and add in some LD (Learning Disabilities) and Autism standards as additional questions supplementing the existing solid national framework. Deputy Head of Estates and Facilities, Liz Bates, was contacted and agreed that this could be explored and a meeting will be scheduled to progress this.
    - To review our waiting areas and receptions to consider the environments in all future redesigns / using best practice examples developed in south west Yorkshire, and develop the use of Autism boxes. Autism boxes to be funded centrally for start-up by Nursing and Quality Directorate.
    - To prioritise non-clinical staff/ administration and reception staff, to have some training on LD and Autism and how we should adapt our service welcome and reception. Our Administration Lead and Consultant Nurse for Learning Disability are arranging dates to have this training.

9. There have been a number of ward and team visits since the last Board. I have held *Ifti on the Road* engagement events at The Old Vicarage, Bolsover and the Radbourne Unit. We have also held a pre-ELT engagement event at the Ritz, Matlock.

    Key themes that emerged from these sessions included:

    - Team really pleased with improvements made to the environment in the team base in Bolsover, who feel listened and responded to by senior leadership.
    - Community vacancies improving and colleagues reported noting a difference
    - Worries about some of the messages communicated around the move towards electronic expenses claiming from April – reassurance provided and action taken to clarify the message in particular the issue of the existence of a managerial override in case extra miles had to be made above postcode to postcode allowance.
    - Neighbourhood catchment area and issues related to GP catchment areas not being local to neighbourhoods particularly as more practices coming together.
    - Some worries expressed in both community and inpatient areas about lack of development opportunities apart from mandatory training – some examples of significant self-funding.
    - Some great examples of innovation shared at the Radbourne Unit including the use of a new Recovery Volunteer to support recovery training in the hub.
    - Importance of improvements and innovations impacting on electronic record being clinically driven and all teams being engaged. This was raised by a CAMHS practitioner who came to see me at the Radbourne Unit.

Carolyn Green (Director of Nursing and Patient Experience) has made a number of visits to services including: Hartington Unit, Radbourne Unit, CAMHS World Mental Health Day Celebration, meeting with students and Children's Services OT (Occupational Therapy) and Physio. Some of the themes included implementation of new skill mixes, best practice around the role of OT's (Occupational Therapists) and AHPs (Allied Health Professionals) in reducing waiting times, the experience of preceptors working in acute services, lack of career options for band 3 colleagues, faster roll out of mobile observations and the Jackie's pantry environment at the Radbourne Unit.

Dr John Sykes our Medical Director made an unscheduled engagement visit to Tansley Ward to meet with the ward leadership team and discussed issues such as the core relationship between trainee doctors and nurses, ward capacity and ability for nurses with specialist skills to use them to enhance interventions and the really positive impact of simulation training.

Feedback from each visit has been logged on our engagement spreadsheet, actions allocated and shared with our Freedom to Speak up Guardian.

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

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 without clarity on post Brexit implications for clinical staff registration our rich mix of experiences in the Trust could be diluted.

Signing up to the 'Race at Work' Charter is best practice and will highlight the commitment of the Board and senior leaders to positively impact on developing a more inclusive culture however it is the associated actions that hold the key to a positive impact on areas such as recruitment, development and harassment and bullying.

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

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

Recommendations

The Board of Directors is requested to:

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

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 November 2018

Integrated Performance Report Month 6

Purpose of Report

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

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

1. Regulatory Compliance dashboard

    - Agency spend
    - IAPT recovery
    - Out of area placements
    - Sickness absence
    - Annual appraisals
    - Compulsory training

2. Strategy Performance dashboard

    - Control total and cost improvement programme
    - Delayed transfers of care
    - Neighbourhood waits
    - Number of patients with a length of stay greater than 50 days

At the end of the report further information is provided regarding some aspects of data quality assurance.

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

Assurance

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 the Finance and Performance Committee, People and Culture Committee and Quality Committee.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

Recommendations

The Board of Directors is requested to;

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

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

1. Regulatory Dashboard

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ
Finance	Finance Score	Finance Scorecard	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Capital Service Cover	YTD	2	2	G	→		
			Forecast	2	2	G	→		
		Liquidity	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure Margin	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure variance to plan	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Agency variance to ceiling	YTD	1	2	R	↑		
			Forecast	1	1	G	↓		
	Single Oversight Framework	Agency costs as % of total pay costs	YTD	2.9%	3.0%	R	→		
			Forecast	2.9%	2.9%	G	→		
		NHS I Segment	YTD		2		→		
Quality and Operations	KPIs	CPA 7 Day Follow-up (M)	Sep, 2018	95.00%	95.00%	G	↓		
			Aug, 2018		100.00%	G			
		Data Quality Maturity Index (DQMI) - MHSDS Data Score (Q)	Sep, 2018	95.00%	96.43%	G	→		
			Aug, 2018		96.71%	G			
		IAPT RTT within 18 weeks (Q)	Sep, 2018	95.00%	100.00%	G	→		
			Aug, 2018		100.00%	G			
		IAPT RTT within 6 weeks (Q)	Sep, 2018	75.00%	97.41%	G	→		
			Aug, 2018		97.68%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Sep, 2018	53.00%	84.21%	G	↓		
			Aug, 2018		86.21%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Sep, 2018	53.00%	90.91%	G	↑		
			Aug, 2018		80.00%	G			
		Patients Open to Trust In Employment (M)	Sep, 2018		10.23%	G	→		
			Aug, 2018		10.42%	G			
		Patients Open to Trust In Settled Accommodation (M)	Sep, 2018		58.18%	G	→		
			Aug, 2018		58.95%	G			
		Under 16 Admissions To Adult Inpatient Facilities (M)	Sep, 2018	0	0	G	→		
			Aug, 2018		0	G			
		IAPT People Completing Treatment Who Move To Recovery (Q)	Sep, 2018	50.00%	49.70%	R	↓		
			Aug, 2018		52.74%	G			
		Physical Health - Cardio-Metabolic - Inpatient (Q)							
		Physical Health - Cardio-Metabolic - EI (Q)							
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)							
		Out of Area - Number of Patients Non PICU (M)	Sep, 2018		25		↑		
			Aug, 2018		22				
		Out of Area - Number of Patients PICU (M)	Sep, 2018		16		↑		
			Aug, 2018		14				
		Out of Area - Average Per Day Non PICU (M)	Sep, 2018	5.2	13.4	R	↓		
			Aug, 2018	6.5	15.4	R			
		Out of Area - Average Per Day PICU (M)	Sep, 2018	24.3	9.1	G	↑		
			Aug, 2018	23.7	8.1	G			
		Written complaints – rate (Q)	Q1 2018/19		0.02		↓		
			Q4 2017/18		0.03				
		Staff Friends and Family Test % recommended – care (Q)	Q4 2017/18		73%		→		
			Q2 2017/18		73%				
		Occurrence of any Never Event (M)	Aug, 2018	0	0	G	→		
			Jul, 2018		0	G			
		Patient Safety Alerts not completed by deadline (M)	Aug, 2018		2		↑		
			Jul, 2018		0				
		CQC community mental health survey (A)	2017		7.3/10		↑		
			2016		7.0/10				
		Mental health scores from Friends and Family Test – % positive (M)							
		Potential under-reporting of patient safety incidents (M)							
Workforce and Engagement	KPIs	Turnover (annual)	Sep, 2018	10.00%	10.45%	G	↑		
			Aug, 2018		10.25%	G			
		Sickness Absence (monthly)	Sep, 2018	5.04%	6.13%	R	↑		
			Aug, 2018		6.35%	R			
		Sickness Absence (annual)	Sep, 2018	5.04%	5.57%	R	↑		
			Aug, 2018		5.48%	R			
		Vacancies (funded fte)	Sep, 2018		11.63%		↓		
			Aug, 2018		11.81%				
		Appraisals All Staff (number of employees who have received an appraisal in the previous 12 months)	Sep, 2018	90.00%	74.55%	R	↓		
			Aug, 2018		77.54%	R			
		Medical Appraisals (number of medical employees who have received an appraisal in the previous 12 months)	Sep, 2018	90.00%	97.00%	G	→		
			Aug, 2018		96.00%	G			
		Compulsory Training (staff in-date)	Sep, 2018	90.00%	82.78%	A	↑		
			Aug, 2018		82.97%	A			
		NHS Staff Survey (A)	Work		60.92%				
			Treatment		72.77%				

Key:

Period Current Month / Previous Month

Achieving target
Not achieving target
Within tolerance
No Target Set

Target

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

1.1 Finance Position

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

All metrics are forecast to achieve their planned outturn including the agency metric with agency expenditure now forecast to be below the ceiling. This is an improvement on last month's forecast.

1.2 Agency variance to ceiling and costs

Comparing the actual expenditure on Agency to the ceiling, we are slightly above the ceiling value by £15k (1%) at the end of September. This generates '2' on this metric within the finance score. Agency expenditure is forecast to be below the ceiling by 2.2% which is generating a score of '1' which is as per the plan. Agency expenditure forecast includes contingency costs estimated at £150k.

The forecast agency expenditure equates to the plan of 2.9% of the pay budgets (3.1% last month). National NHSI benchmarking information from 2017/18 showed agency expenditure at 4.5% of pay budgets with Midlands and East region at 5.2%.

1.3 IAPT (Improving Access to Psychological Therapies) people moving to recovery

Although there has been a dip in-month, this is a rolling three month target which has been achieved to date and there has been further improvement in October. To be monitored on an ongoing basis.

1.4 Out of area adult placements (non-PICU (Psychiatric Intensive Care Unit))

This continues to be a concern both locally and nationally with many providers reporting increases in the use of out of area beds. The urgent care improvement plan continues to be progressed and implemented.

Actions include a review of leave policy; review of repatriation processes; review of medical discharge; case review of patients with length of stay 50 days plus; review of crisis bed use; review of rehab bed referral process; review of social care/ward interaction; review of crisis and neighbourhood capacity; creation of flow coordinator roles.

The Board will receive a detailed progress report on the urgent care improvement plan at its December meeting.

In addition, NHS Improvement and England (Midlands and East) in recognition of local and national out of area placement pressures have developed an improvement collaborative, with the aim of facilitating sustainable improvement across all Midlands and East mental health providers and commissioners. The collaborative is expected to run for nine months and will be supported by national and local clinical and quality improvement experts who will share their experiences and expertise through a series of networking events. The first workshop is being held on 20 November. The Trust has a team who will be part of this collaboration over the next nine months.

1.5 Sickness Absence

The monthly sickness absence rate in September 2018 is very slightly lower than the previous month.

The latest available Trust annual sickness absence rate is running at 5.6%. Anxiety / stress / depression / other psychiatric illnesses remain the Trust's highest sickness cause for absence.

The People and Culture Committee has requested further assurance on plans to address sickness absence levels at its December meeting when a deep dive on this topic will be provided.

1.6 Appraisals

The number of employees who have received an appraisal within the last twelve months has decreased this month to 74.6%.

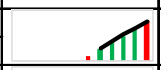
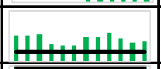
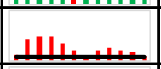
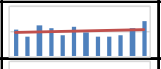
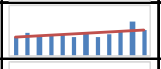
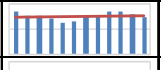
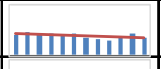
1.7 Training

Compulsory training compliance rates have reduced slightly to 82.8%. The table below provides Board members with an overview of key actions being undertaken to lower sickness absence rates and vacancies and improve rates of training and appraisals:

KPI	What are we doing to improve performance?	What has worked and hasn't worked?	What next?
Sickness Absence	Full analysis of FirstCare reports has identified areas of high sickness levels and where dedicated support needs to be focused. Plans are in place to support areas that are experiencing high sickness, whether that be short or long term. Divisional People Leads are now attending divisional meetings on a regular basis and are actively encouraging teams to ensure that sickness and wellbeing plans are on the agendas. Updated positions are being provided to General Managers.	DPL's and Employee Relations are supporting managers with advice regarding the content of their Occupational Health Referrals. Recent referrals have not always given the manager the information they require to address the employee's ill health concerns. Managers are being encouraged to ask for clear guidance and advice regarding support or changes that need to be made following an OH referral, managers are also being encouraged to speak direct to OH and to be more specific in their referral questions	Engagement sessions with leaders to discuss main reasons for high sickness absence and to further explore proactive wellbeing strategies. Working to provide dedicated support to hotspot teams where there are outstanding Return to Work interviews required / outstanding. Feedback received from leaders within hot spot areas around concerns that staff are close to burnout and proactive support is required to prevent absence, request from managers to consider phased return to work in reverse in exceptional cases to allow individuals with time off to support work life balance . Divisional People Leads to support operational teams on raising the profile of People Management Policies, including Flexible Working, Chronic Illness and Special Leave in addition to supporting leaders and managers on their roles and responsibilities for effective strategies on absence management. Change shave been proposed to the Health and Attendance employee guide, subject to feedback from Staff Side this can then be used to further support staff and managers. A recent audit on managing absence from KPMG will provide for further recommendations going forward

KPI	What are we doing to improve performance?	What has worked and hasn't worked?	What next?
Vacancies	The vacancy percentage has increased since April 2018 due to the government investment into mental health services. We are actively recruiting by making use of our social media platform, university links and promotion of the recruitment microsite. We are completing a full review of vacancies and where the gaps are we are using staff flow data to inform our workforce plans so that we can better plan, understand where we need to focus and what are the risk areas, reviewing advert wording, building microsite as well as promoting international recruitment for medical. Further work is required in terms of reaching out to medical students and junior doctors for future preparation and development that will meet service needs. Recent careers evenings have been well attended by People Services representatives and we are growing our reputation as a place to work in Mental Health Services.	Linking in with universities - a number of students have been recruited to our Inpatient wards including Radbourne Unit and are due to commence in October through to December. Medical recruitment remains a challenge but we continue to advertise all vacancies including a dedicated advert in the HSJ.	Working to speed up the recruitment process from start to completion, regional work and collaboration to inform strategic planning, working closer with operational managers looking at rotational posts and different ways of working, seeking views from candidates to try and reduce non-attendance at interview. New videos and commentary from medical staff and hard to recruit areas are being developed to boost the microsite content, this will be regularly refreshed and will be part of the new DHCFT website
Appraisals All Staff	Crisis staffing levels in certain clinical areas has contributed to the decrease in compliance levels last month. There is a focus on trying to support the teams with the lowest appraisal scores which has included additional clinical leadership to allow managers to leave the ward to focus on outstanding appraisals.	Feedback continues to be that the process needs to be condensed and simplified.	Consultation with leaders and teams is currently under way to develop a new appraisal process which aims to be more simplified and meaningful and is expected to result in compliance. Divisional People Leads to support operational teams with strategies for achieving and monitoring the required expectations.
Compulsory Training	Many of the components within the compulsory training offer is undertaken by eLearning and there have been several issues with eLearning and the server on which this hosted and this has contributed to a lower than expected compliance rate. However in the last month this has now been rectified and staff should be able to successfully complete the required eLearning package. Following this it is expected there will a steady increase in compliance.		A work stream will be commencing to begin to review all the passports and streamline these against all roles, this has already commenced with IT&M service. This will commence across all services. This will provide colleagues with a clearer expectation of their training requirements.

2. Strategy Delivery

Category	Metric	Period	Target	Actual	Variance	Trend	Last 12 Months	DQ
Finance Scorecard	Finance Scorecard	YTD	1	1	G	→		
		Forecast	1	1	G	→		
	Control Total position £000	YTD	842	973	G	↑		
		Forecast	2331	2331	G	↓		
	CIP achievement £m	YTD	2.354	2.102	R	↑		
		Forecast	4.871	4.871	G	→		
		Recurrent	4.871	2.205	R	↑		
	Agency £m	YTD	1.518	1.533	R	↑		
		Forecast	3.030	2.964	G	↓		
	Cash £m	YTD	21.177	26.370	G	↓		
		Forecast	21.608	22.915	G	↑		
Quality and Operations Scorecard	RTT Incomplete Within 18 Weeks (%)	Sep, 2018	92%	94.0%	G	→		
		Aug, 2018		93.8%	G			
	CPA Review in last 12 Months (on CPA > 12 Months)	Sep, 2018	95%	95.4%	G	→		
		Aug, 2018		95.5%	G			
	Delayed Transfers of Care (%)	Sep, 2018	0.8%	0.83%	R	→		
		Aug, 2018		1.60%	R			
	North Neighbourhood Average Wait (weeks)	Sep, 2018		8.2		↓		
		Aug, 2018		8.5				
	North Neighbourhood Current Waits (number)	Sep, 2018		1791		↓		
		Aug, 2018		1829				
	City Neighbourhood Average Wait (weeks)	Sep, 2018		7.5		↑		
		Aug, 2018		6.8				
	City Neighbourhood Current Waits (number)	Sep, 2018		1507		↑		
		Aug, 2018		1444				
	South Neighbourhood Average Wait (weeks)	Sep, 2018		11.9		↑		
		Aug, 2018		9.5				
	South Neighbourhood Current Waits (number)	Sep, 2018		1884		↑		
		Aug, 2018		1820				
	CAMHS Average Wait (weeks)	Sep, 2018		9.8		↓		
		Aug, 2018		13.4				
	CAMHS Current Waits (number)	Sep, 2018		343		↓		
		Aug, 2018		356				
	Community Paediatrics Average Wait (weeks)	Sep, 2018		17.5		↓		
		Aug, 2018		21.1				
	Community Paediatrics Current Waits (number)	Sep, 2018		782		↓		
		Aug, 2018		823				
	Number of Adult Acute Inpatients (Hartington and Radbourne) LoS > 50 Days	Sep, 2018		73		↓		
		Aug, 2018		84				
Workforce and Engagement Scorecard	RETAIN - Staff engagement score	2017 Annual	To see an improvement in the staff engagement score	3.740	G	↑		
		2016 Annual		3.690				
		Q1 Jun 2018		72%	G	→		
		Q4 Mar 2018		72%				
	DEVELOP - Recruitment of preceptorship staff	2017/18	Number of students recruited into preceptorship	31	R	↓		
		2016/17		46				
	ATTRACT - Retention of preceptorship staff	2017 Annual	Number of students recruited into preceptorship who stay for at least one year	91%	G	→		
		2016 Annual		91%				
	LEADERSHIP & MANAGEMENT - Employee relations cases	Q2 Sep 2018	To see a reduction in the number of cases	34	G	↓		
		Q1 Jun 2018		40	G			
		Q4 Mar 2018		48	R			
		Q3 Dec 2017		45				

Key:

Period Month
Previous Month

Achieving target
Not achieving target
No Target Set

Target
Trend

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

2.1 Control Total position

The surplus in the month of £197k was £36k above plan, so the year to date favourable variance has increased to £131k. The forecast remains to achieve the control total at the end of the financial year. We currently anticipate that in order to do so we will need to use all 'reserves'.

There remain financial pressures to manage in order to achieve the control total, in particular the costs of adult acute out of area placements.

2.2 Cost Improvement Programme (CIP)

At the end of September £4.2m of CIP has been assured in the ledger (£2.1m YTD) which leaves an unassured gap of £660k. There are several schemes still to be actioned which are being forecast to deliver. Of the forecast savings 41% is to be saved recurrently:

£m	Annual	REC	NR
Target	**4,871**		
Assured in the ledger	4,211	1,721	2,490
Schemes being forecast	660	258	402
Gap	**0**	0	0
		1,979	2,892
		41%	59%

2.3 Delayed Transfers of Care (DTOC)

A number of recent escalation meetings have taken place with senior social care leads in order to review and improve the DTOC process, with the following outcomes:

- Agreed the final position on retrospective submissions and the September submission.
- Reviewed and agreed DTOC process and practice implementation based on national guidance.
- Revised process guidance (including escalation protocol) has been written and briefed to the Radbourne Unit and Hartington Unit. The guidance has also been shared electronically.
- PARIS to incorporate notification email to Social Care upon reporting DTOC.

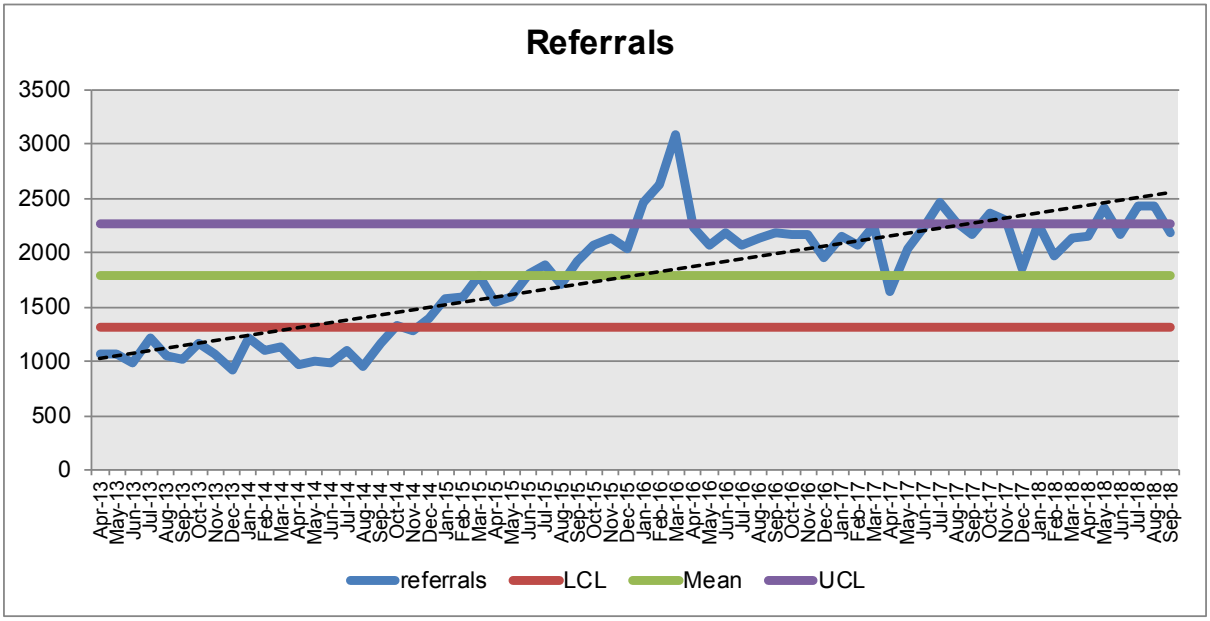
Further Paris developments are required in terms of a Social Care tile, notification of admission and request for Social Care assessment.

A joint protocol for the Trust and Social Care is being written.

2.4 Neighbourhood Waits

The number of referrals received has been steadily increasing over time. This is likely to continue in line with population growth.

Population aged 65 and over, projected to 2035	2017	2020	2025	2030	2035
Derby: Total population aged 18-64	157,400	159,400	161,700	163,500	164,000
Derby: Total population 65 and over	41,700	43,200	47,100	53,100	58,800
Derbyshire: Total population aged 18-64	466,500	465,200	461,300	454,500	446,900
Derbyshire: Total population 65 and over	169,500	179,200	197,900	221,200	242,200
Total adult population	**835,100**	**847,000**	**868,000**	**892,300**	**911,900**
Projected increase		**1%**	**4%**	**7%**	**9%**



The review of neighbourhood services continues to be undertaken with specific outcomes seeking to address current issues across community mental health services. The review of neighbourhood services case for change paper has been drafted. The proposals within, if accepted, will have a positive impact on capacity within community services, but also may result in some patients not receiving the service that is currently offered to them.

In addition, the Waiting list policy has been actioned, which sets out the need for colleagues to communicate effectively with referrers and those on the waiting list. This is in turn being underpinned by having a consistent approach to managing waiting lists.

A detailed paper around this issue and associated mitigation is to be presented at the next Quality Committee in November.

2.5 Number of patients with a length (LOS) of stay greater than 50 days

The urgent care improvement plan contains a number of key deliverables to help improve the flow of patients through our wards, these include;

- Weekly clinical meetings in place where each ward manager/ Responsible Clinician review and agree discharge plans/blockages for patients with a LOS of 50+ days.

- Clinical lead reviewing patients with LOS of 40 + days and working alongside multidisciplinary teams to challenge / support the proactivity of discharge plans and support escalation processes where there are blockages.

Data Quality Kite Mark

Background

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

Approach

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

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

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

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

KPI Data Quality Reviews

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors - 6 November 2018

Quality Report – 'Use of Resources'

Purpose of Report

This paper provides the Trust Board with a focused report on Use of Resources as part of the wider expanded quality reporting relating to CQC domains and NHS Improvement. It is written to aid strategic discussion on how best to improve our use of resources.

Executive Summary

Use of resources covers a wide range of measures. Carter in his recent report of 'Operational productivity in mental health and community providers' points to some important factors for us to consider in making best use of our resources, which are summarised in the report.

The key lines of enquiry for Use of Resources are: Clinical services, People, Clinical support services, Corporate services, procurement, estates and facilities and Finance.

In all areas, the focus of consideration should be on how well we are using the resources to operate as productively as possible to maximise patient benefit and provide high quality care in sustainable services.

This is still an emerging area and benchmarking is not available for all measures as yet. The 'Model Hospital' is also evolving and the majority of its comparators are for services provided in hospital settings. (They acknowledge the need to expand on this for non-acute providers who, like us, provide the vast majority of their services outside of such settings.)

The trends and benchmarks included in the report show that there are opportunities for improvement in the use of resources. In many instances these are areas that we are very aware of. For example workforce measures and action planning around recruitment, retention and development of staff and these factors feature as a key strategic risk in the Board Assurance Framework.

However the main area that arguably warrants additional consideration is sickness absence, where the Trust is currently losing an average of 2,700 days a month. At a cost per day of something in the 'ball park' of £113 this equates to £305k per month (excluding any costs of backfill). Carter suggests that mental health providers lose on average two extra days per person per year to sickness absence.

Some of the benchmarking suggests the Trust is not as cost effective as it could be eg some corporate costs per £100m turnover (eg governance and risk, IM&T, HR and Finance), and there are others where we are exemplar (eg procurement).

Clearly, in terms of making the most material improvement in use of resources we must ensure there is the sufficient attention on those factors affecting the whole

workforce, in particular sickness absence and in clinical service delivery where the majority of costs and cost pressures are situated.

So in summary for us, the key areas that need to (continue to) feature in our improving use of resources objectives are:

- Increasing our focus on improving staff wellbeing and satisfaction in particular to reduce rates of sickness absence and the associated costs (in people and financial terms)
- Delivery of the new Leadership and Management strategy supporting recruitment, retention and workforce development
- Implementation and oversight of more robust e-rostering and job planning
- Elimination of Adult Out of Area placements
- Better use of digital technology
- Medicines optimisation and e prescribing
- Streamlining access to services and improving missed appointments
- Optimising utilisation of estates (particularly addressing empty wards)
- Considering the appropriate size and function of corporate services
- Improved administration and communication

Helen Austin of the Midlands and East Productivity Team in NHSI is visiting the Executive Leadership Team on 26 November for a Productivity Model Hospital visit to discuss an overview of possible opportunities.

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 consideration of the use of resources touches on many of the risks on the Board Assurance Framework, not just the delivery of financial plans. The financial performance is a direct result of the use of resources in its broadest sense.

The proposed level of assurance for this paper is **significant** overall in terms of the Trust is looking at the right areas to improve use of resources. However achievement to date against some areas could be determined as **limited**.

Consultation

This paper has not been formally considered by other meetings but has been shared with Execs and its principles discussed at Programme Assurance Board on 24 October 2018.

Governance or Legal Issues

There are no other legal or governance issues impacted on by this paper other than the regulatory requirements of CQC and NHSI as described.

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 paper explores the use of resources at whole Trust level rather than by patient or staff groups who may have protected characteristics.

However the Board will be aware that there are known equality, diversity and inclusion issues that will adversely affect some of the measures of use of resources.

For example, the differential experience of BME members of staff as reported in workforce race equality standards (WRES) and issues such as the gender pay gap will likely to have a direct consequence on workforce measures in those groups.

As a Trust we are working hard to improve these factors but there is work still to do.

Recommendations

The Board of Directors is requested to;

1. Consider whether our current priorities for transformation, business and quality improvement adequately address our key opportunities for enhancing our use of resources.

2. Consider whether they wish for any additional information to be included in the integrated performance report, either regularly or periodically.

3. Confirm their level of assurance obtained on current use of resources across the areas presented. It is suggested that there is significant assurance that the areas being addressed are the right ones, but limited assurance on delivery because the work is not concluded

Report presented by: **Claire Wright Deputy CEO and Finance Director**

Report prepared by: **Claire Wright Deputy CEO and Finance Director and Rachel Leyland Deputy Finance Director**

Quality Report – Use of Resources

From 5 March 2018 the Use of Resources (UoR) assessments consider a sixth key question alongside CQC's existing quality ratings for safe, caring, effective, responsive and well-led. Like CQC's five quality questions, Use of Resources is given a rating of outstanding, good, requires improvement or inadequate.

It should be noted that UoR assessments currently only take place in acute non-specialist trusts, however this paper considers equivalent or nearly equivalent measures to enable the Board to have a strategic discussion of the use of our resources.

1. Policy and regulatory context

1.1 The NHSI Single Oversight Framework - NHSI Finance Score

The monthly finance score is calculated by scoring providers on a scale of 1 (best) to 4 against the following five metrics and averaging these scores to derive an overall figure:

- Capital service capacity
- Liquidity
- Income and expenditure margin
- Distance from financial plan
- Agency spend

Performance against these measures are covered in the final section of the report

1.2 NHSI/CQC Use of Resources Assessments

From Autumn 2017, a new use of resources assessment was introduced. Under this framework, NHS Improvement will periodically undertake UoR assessments of providers. These new assessments currently only take place in non-specialist acute trusts, due to the greater availability and quality of operational productivity data for these trusts, with the aim of rolling out across the sector when more information is available on productivity in other types of providers. Timeframe for wider rollout is unknown.

The framework has been developed with CQC, which will publish providers' UoR reports and ratings.

The aim of UoR assessments is to understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care for patients. NHS Improvement will do this by assessing how well trusts are meeting financial controls, how financially sustainable they are, and how efficiently they use their workforce, clinical and operational services to deliver high quality care for patients.

The assessments focus on delivery and performance at trust level currently and over the previous twelve months through the lens of five Key Lines of Enquiry:

- Clinical services
- People
- Clinical support services
- Corporate services, procurement, estates and facilities
- Finance

The measures included in this report are based on the above categories.

1.3 Model Hospital

The Model Hospital is a new digital information service provided by NHS Improvement to support the NHS to identify and realise productivity opportunities.

NHS trusts are able to explore their comparative productivity, quality and responsiveness, to provide a clearer view of improvement opportunities. Whilst some variation in trust activity is expected and warranted, the Model Hospital supports trusts to identify and tackle unwarranted variation.

The information contained in Model Hospital is limited for Mental Health Trusts and has been focused on Acute Trusts. The information in our part of the site mainly relates to the Single Oversight Framework and Corporate benchmarking information.

The performance measures included in this report have been linked to the information contained on the Model Hospital site where possible to allow for consistent reporting. However some of the measures included in this report are not available on the Model Hospital and so have been calculated from information the Trust has available.

1.4 Carter: NHS operational productivity: unwarranted variations in mental health and community health services

This review led by Lord Carter covered the operational productivity of English NHS community and mental health services. The final report made 16 recommendations and indicated productivity benefits worth £1bn can be achieved of which 80% of this will be through clinical and workforce productivity.

Carter's recommendations are discussed in the context of each of the relevant areas of this report.

2. Performance

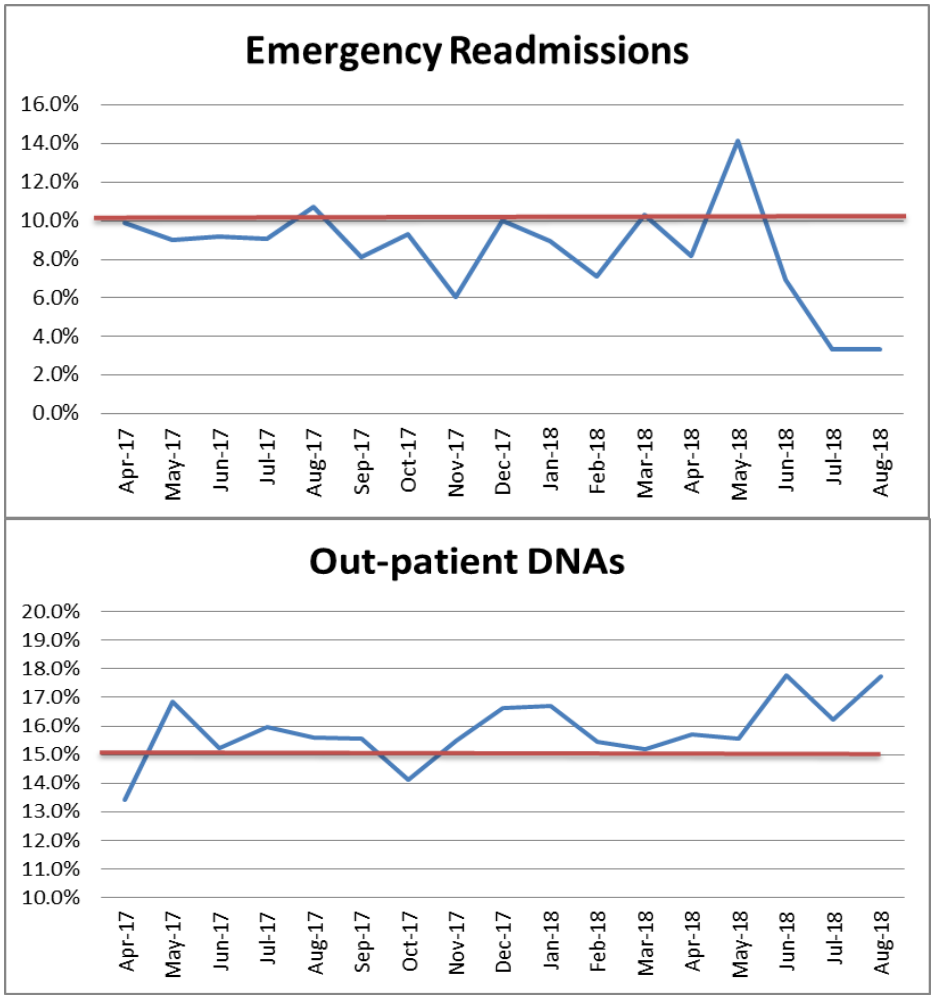
This section looks at the actual metrics which have been identified and reports the monthly position for 2018/19 including where applicable historic information and any benchmarking information reported on Model Hospital.

2.1 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

- Emergency readmissions (28 days)
- Did not attend (DNA) rate

The information for these two measures is taken from the Trust's performance dashboard and is reported to Finance and Performance Committee within the Operational Performance report.

Readmission and DNA rates



Emergency readmissions have mostly been below the target of 10%. The peak in May 2018 relates to 16 readmissions within 28 days of discharge. Of which 3 were actually transfers to and from PICU.

The DNA rate continues to be above the target of 15%. Two Associate Clinical Directors will task their junior doctors with undertaking an audit of DNAs once they are in post.

These two metrics do not appear to be reported on our part of the Model Hospital site so cannot provide benchmark at this time.

Improvements in the level of DNAs and emergency readmissions are opportunities to make better use of resources. Carter cites that 16% of mental health appointments are missed, leading to significant waste of clinical capacity and to compromise in patient outcomes.

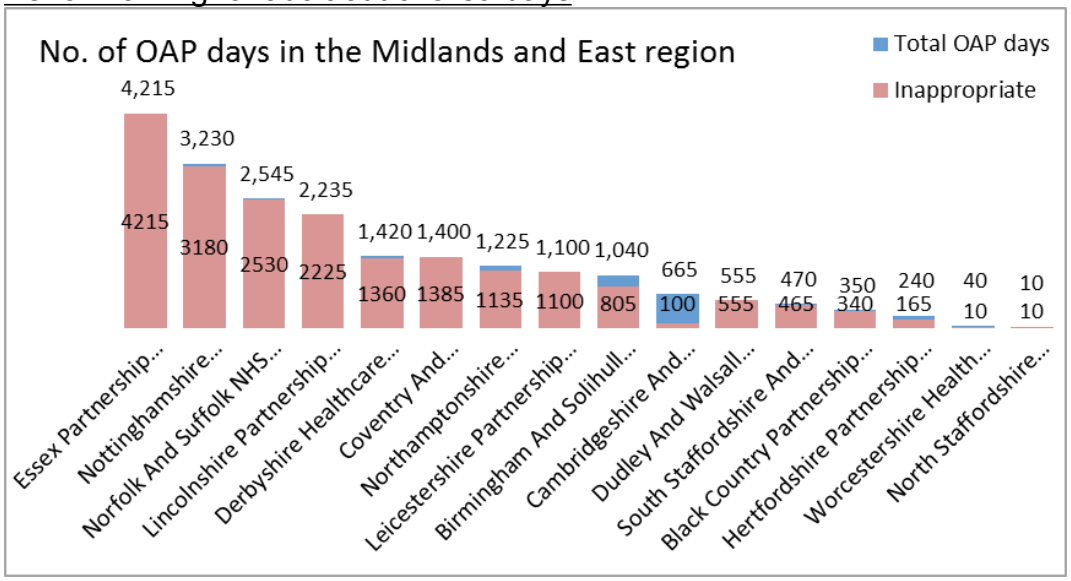
- **Adult Acute Out of Area placements**

Carter references the concept of Getting it Right First Time and in his report points to out of area placements as a key area for improvement. We are well sighted on this because it is already highlighted as one of our most important areas to improve from a quality perspective as well as financial. We have significant work still to do to improve this. (There is also the regulatory requirement to eliminate inappropriate out of area placements by 2021)

The Out of Area (OOA) and Step-down (SD) budget is overspent by £1m at the end of September and is forecasting an overspend of £2m at the end of the financial year.

This pressure is not limited to this Trust and is a national issue. Benchmarking below suggests that we are currently the fifth largest user of out of area beds in Midlands and East.

Benchmarking for adult out of area days



This area needs to be addressed both in numbers of placements and the variability in cost of placements This is proving to be a stubborn challenge.

In terms of delivering clinical services the majority of activity takes place in community settings and Carter suggests that there is significant variation in structure, composition and skill mix of community teams and that there is scope to exploit improvement through better use of digital technology, streamlining access to services, better communication and administration in order to reduce missed appointments

With regard to community services - the comparison charts below evidence that we have above-average community caseloads per 100k weighted population but with

comparably lower level of investment in Crisis and CRHT community resource. Simply speaking we have comparably fewer staff with larger caseloads.

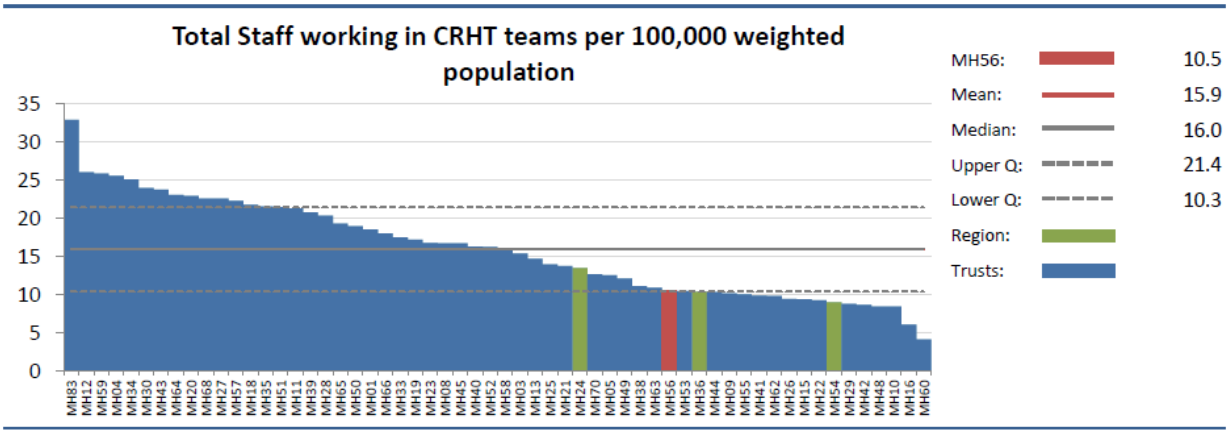


Figure 67

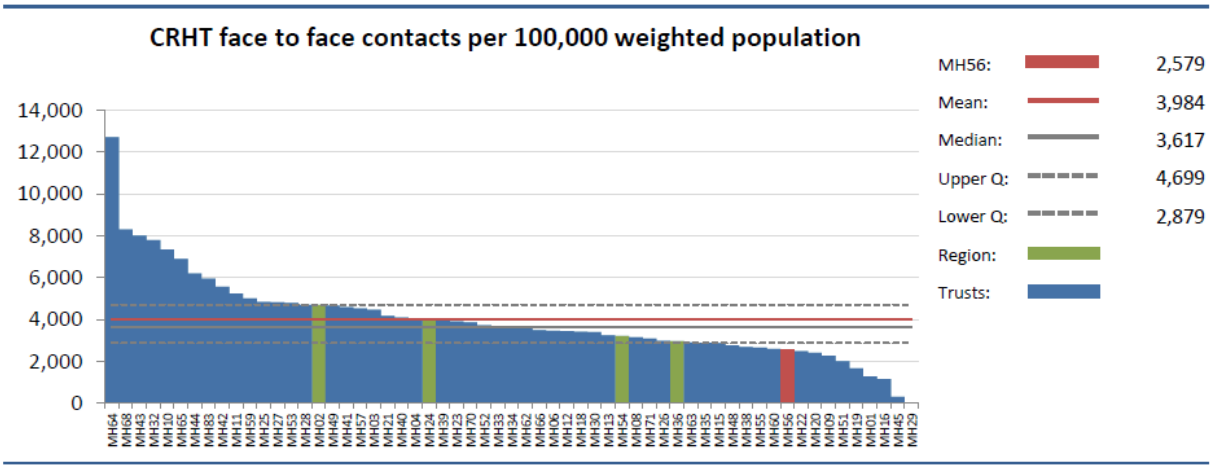


Figure 66

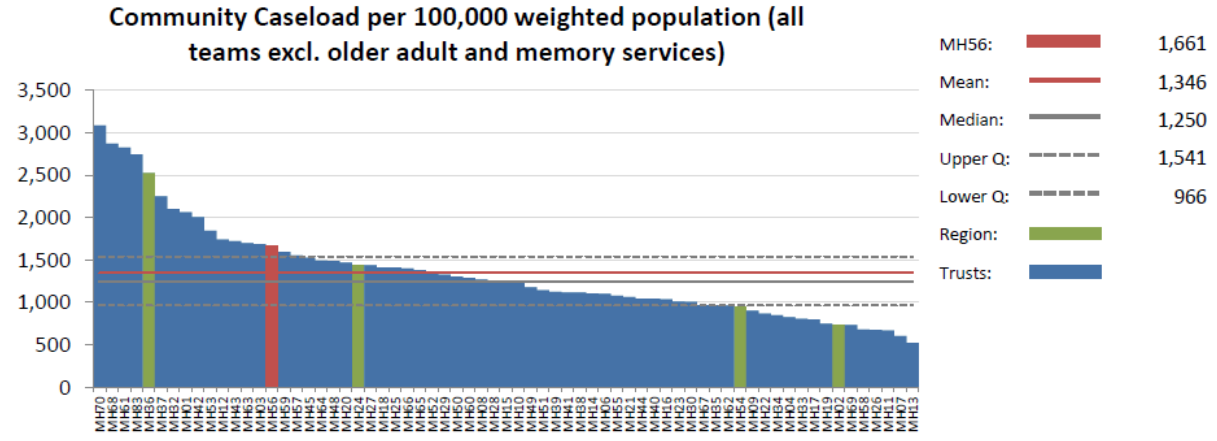


Figure 52

2.2 People: How effectively is the Trust using its workforce to maximise patient benefit and provide high quality care?

Carter clearly highlights that workforce is a key driver for efficiency improvements and emphasises the link between productivity and culture, leadership and engagement. He suggests that mental health staff report poorer levels of overall satisfaction compared to the acute sector and he suggest Trusts should have leadership strategies that address these issues and that there be more training for staff moving into management. These factors have been taken into account in developing our new Leadership and Management strategy.

Carter also points to the levels of bullying, harassment, sickness absence and vacancy rates in mental health and community services and cites that our sector loses on average an extra two days per staff member per year to sickness compared to acute sector. Intensity of work, varied geography, work-life balance and levels of patient acuity are all differentiating factors compared to acute. Furthermore, he says that staff working in mental health trusts in particular, are more likely to experience physical abuse, bullying or harassment.

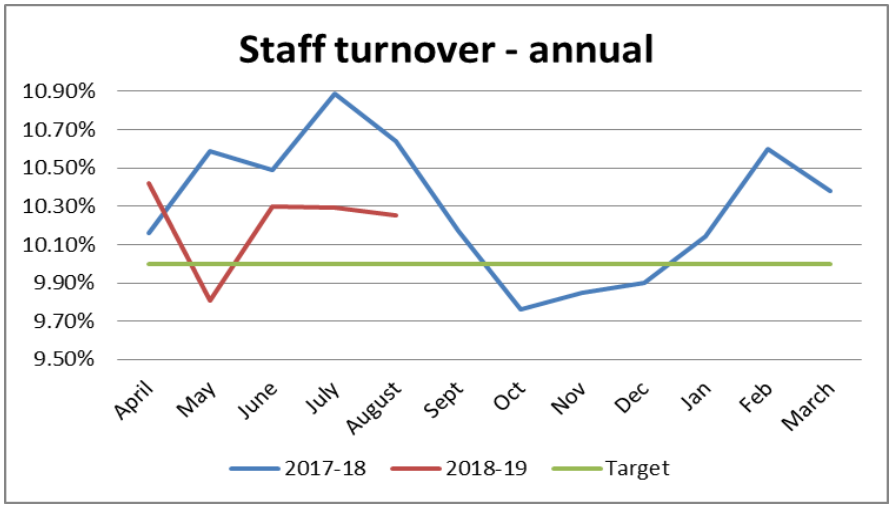
With regard to staff turnover again the MH sector performs worse than the acute sector, with turnover rates ranging from 9% to 45% at the time of the Carter report (May 2018). Factors highlighted include ageing workforce, national pay policy, access to Continuing Professional Development and suggests Trusts should have a specific retention policy.

Clearly optimising workforce wellbeing and engagement is a key priority that we recognise and we continue to seek ways to improve engagement, retention and wellbeing of our staff but there is work still to do.

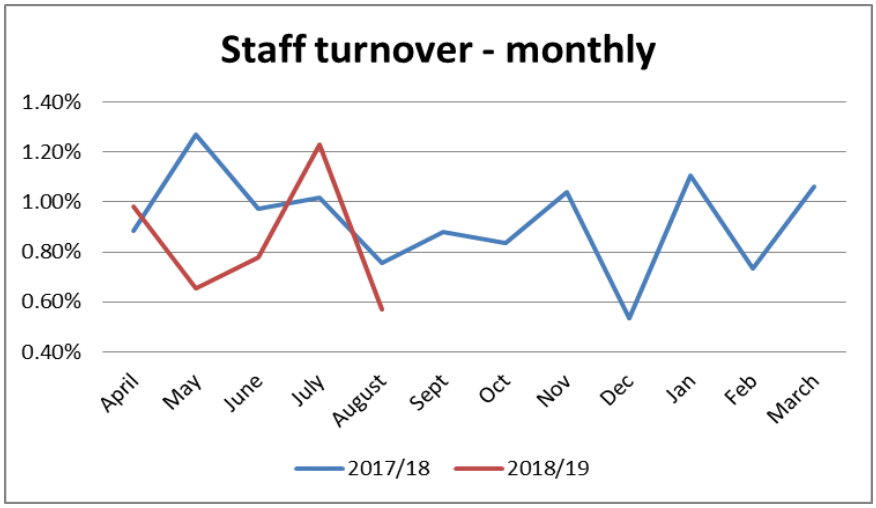
- **Staff Turnover rates (annual and monthly)**

The information shown in the graph below is taken from the monthly workforce returns submitted to NHSI and is also contained in the dashboard of the public board report.

This information is based on the 'annual turnover' which counts the number of leavers over the last twelve months and divides by the average headcount for the last twelve months. This shows a reduction in turnover for 2018/19 compared to the previous year against a target set at 10%.

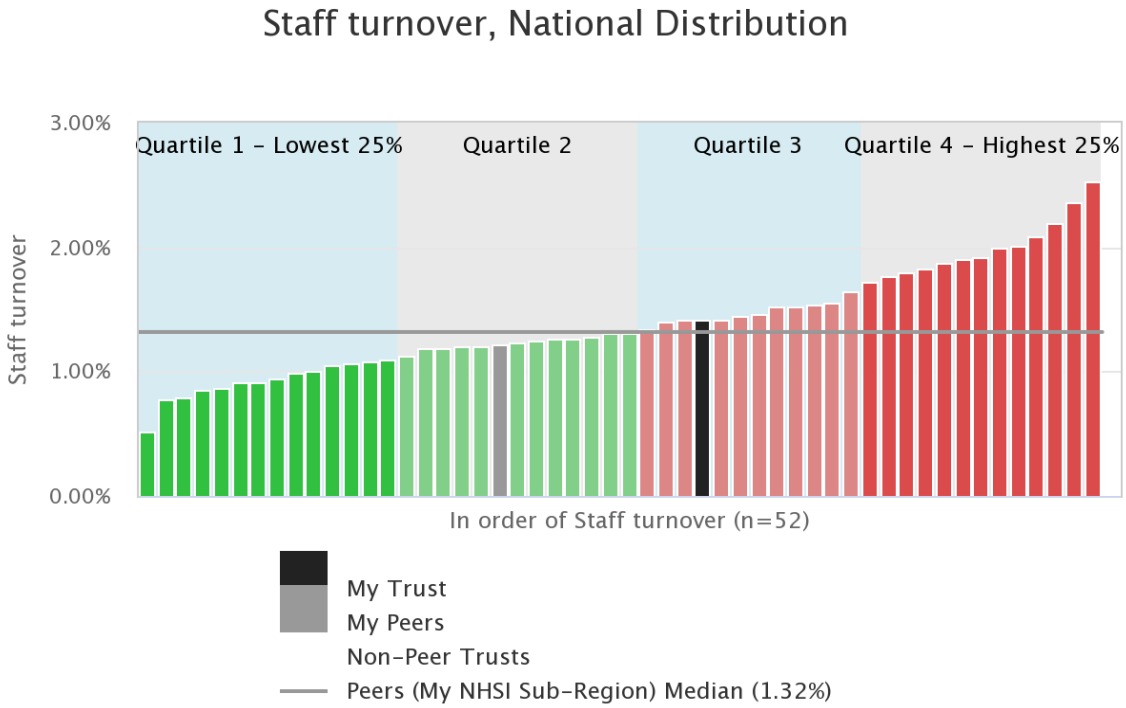


Instead of annual turnover the Model Hospital uses 'monthly turnover' rate. The monthly turnover rate shows the number of leavers for the month divided by average headcount for previous twelve months. This information has been calculated by People Services and is presented in the graph below. The percentages fluctuate between 0.6% and 1.2%.



The graph below shows the benchmark information from the Model Hospital for monthly turnover. For July 2018 it is reporting the Trust at 1.41% against a peer median of 1.32%. (NB People Services reports July at 1.23%.)

Benchmarking for monthly staff turnover

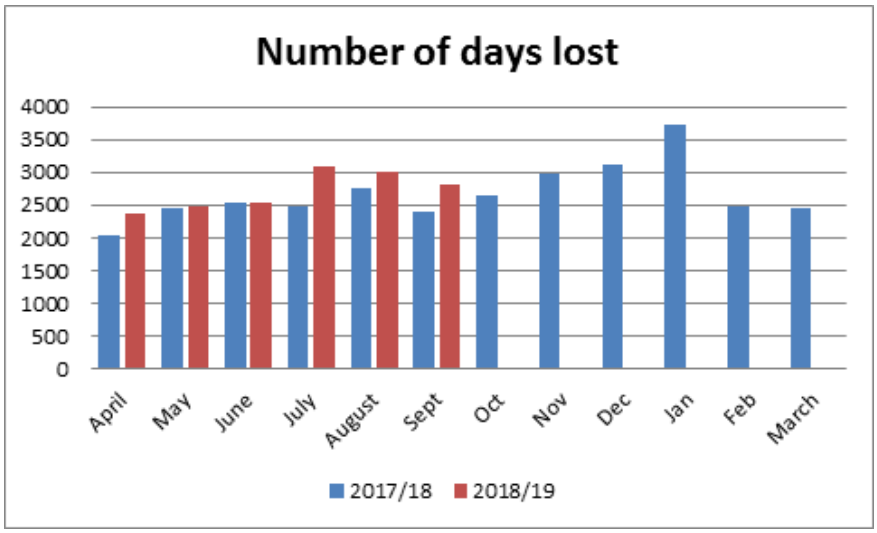


- **Sickness absence**

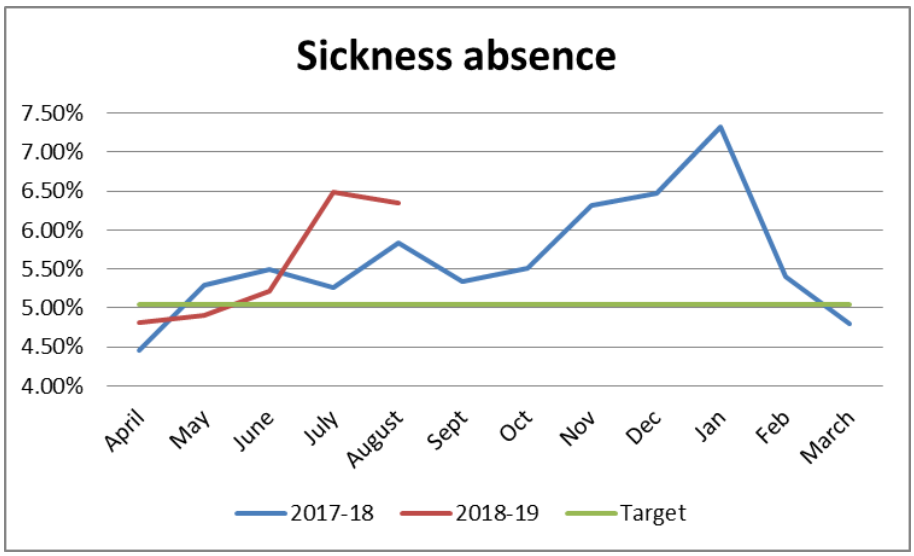
The graph below shows the number of days lost to sickness each month during the last 18 months (as reported through Firstcare). The least is 2,049 days lost in April 2017 and the highest is 3,715 days in January 2018

The average daily cost of our workforce is c£113 per day. Losing 2,049 days would equate to £232k in that month and losing 3,715 days would equate to £419k in that month. Between April 17 and March 18 we lost 32,049 days to sickness costing something like £3.6m. This is just using the average cost of one person not including the cost of backfill. Between April 18 and September 18 we have lost 16,268 days year to date (£1.8m), an average of 2,711 days per month.

Carter says mental health providers lose on average an extra two days per staff member per year to sickness. With an approximate number of staff of 2,500 with an average cost per day of £113; if we could improve by an average of two days per worker not lost to sickness this would save £565k a year.



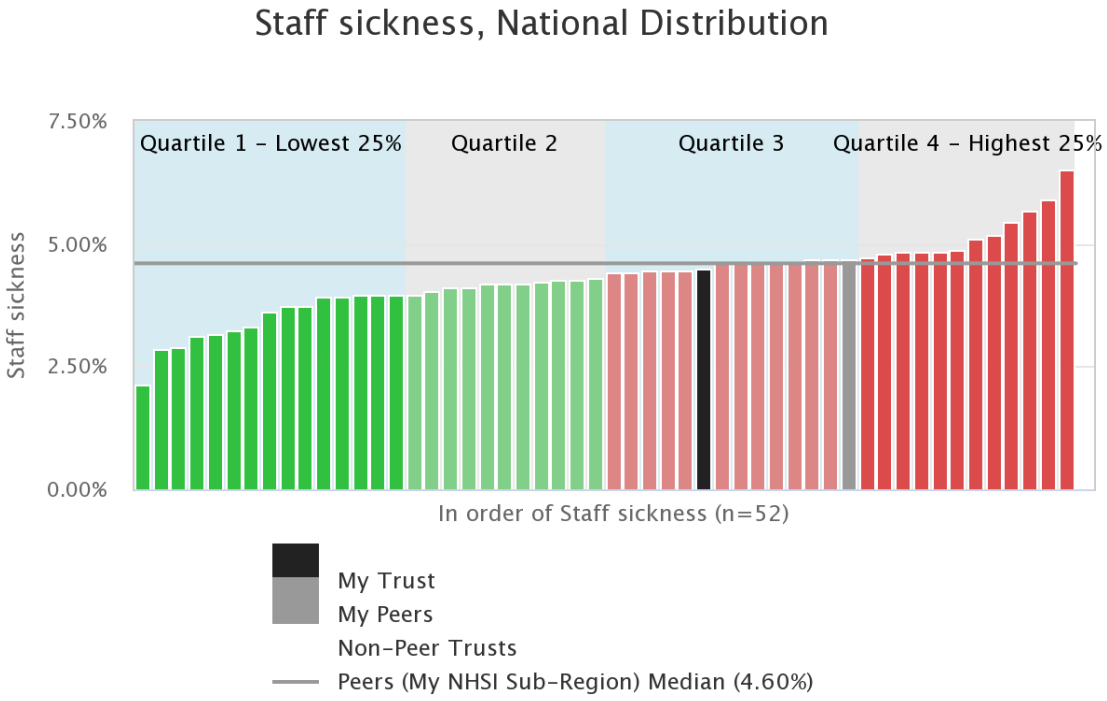
In terms of % rates and trends, the following information is taken from the NHSI monthly workforce return and is also reported in the Regulatory dashboard to the public board meeting.



The chart above shows that our current sickness levels are higher than the same time period the previous year and has been increasing since the start of the financial year.

The chart below from the Model Hospital is based on data as at *April 2018* and shows that the Trust at 4.51% is lower than the peer median of 4.6%

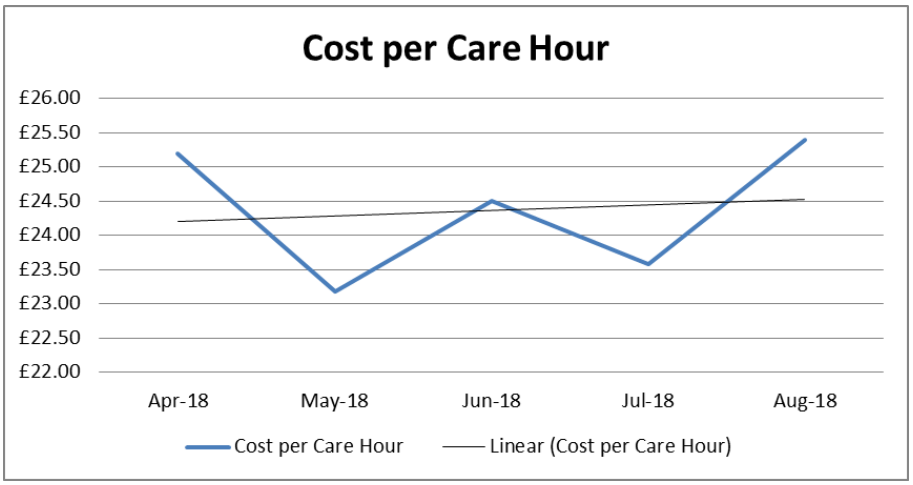
Benchmarking for staff sickness



- **Cost per care hour**

This measure is not reported on the Model Hospital for our Trust therefore it has been derived as a proxy measure from two returns to NHSI: the safer staffing return which captures Care Hours Per Patient Day (CHPPD) and the monthly finance return to NHSI which contains the staff cost for each of the in-patient wards. The cost has been divided by the hours to derive the Cost per Care Hour.

The information submitted includes all the Trust's in-patient wards only, not community costs per care hour.



The costs are running between values of £1.315m in June and £1.397m in August, with the lowest hours in June of 53,687 and the highest of 57,570 in May. Therefore the dip in May is due to the highest hours and the dip in July is one of the lower months of costs. The values fluctuate each month but are showing a linear increase over the first 5 months of the financial year. It is important to note that the AfC (Agenda for Change) pay increase was paid in July with the arrears paid in August. This emerging metric will continue to be monitored over the financial year.

There is no benchmarking available in model hospital for this measure currently.

- **E-Rostering**

As part of the recommendations from the 'NHS operational productivity: unwarranted variations in mental health and community health services' review there was a recommendation that 'all community and mental health trusts should use an effective e-rostering system and set up formal processes to tackle areas of rostering practices that require improvement'.

The Trust does have an E-rostering system already across all in-patients units but it is not as yet working to optimise use of resources. Therefore there are currently two projects to address this; one looking at cleansing the current rosters and the second looking at developing an improved rostering approach including more standardised policies and procedures. The workforce approach also includes developing a medical job planning / e rostering IT system.

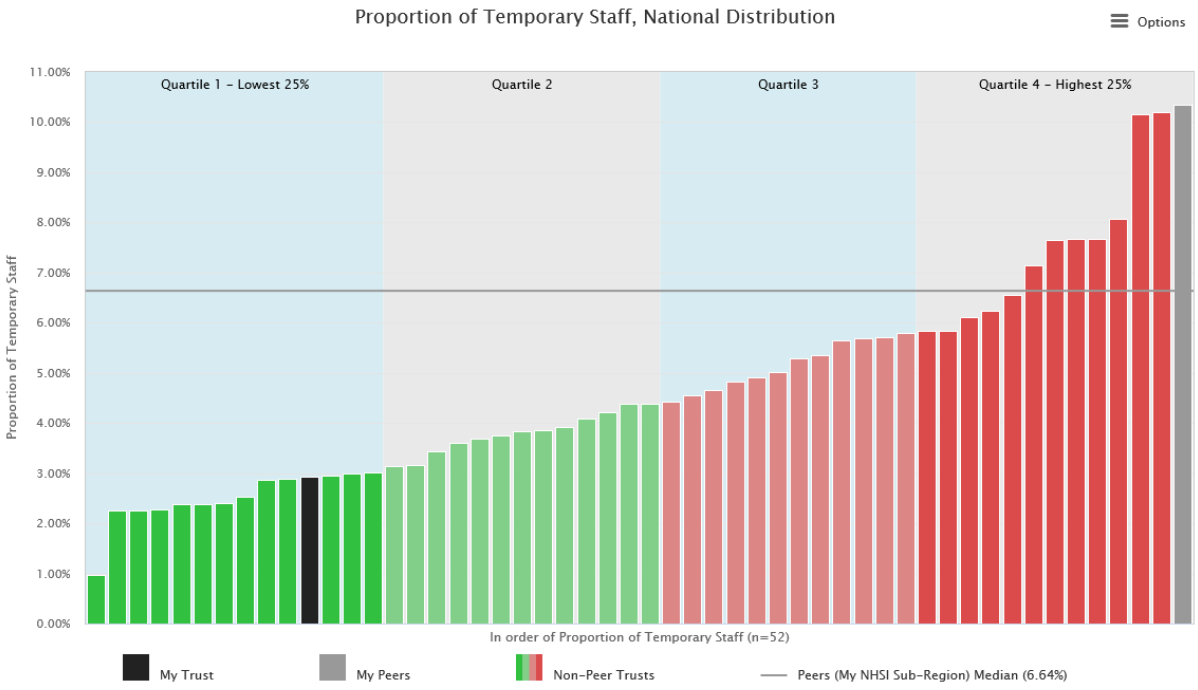
Carter found that there is scope for significant improvements to better manage unused hours, approve rosters six weeks in advance and reduce spend on bank and agency staff for example

Generally, the use of all kinds of temporary staffing, whether bank, agency or overtime, features highly in our efficiency programme and is one of the main objectives of the e-rostering projects.

With regard to agency in particular the Trust has made excellent progress in reducing agency expenditure from c£5m in 16/17 to c£4m in 2017/18 to forecast of around £3m in 2018/19.

In terms of the measure of agency spend as % of total pay costs the Trust now benchmarks well (see chart below)

Benchmark: July 2018 - **Agency** temporary staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs



In summary, in terms of optimising clinical resources Carter recommends developing measures for analysing workforce deployment, using effective rostering, reviewing job planning to ensure the right doctor is available at all times using effective and comprehensive job planning and rostering as well as identifying any improvements in clinical efficiency and productivity. In addition he highlighted medicines and pharmacy optimisation as key to enable pharmacy staff to spend more time with patients and on medicines optimisation.

2.3 Clinical Support services: How effectively is the Trust using its clinical support services to deliver high quality sustainable services for patients?

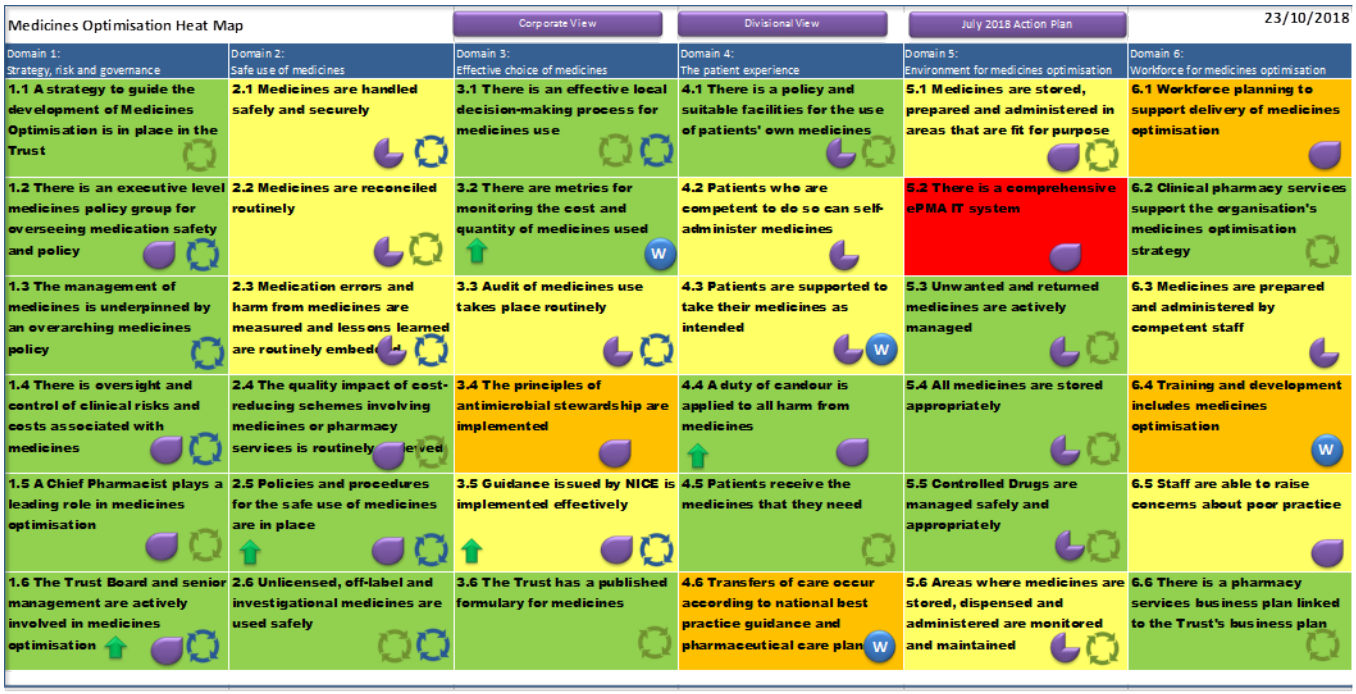
- **Medicine Costs**

This information is not yet reported on the Model Hospital website, although this is an area of development and information will soon be required to be submitted. It is anticipated that information will be reported on the Model Hospital from April 2019. Therefore the cost for this measure is taken from the financial ledger. The costs reported in the table below are after any recharges that are made which are income backed.

	2017/18				2018/19				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Medicine Costs	167,281	175,873	188,165	189,652	151,178	228,831	184,264	252,638	203,779

This shows that how costs have fluctuated over last year and this year. These values are clearly a function of cost, volume and prescribing choices. In order to support deeper understanding of this area the Chief Pharmacist has developed interactive dashboards reported at Trust Management Team, examples are shown below.

The 'Medicines Optimisation Heat Map' is action-focused across the 6 key domains of medicines optimisation: strategy; safety; choice; experience; environment; workforce.



Drug Use and Expenditure (DUE) Drill-down dashboard to support teams to better understand and to signpost to areas that would improve use of these resources

Trust (excl. Sub. Mis.)	Neigbourhood	Campus	Children's/CAMHS	Central	Corporate	Substance Misuse
Headlines						
Summary	Summary	Summary	Summary	Summary	Summary	Summary
Top 20 Drugs	Top 20 Drugs	Top 20 Drugs	Top 20 Drugs	Top 20 Drugs	Top 20 Drugs	Top 20 Drugs
Top 10 Trend	Top 10 Trend	Top 10 Trend	Top 10 Trend	Top 10 Trend		Top 10 Trend
Antiinfectives	Antiinfectives	Antiinfectives	Antiinfectives	Antiinfectives		Antiinfectives
		Antiinfectives by ward				
Antipsychotic depots	Antipsychotic depots					
		Ward comparison summary				
		Ward comparison detail				
		Ward issues for stock list review				
	FP10 prescriber summary	FP10 prescriber summary	FP10 prescriber summary	FP10 prescriber summary		FP10 prescriber summary
	FP10 prescriber comparison					
	FP10 prescriber detail	FP10 prescriber detail	FP10 prescriber detail	FP10 prescriber detail		FP10 Prescriber detail
FP10 "Specials"	FP10 "Specials"		FP10 "Specials"	FP10 "Specials"		
Hypnotics, anxiolytics and antiepileptics	Hypnotics, anxiolytics and antiepileptics	Hypnotics, anxiolytics and antiepileptics			Hypnotics, anxiolytics and antiepileptics	
Opiates and addiction	Opiates and addiction	Opiates and addiction		Opiates and addiction	Opiates and addiction	
ADHD	ADHD		ADHD			
Liothyronine						
Dosulepin						
Medicines of Interest						
Dementia	Dementia					
Unit prices of medicines						

- **E Prescribing**

As part of the recommendations from Carter review it was found that Pharmacy services are ‘underused in both community and mental health services’. It highlights opportunities including the implementation of electronic prescribing and medicines administration.

The Trust is keen to develop electronic prescribing and medicines administration (ePMA) IT system as soon as it is able in the near future. This will present a strong opportunity to understand how best to improve use of these resources.

2.4 Corporate Services, procurement, estates and facilities: How effectively is the Trust management its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?

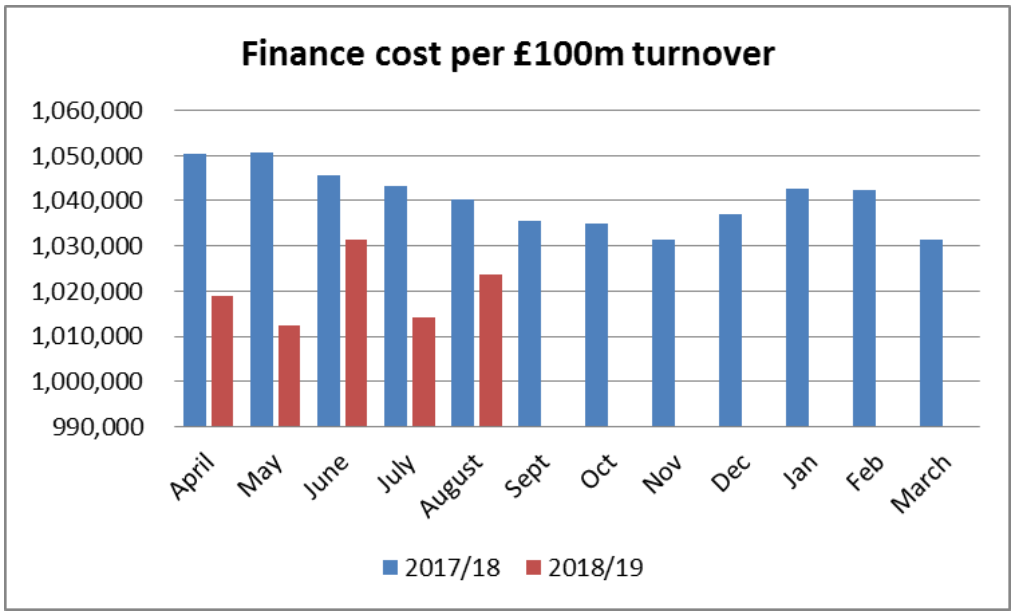
For corporate services as a whole, Carter highlights that mental health trusts operate smaller corporate entities and the spend in this area does tend to benchmark higher than other organisations therefore report advises that trusts consider the most appropriate scale of their business functions.

Carter advises that there is clear efficiency of scale with larger organisations spending less on corporate services as a proportion of turnover and suggests collaboration to standardise and share corporate services especially for smaller trusts.

- **Finance and HR cost per £100m turnover**

The above two measures are published from the NHSI Corporate benchmarking exercise and are also included on the Model Hospital website but only for 2016/17. However this exercise is only done once a year for the benchmarking return and therefore a much simpler calculation is included in this report as well.

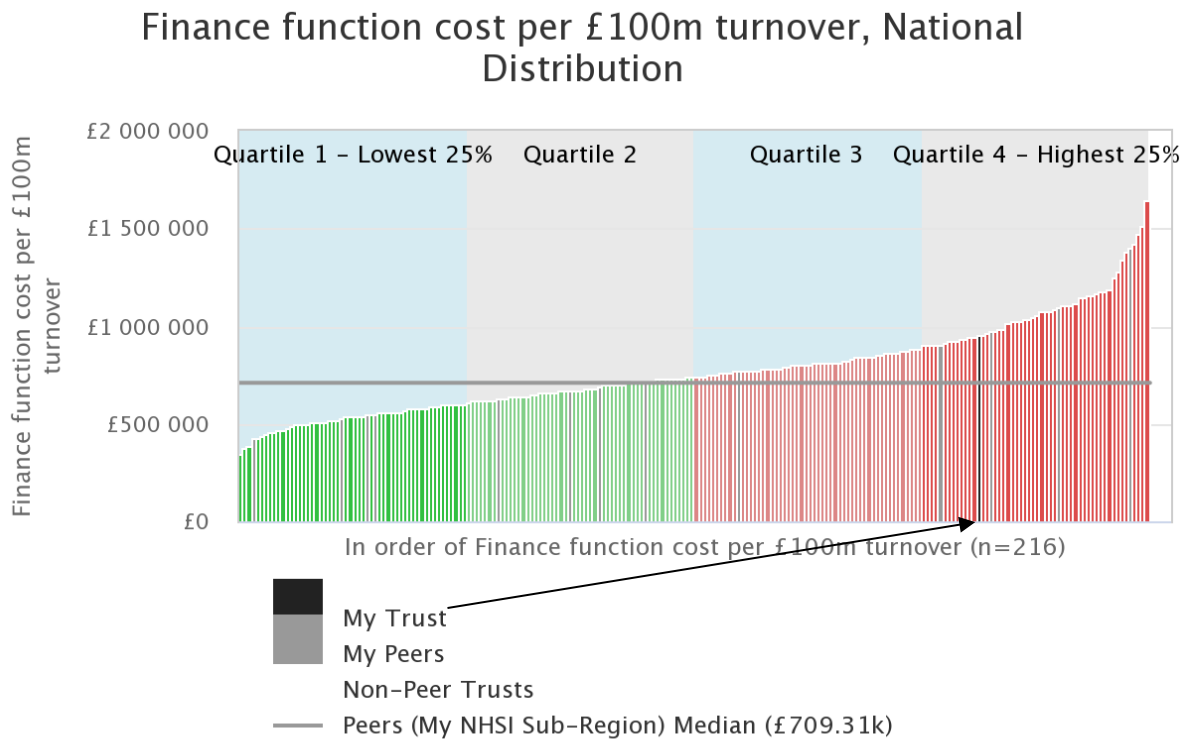
The costs for the two measures for this report are taken from the financial ledger for the Finance Department and the People Services Team. The benchmarking return includes other teams within the 'Finance' label benchmark such as the Contracting and Transformation Teams.



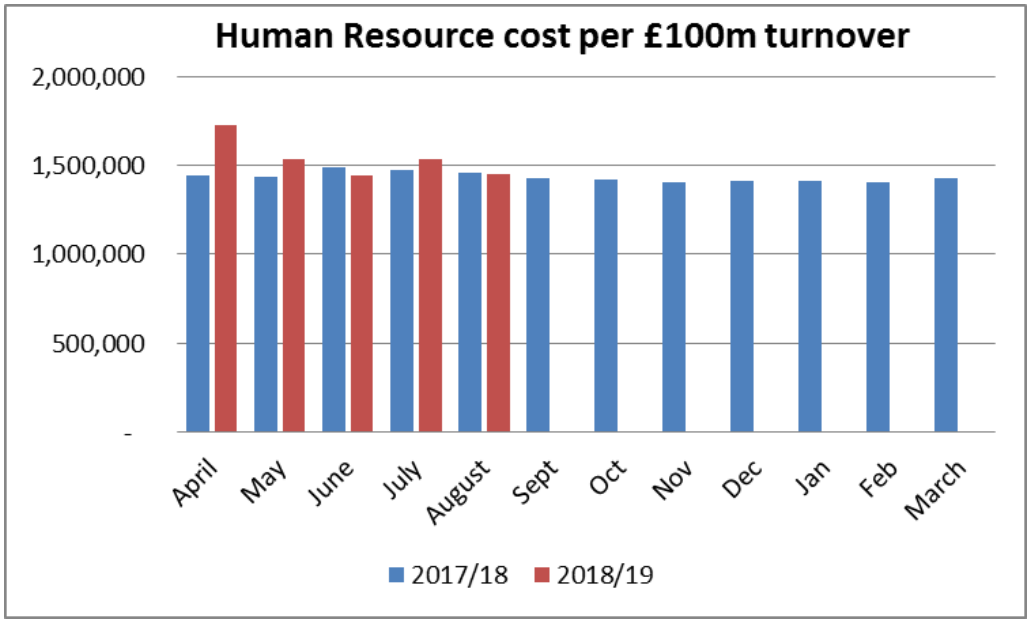
During 2017/18 there was a staff member who left and then a new starter around December which explains the down turn and then up-turn in costs for 2017/18. The costs have reduced in 2018/19 compared to 2017/18 which is due to a £50k saving on the working capital facility.

The graph below is taken from the Model Hospital which is based on the submitted corporate benchmarking information from 2016/17. The Median is at £709k with our Trust above that at £951k per £100m turnover.

Finance function benchmarking



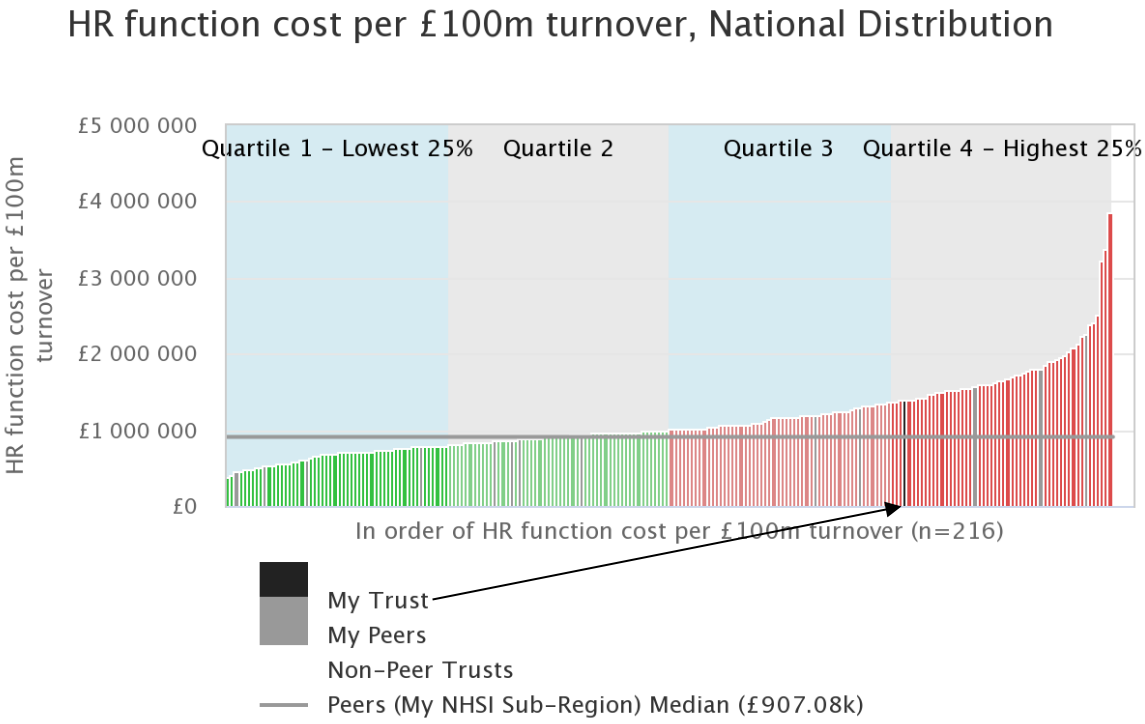
The information from the 2017/18 return has recently been received and the Finance cost per £100m turnover has reduced from £951k to £942k against the median which has increased to £721k.



The cost for the Human Resources team was fairly static in 2017/18. There was a peak in April which is mainly due to the restructure of the Shared Service with some costs remaining with our Trust that was then later recharged to the Shared Service.

The graph below is taken from the Model Hospital which is based on the submitted corporate benchmarking information from 2016/17. The Median is at £907k with our Trust above that at £1,404k per £100m turnover.

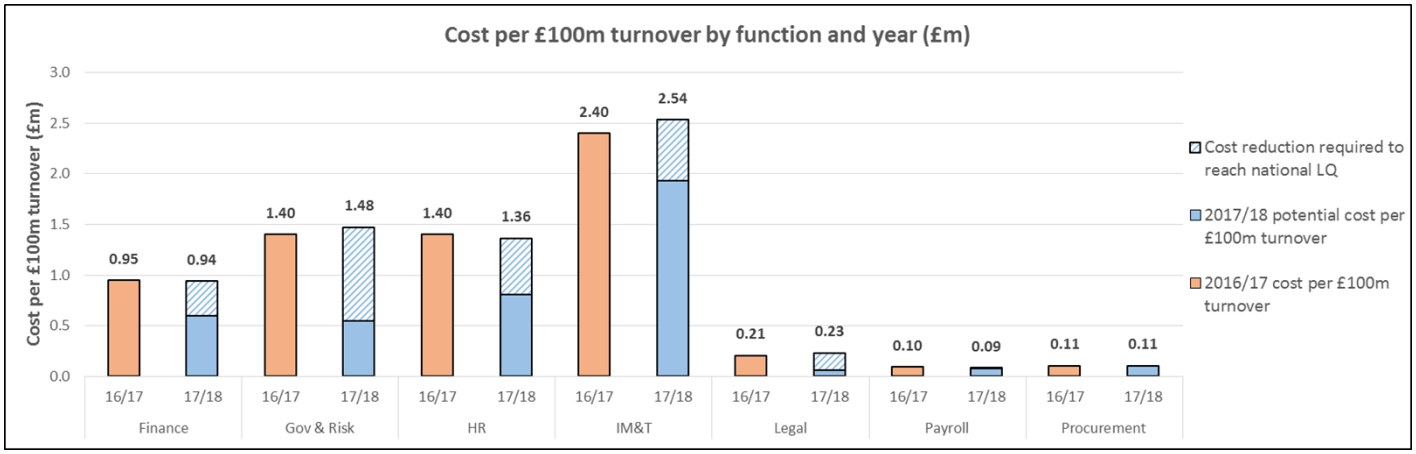
HR Function benchmarking



The information from the 2017/18 corporate benchmarking return has recently been received and the Human Resources cost per £100m turnover has reduced from £1,404k to £1,363k against the median which has increased from £907k to £1,104k.

Overall Corporate benchmarking opportunities

The 2017/18 corporate benchmarking exercise has recently become available on the Model Hospital. The summary results are shown in the graph below for the different corporate functions with the comparison to the previous year's results.



The graph illustrates the differences in cost per £100m turnover that could be achieved if we reached the lowest quartile for each of the functions

The biggest opportunities if we moved to lowest quartile values are:

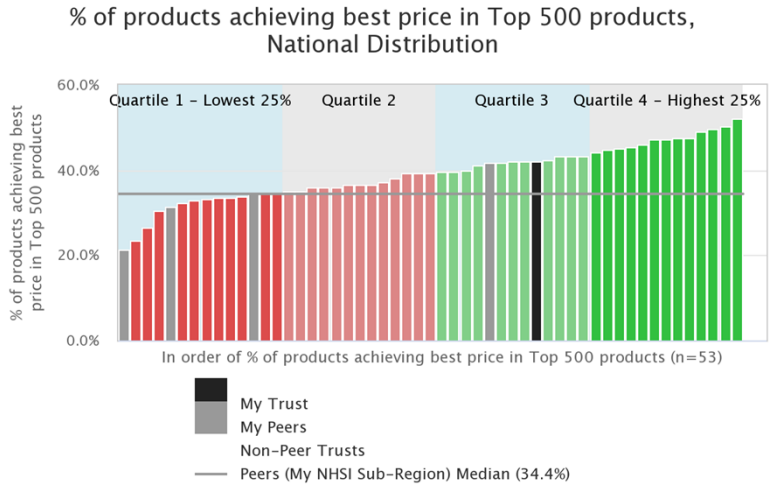
- Governance and Risk where costs per £100m could move from £1.48m to c£0.5m
- IM&T where costs per £100m could move from £2.54 to c£2.0m
- HR where costs could move from £1.36m to c£0.8m, and
- Finance where costs could move from £0.94m to c£0.6m.

- **Procurement Process Efficiency**

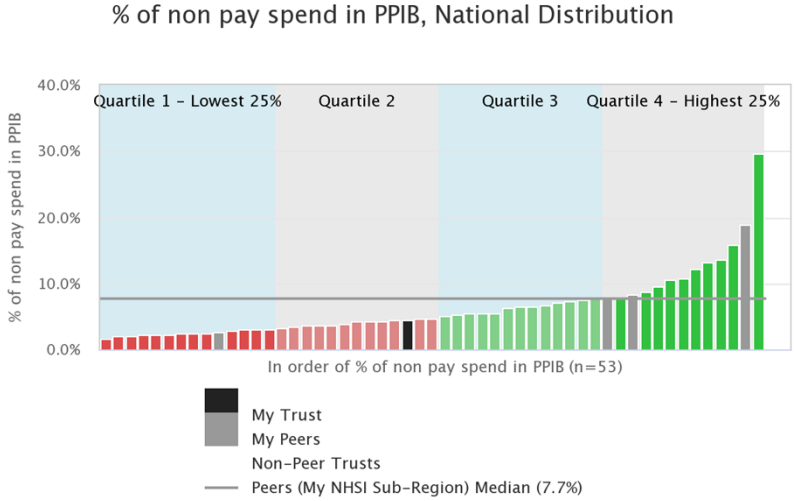
There are several procurement metrics that are published on the Model Hospital website under Purchase Price Index and Benchmarking (PPIB). Two of the metrics have been chosen to include in this report:

- Procurement - percentage of products achieving best price in top 500 products
- Procurement - percentage of non-pay spend in PPIB

42% of our products achieve best price in the top 500 products for Q4 2017/18 which is **better than the national median** of 39.4%.



Only 4.5% of non-pay spend is in PPIB for Q4 of 2017/18 against the national median of 4.6% and peer median of 7.7%.



- **Estates costs**

The information reported on the Model Hospital site is based on the information submitted through the Estates Return Information Collection (ERIC) return.

In 2016/17 our estate costs were £386 per m2 against a benchmark of £317 and peer median of £287. The table below replicates similar information showing monthly variability

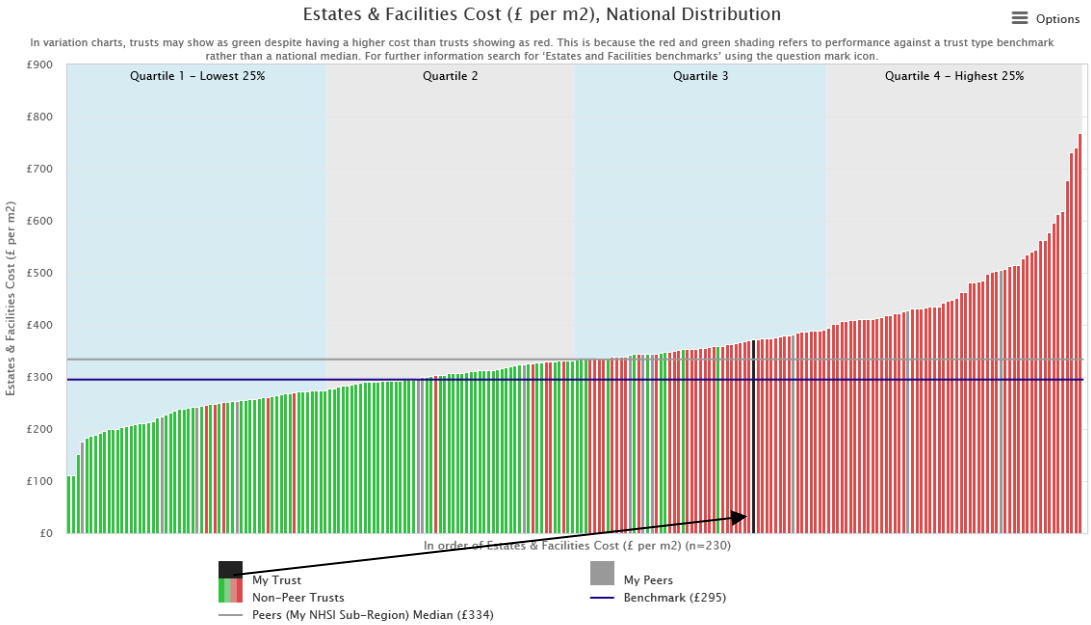
	2018/19				
	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Estates and Facilities cost per m2	300	315	322	308	337

The Model Hospital highlights Estates and Facilities as an opportunity for us, with an estimated productivity gain of between '£0m and £2.5m'.

The three metrics they identify that provide us with opportunities are:

- Hard FM potential opportunities
- Amount of under-utilised space
- Soft FM potential opportunities

<u>Benchmarking EFM costs per m2 for 2017/18</u>



Carter identified that Estate represents the largest area of non-clinical spend in the sector.

Carter highlights better succession planning, improved sustainability and energy consumption along with addressing empty and underutilised estate. It suggests rationalising estate within the STP footprints. We have PFI buildings, two empty older adult wards as well as one under-occupied low secure ward and heavily over-occupied adult acute wards.

The upcoming new estates strategy will look to address utilisation levels but it will also consider if there are any areas of 'overcrowding' or other factors that need to be addressed in order to better deliver clinical services and/or address People First priorities.

2.5 Finance: How effectively is the Trust management is financial resources to deliver high quality sustainable services for patients?

- **Finance Score**

The high level Finance Score information is generated each month from the monthly returns sent to NHSI. This score is reported in the Regulatory dashboard to the public board meeting. This information is also published on the Model Hospital website.

	2017/18	2018/19				
	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Capital Service Capacity	1	2	2	2	2	2
Liquidity	1	1	1	1	1	1
Income and Expenditure Margin	1	1	1	1	1	1
Distance from Plan	1	1	1	1	1	1
Agency Spend	2	1	1	1	1	1
Overall	1	1	1	1	1	1

The Trust has historically achieved satisfactory outcomes in terms of overall financial year end outturn. But within that overall performance there has been considerable variance in actual income and cost compared to initial planning expectations. We have also experienced increasing difficulty meeting recurrent cost improvement requirements. These factors cannot be appreciated from the high level summary metrics in the table above.

The capital service capacity measure is our worst score and is affected by having PFI as a liability and so would require a much larger surplus to pass the threshold for a score of 1.

The new approach to planning has recently been published and signals a very different approach to financial performance and a revised financial framework including a move towards breakeven, not surplus, being the target/norm. Clearly the NHSI performance metrics will need to be changed in light of this movement in approach.

In essence, our overall financial sustainability will be driven by:

- The successful delivery of productivity improvement opportunities;
- Risk management of the issues described in this paper
- Long term recurrent CIP/efficiency plan
- Successful contracting outcomes
- STP system collaborative working
- Robust income streams (in a payment system that Department of Health are signalling is likely to change fundamentally in 2019/20)

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 November 2018

Business Plans on a Page 2018/19
Quarter 2 Update

Purpose of Report

The Trust's Business Planning Process for 2018/19 includes a 'plan on a page' summary for each clinical division, corporate areas and clinical support services. Each plan on a page was turned into an action matrix, which could be monitored through the Trust Management Team (TMT) as part of the divisional performance reviews and summarised to the Trust Board on a six monthly basis to provide an update of delivery against plans, and ultimately delivery of the Trust's strategy. This report includes the Quarter 2 performance summary and the action matrix updated for Quarter 2 presented as a balanced scorecard.

Executive Summary

The report demonstrates the position forecast for Quarter 2 against the 2018/19 Plans on a page.

To give assurance, where areas are red, these are being picked up via the operational route and challenged in performance reviews through TMT or via escalation to the Executive Leadership Team (ELT). For information, where areas are seen as amber this indicates that work is ongoing and has not yet been completed, the detail of which is being discussed within performance meetings.

We are reviewing the plan on a page reporting process to ensure that it is embedded within the Trusts performance reporting framework. The plan on a page is seen as a key output from the business planning process for next year, and that it is fully embedded operationally.

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

To give assurance, where areas are red, these are being picked up via the operational route and challenged in performance reviews through TMT or via escalation to ELT. For information, where areas are seen as amber this indicates that work is ongoing and has not yet been completed, the detail of which is being discussed within performance meetings.

Consultation

This report will routinely be reviewed at Trust Management Team meetings, and as part of Divisional performance review meetings.

Governance or Legal Issues

There are no immediate governance or legal issues to note.

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

Some developments or service changes may impact on people with protected characteristics. These will be reviewed as and when they arise.

Recommendations

The Board of Directors is requested to:

1) Note the content of the paper.
2) Be assured by the performance management mechanisms that have been put in place

Report presented by: **Gareth Harry**
Director of Business Improvement and Transformation

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

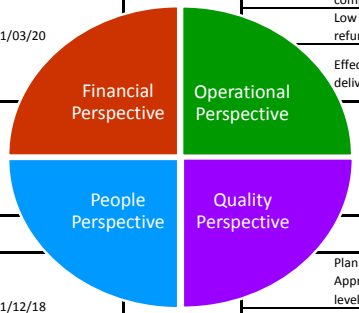
Business Plans on a Page 2018/19
Quarter 2 Update

Department	Q2 Performance		
	Red	Amber	Green
Campus	3	14	6
Central	0	18	6
Children's Services	2	23	21
Neighbourhoods	2	12	9
Pharmacy	2	3	8
Information Management, Technology and Patient Records	0	2	13
Estates	0	0	7
Communications	0	6	1
Legal Affairs	0	2	2
Governance	0	1	3
Contracting	1	4	3
Procurement	2	0	2
Programme Assurance	0	2	5
Nursing and Quality	0	3	21
People and Engagement	2	6	5
Finance	0	5	1
Total	**14**	**101**	**113**

Red = not completed or meeting trajectory for completion
Amber = not yet delivered but work in progress
Green = completed or assured of delivery

Campus Services
Plan on a Page Scorecard

Milestone	RAG	Update	Owner	Target
Create and deliver a recurrent Cost Improvement Plan		Plan in place, not yet delivered	M.H.	31/03/19
Minimse agency usage to contribute towards the Trust achieving agency ceiling		Agency spend reducing	M.H.	31/03/19
Provide information on expenditure and accurate forecast information		0	R.L	31/03/19
Contribute and support the Costing Transformation Programme - ongoing development of PLICS		0	K.P	31/03/20



Milestone	RAG	Update	Owner	Target
Urgent care clinical model review		Clinical model review and pilot underway	M.H.	31/12/18
Stepdown - Review current model and address any governance concerns		Work ongoing - still operspent	M.H.	31/12/18
High Intensity Network (HIN) - Develop work programme to address pathway issues for this cohort, establishing exactly who the term applies to and conducting a case review for the last financial year		Work programme commenced, networks and funding in place	F.W	31/12/18
Delivery of bed optimisation programme, including repatriation of out of area patients		Still overspent. BOP inlcuded in Urgent Care Action Plan and reduction in OOA	K.L	31/03/19
Review of rehab pathway, identifying a pathway to pursue and competing an options appraisal		Now under a new division	K.L	31/03/19
Low secure - Ensure full bed occupancy at Kedleston following refurbishment		Now under a new division. Bed occupancy still low and associated income risk	T.H.	31/03/19
Effective and timely rostering processes in place to support operational delivery		full roster cleanse completed on Radbourne and Kingsway. Reviewing rota system and shift pattern work still to be undertaken	C.S	31/03/19

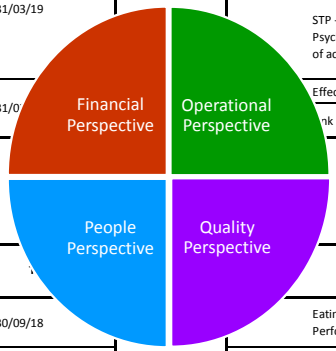
Milestone	RAG	Update	Owner	Target
Build a sustainable workforce by reviewing skill mix, plans for recruitment and retention and training opportunities		Reviewed workforce and plans for recruitment and retention under review.	M.H.	31/12/18
Reduce vacancies to maximum of 5%		Work ongoing	C.S	31/03/19
Develop empowered and compassionate leaders through the Leadership Development Programme (Team Derbyshire Healthcare), talent management and succession planning		0	C.S	31/03/19
Amplify colleague voice through pulse check feedback and staff survey results		0	C.S	31/03/19

Milestone	RAG	Update	Owner	Target
Plan created for implementation of improved audit of Care Programme Approach (CPA) and discharge summaries, with approval sought at Trust level		0	M.H.	30/06/18
Complete CQC Action Plan		2016 action plan completed, 2018 action plan ongoing	M.H.	30/06/18
Complete Green Light Toolkit		0	M.H.	31/03/19
Meeting Physical healthcare Strategy standards and the CQUIN requirements for health checks		0	D.Th	31/03/19
For all staff to have access to and undertake autism awareness training		0	D.Th	31/03/19
Improve physical healthcare for people who use our services		0	D.Th	31/03/19
Improve services for people with mental health needs who present to Accident and Emergency		0	D.Th	31/03/19
Increase staff uptake of flu vaccine in support of the Physical Healthcare CQUIN		0	C.S	31/03/19

Central Services
Plan on a Page update

Milestone	RAG	Update	Owner	Target
Create and deliver a recurrent cost improvement plan		Plan in place	DH	31/03/19
Minimise agency usage to contribute towards the Trust achieving agency ceiling		Plans in place	DH	31/03/19
Provide information on expenditure and accurate forecast information		0	RL	31/03/19
Contribute and support the Costing Transformation Programme - on-going development of PLICS		0	KP	31/0

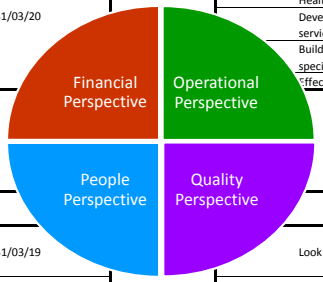
Milestone	RAG	Update	Owner	Target
Service Models: Ongoing developments of models within services; review Service Models based on feedback within Perinatal; Learning Disabilities (LD) to complete clinical pathways work; - LD to develop operational model in line with Transforming Care		Service progressed but not fully delivered	DH	31/03/19
Business Case: Improving Access to Psychological Therapies (IAPT) business case to expand into Serious Mental Illness (SMI) 3+ services; complete to ensure that new models are viable		Funding to be confirmed	JW	30/06/18
Service Specification: develop Cognitive Behavioural Therapy (CBT) specification for Specialist Psychological Therapies; IAPT to develop treatment options by exploring electronic/remote options		IAPT completed. Further work to be done on wider psychological therapy review.	DH	30/06/18
Service Evaluation: Substance Misuse service to evaluate new services, new ways of working and lessons learnt after 6 months		0	HP	30/09/18
Linking with other services and teams to develop integrated ways of working; exploration of internal requirements across services;, explore LD and Mental Health (MH) teams working closely together with formal definitions of roles		Linked to wider LD consultation	DH	30/06/18
STP - Work with Commissioners and providers to highlight client need after diagnosis; Health Psychology to work with the wider physical healthcare teams and review work undertaken and level of activity Perinatal to undertake 3 methods of working with patients and partners		On track	DH	31/03/19
Effective and timely rostering processes in place to support operational delivery		Service issues in Perinatal	CS	31/03/19
nk CBT with improved neighbourhood pathway review and redesign		Linked to Neighbourhood and psychological therapies strategy	DH	31/03/19



Milestone	RAG	Update	Owner	Target
LD service to review skill mix as part of service specification and consultation		Consultation ongoing	LR	30/09/18
Deliver basic Autism Spectrum Disorder (ASD) training and more advanced skill based training		ASD training delivered. Advanced E-Learning and bespoke training on track.	DH	30/06/18
Retraining of substance abuse staff in physical healthcare interventions		0	DH	30/06/18
Reduce vacancies to maximum of 5%		LD vacancies monitored as part of pre-consultation	CS	31/03/19
Develop empowered and compassionate leaders through the Leadership Development Programme (Team Derbyshire Healthcare), talent management and succession planning		Ongoing	CS	31/03/19
Amplify colleague voice through pulse check feedback and staff survey results		Create a better link between People Services and the teams	CS	31/03/19

Milestone	RAG	Update	Owner	Target
Eating disorders to agree new outcome tool with clinicians and joint development of Key Performance Indicators (KPIs)		Proposals under review	DH	30/09/18
Meeting Physical Healthcare Strategy standards and the CQUIN requirements for health checks		0	DTh	31/03/19
In central services, delivering compliance with Annual Health checks and Lead the Greenlight toolkit		Green light toolkit for inpatients completed. Further work to be done	DTh	31/03/19
In central services, develop a well-rounded personal health plan that identifies, prevention and reduction of avoidable admission		Linked to LD review, need to build audit cycle	CG	31/03/19
Progress and work on the High Need Support Group (157) offering interventions		0	DTh	31/03/19
For all staff to have access to and undertake autism awareness training		0	DTh	31/03/19

Milestone	RAG	Update	Owner	Target
Create and deliver a recurrent Cost Improvement Plan		Delivering above target at M5 but difficult to identify recurrent savings.	HD	31/03/19
Minimise agency usage to contribute towards the Trust achieving agency ceiling		Agency in use in CAMHS (medical), CAMHS (Dietetics) & paediatrics.	HD	31/03/19
Provide information on expenditure and accurate forecast information		x	RL	31/03/19
Contribute and support the Costing Transformation Programme - on-going development of PLICS		x	KP	31/03/20



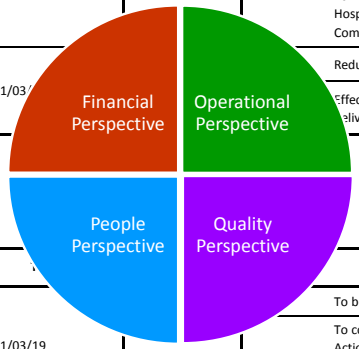
Milestone	RAG	Update	Owner	Target
Continued development and evaluation of home treatment and support in Child and Adolescent Mental Health Services (CAMHS)		Recruitment of B7 and B6 complete.	HD	31/03/19
Scope services along with commissioners around services in CAMHS becoming 0-25		Other initiatives being embedded, await White Paper.	HD	31/03/19
Continue workforce development of Future in Mind (FiM) – and interdependencies with 'place' based care		x	HD	31/03/19
0-19 services – scope alignment to localities and school clusters re future provision		x	HD	31/03/19
Provision of a clearer service delivery model for specialist paediatric services		Planning Nov '18. Specification review commening.	HD	31/03/19
Ongoing participation in workstream 7 led by CCG – out of area placement (CAMHS & Special Educational Needs and Disability (SEND))		x	HD	31/03/19
Participation in scoping of 'place of safety' discussions in Southern Derbyshire CCG (SDCCG) – and developing our response and role in development		No further discussions underway at present.	HD	31/03/19
Development of a crisis response in line with FiM		Commissioners have asked to meet, no date as yet.	HD	31/03/19
Develop an integrated Neurodevelopment pathway across services within DHcFT and with wider service providers		New pathway commencing Sept'18. Needs new website design to support.	HD	31/03/19
To work with partners on delivery of a regional Sexual Assault Referral Centre (SARC) service – mobilisation and delivery of specification		Contract commenced Sept '18.	HD	31/03/19
Future in mind developments – alignment with 0-19 services – develop shared pathways to increase community resilience		EWP workforce development ongoing.	HD	31/03/19
Alignment to trauma based services		Trauma pathway in CAMHS established.	HD	31/03/19
Review of all outstanding service specifications, providing clarity on current identified gaps		About to commence review of 2 Paed specifications. 2 CAMHS specs under review.	HD	31/03/19
Focus on future tenders – 0-19		1st year extension granted.	HD	31/03/19
Lifespan service review – eg eating disorders services		Initial discussions with Commissioners, no timetable for review.	HD	31/03/19
To work with commissioners on clarifying role and subsequent service delivery of Primary mental Health Workers (PMHW) within CAMHs services		Work underway.	HD	31/03/19
Develop an integrated Neurodevelopment pathway across services within DHCFT and with wider service providers		as above.	HD	31/03/19
Building stakeholder relationships in a changing education provision around complex health – eg special schools health provision		Work with SEND and Special Schools.	HD	31/03/19
Effective and timely rostering processes in place to support operational delivery		x	CS	31/03/19

Milestone	RAG	Update	Owner	Target
Continue workforce development of Future in Mind – and interdependencies with 'place' based care		Represented at STP	HD	31/03/19
Develop a framework of development opportunities across Division		methods being tried, eg attendance at COAT, TMT.	HD	31/03/19
Succession and progression plan for Division – including resilience of staff		x	HD	31/03/19
Ongoing review of skill mix across the services – alignment with workforce strategy		x	HD	31/03/19
Scoping and alignment of all of the roles across those who interface across age range 0-19		x	HD	31/03/19
Explore joint training / development opportunities		x	HD	31/03/19
Sharing expertise of roles across the care pathway		x	HD	31/03/19
Review of tools for the 'job' – IT systems, IT infrastructure & equipment		Trial of voice recognition software to commence.	HD	31/03/19
Work to identify flexible working and agile working opportunities and create explicit expectations around this for the service		x	HD	31/03/19
Develop 'you said we did' feedback mechanism with clinical leads, focussing on staff wellbeing		x	HD	31/03/19
Reduce vacancies to maximum of 5%		x	CS	31/03/19
Build a sustainable workforce by reviewing skill mix, plans for recruitment and retention and training opportunities		x	HD	31/03/19
Develop empowered and compassionate leaders through the Leadership Development Programme (Team Derbyshire Healthcare), talent management and succession planning		x	CS	31/03/19
Amplify colleague voice through pulse check feedback and staff survey results		x	CS	31/03/19

Milestone	RAG	Update	Owner	Target
Look for opportunity to reduce duplication of clinical intervention		x	HD	31/03/19
Further Develop transitions process for Children and Young People (C&YP) from CAMHS – CQUIN		x	HD	31/03/19
Ongoing dialogue with Commissioners re services aged 16-18 – prescribing agreements, stepdown provision,		x	HD	31/03/19
Pathways – across providers – underpinnned by SEND, among others – End of Life Care (EOLC)		EOLC - we provide sessional input and participate in research.	HD	31/03/19
Transitions between providers – need to review and agree in distinct areas		About to participate in MAPPA trannsitions work.	HD	31/03/19
Meeting Physical Healthcare Strategy standards and the CQUIN requirements for health checks	N/A	Division not part of CQUIN.	DTh	31/03/19
In children's services, contribute to one of the following: Achieving Baby Friendly status / A personal health or family support plan / A plan to reduce deterioration which results in avoidable admission		Baby Friendly status achieved 2018.	CG	31/03/19
A well rounded health and psychological plan that identifies, relapse signature and prevention reduction of avoidable admission		x	CG	31/03/19
Progress and work on the High Need Support Group (157) offering interventions	N/A	Not appicable to Divison.	DTh	31/03/19
For all staff to have access to and undertake autism awareness training		x	DTh	31/03/19
Developing EPR and technological solutions to help our teams care plan well		x	CG	31/03/19

Neighbourhood Services
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Create and deliver a recurrent cost improvement plan		Recurrent CIP not identified	DT	31/03/19
Minimise agency usage to contribute towards the Trust achieving agency ceiling		x	DT	31/03/19
Provide information on expenditure and accurate forecast information		x	RL	31/03/19
Contribute and support the Costing Transformation Programme - on-going development of PLICS		x	KP	31/03/



Milestone	RAG	Update	Owner	Target
To complete Neighbourhood Review		x	DT	31/03/19
To implement recommendations from Neighbourhood Review		Work on recommendations from review ongoing	DT	31/03/19
To recruit and operationalise the North Dementia Rapid Response Services (DRRT)		x	AH	31/12/18
To establish STP plans for the following services: Older Peoples Day Hospital; Community Rehab Services; Community Personality Disorders (PD) Services; Community Forensic Services		x	TBC	31/03/20
To implement STP plans for the following services: Older Peoples Day Hospital; Community Rehab Services; Community PD Services; Community Forensic Services		x	DT	31/03/20
Reduce vacancies to minimum of 5%		x	CS	31/03/19
Effective and timely rostering processes in place to support operational delivery		x	CS	31/03/19

Milestone	RAG	Update	Owner	Target
Reduce vacancies to maximum of 5%		x	CS	31/03/19
Develop empowered and compassionate leaders through the Leadership Development Programme (Team Derbyshire Healthcare), talent management and succession planning		x	CS	31/03/19
Amplify colleague voice through pulse check feedback and staff survey results		x	CS	31/03/19

Milestone	RAG	Update	Owner	Target
To benchmark services against NICE Guidelines		x	PB	30/09/18
To complete Comprehensive Case File Audit and implement associated Action Plan		Not all due in until October. Pushed back to December	KW	31/12/18
To hold bi monthly meetings to embed effective Neighbourhood Dementia Lead network		x	SW	31/03/19
To implement a county wide service monitoring physical health needs of people prescribed anti psychotic medication		x	DTh	30/06/18
Meeting Physical Healthcare Strategy standards and the CQUIN requirements for health checks		x	DTh	31/03/19
A well rounded health and psychological plan that identifies, relapse signature and prevention reduction of avoidable admission		x	CG	31/03/19
Progress and work on the High Need Support Group (157) offering interventions		x	DTh	31/03/19
For all staff to have access to and undertake autism awareness training		x	DTh	31/03/19
Developing EPR and technological solutions to help our teams care plan well		x	CG	31/03/19

Pharmacy
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Provide Associate Clinical Director (ACDs) and prescribers with information on prescribing costs, volume and patterns to allow benchmarking between colleagues		Currently proveded every 6 months. In future will be shared quarterly with MMC, TMT and QC	SJ	31/03/19
Provide information on trends and changes in medicines expenditure to the Drug and Therapeutics Committee and the Trust management Team		Quarterly presentation to TMT and MMC (formerly D&T)	SJ	31/03/19
Review the current model for purchasing and distributing pharmaceuticals in-line with anticipatd publication of Lord Carter's report into prouctivity of Mental Health and Community Health Services NHS Trusts in England		Review will be completed in Q4	SJ	31/03/19

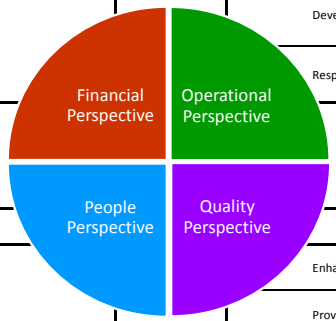
Milestone	RAG	Update	Owner	Target
Provide pharmacist and pharmacy technician support to the Dementia Rapid Response Teams to improve access to medication for service users and to support clinical teams in the pharmacological management of complex cases		Technician role created in DRRT south (no funding for pharmacist support). Provide 0.1 WTE Technician and 0.1 WTE Pharmacist support to DRRT High Peak as per funding. Will provide 0.1/0.1 to DRRT Chesterfiled when resources permit	SJ	30/06/18
Provide pharmacist and pharmacy technician support to the Crisis Resolution and Home Treatment teams to improve access to medication for service users and to support clinical teams in the pharmacological management of complex cases		Technician appointed to role supporting CRHT north 0.6WTE - yet to commence in post. Technician role created in CRHT south - to be readvertised. No fundingprovided for pharmacist support to DRRT	SJ	31/03/19
Focus a greater proportion of specialist mental health pharmacist resource towards the Neighbourhoods to support work through clinical advice and contact with service users to reduce frequency of admission to inpatient care		No resources currently available to permit new work, and not possible to detach resources from inpatient wards	SJ	30/09/18
Focus a greater proportion of Pharmacy Technician resource towards the Neighbourhoods to support the development of systems to better manage medicines, particularly depot injections in the first instance, to reduce the risk of treatment breakdown		No resources currently available to permit new work, and not possible to detach resources from inpatient wards	SJ	30/09/18

Milestone	RAG	Update	Owner	Target
Introduce a new role of Chief Pharmacy Technician – team Manager to provide management support for and lead development of Pharmacy Technicians and Pharmacy Support Workers in the department		Role currently filled as "acting-up". To be made substantive in Q4	SJ	30/06/18
Continue to generate revenue from pharmacy staff developing and / or delivering resourced training		Revenue generated from training activities including pre-registration pharmacist placements from the University of Nottingham	SJ	31/03/19
Support pharmacy staff to study for advanced qualifications relevant to their specialist role, to enable them to support Trust teams with this expertise and to facilitate recruitment and retention in a challenging environment		Three pharmacists currently undertaking courses (1 certificate, 2 diploma)	SJ	31/03/19

Milestone	RAG	Update	Owner	Target
Work with Senior Management to develop an implementation strategy for Electronic Prescribing and Medicines Administration		Work in early stages. Support provided includes highlighting national funding available and requirements for application	SJ	31/03/19
Continue to work with Derbyshire Community Health Services (DCHS) and East Midlands Ambulance Service (EMAS) to provide high-quality medicines supply services		DCHS fully supported until the end of their contract on 31/10/18. Continue to provide service to EMAS and to the St Oswald's outpatients department (part of Derby Teaching Hospitals NHSFT)	SJ	31/03/19
Continue to work with DCHS to provide clinical services		Continue to work with DCHS until the end of their contract on 31/10/18	SJ	31/03/19

Information Management, Technology and Patient Records
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Deliver required Cost Improvement Plan (CIP)		Budget costs all identified and budget removed	PC	31/03/19



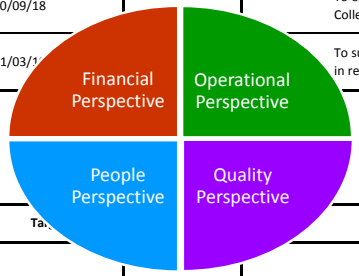
Milestone	RAG	Update	Owner	Target
Investigate Electronic Prescribing and Medicines Administration (EPMA) system functionality		Forming part of the current EPR review	PC	30/09/18
Explore the capabilities of Voice Recognition		Not currently a priority as resources are working on eRostering	PC	31/03/19
Continue to enhance integration within the Trust and with other organisations to make the Trust more efficient		Working on the EPR based on CRG direction	PC	31/03/19
Ensure patients have appropriate access to their records		processes in place to redcat and deliver patients records when requested	PC	31/03/19
Development of apps to support clinicians and patients		Development of Obs App. 2 development team members in the process of being recruited	PC	31/03/19
Respond efficiently and affectively to any issues or enhancements raised by the Trust		continual improvement based on Trust requests	PC	31/03/19

Milestone	RAG	Update	Owner	Target
Enhance network to support Agile working		HSCN contract signed	PC	31/03/19

Milestone	RAG	Update	Owner	Target
Enhance Electronic Patient Record to reflect required clinical processes		Working on the EPR based on CRG direction	PC	31/03/19
Provide reliable technical environments and support services		Implementation of ATP, Windows 10 and EPR platform upgrade	PC	31/03/19
Maintain appropriate Cyber Security measures to protect the Trust		Implementation of ATP, windows updates, rigor processes	PC	31/03/19
Deliver all NHS England or Clinical Commissioning Group (CCG) mandated information on time and of the required quality		All information provided on time	PC	31/03/19
Maintain our Information Governance (IG) excellence and implement General Data Protection Regulation (GDPR) by end of May 2018		GDPR plan developed and actions progressing to plan	PC	31/03/19
Ensure patients paper records are efficiently processed and stored		Reduction in on site storage of paper records now supporting other teams to undertake the process	PC	31/03/19
Provide access to SystmOne or PARIS to ensure clinicians can access records when appropriate		All those who ask for access have been provide with it	PC	31/03/19

Estates
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Create and deliver a recurrent cost improvement plan		Complete	LB	30/09/18
Work within budget constraints make sure break even at year end		On track	SD	31/03/1



Milestone	RAG	Update	Owner	Target
To ensure completion of annual returns Estates Return Information Collection (ERIC) and Project Assurance Model (PAM)		ERIC completed and PAM ongoing	SD	31/03/19
To support through capital and the Trust Estate Strategy, clinical services in redesigning their services		Ongoing	SD	31/03/19

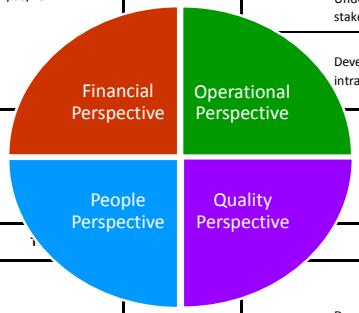
Milestone	RAG	Update	Owner	Ta.
To work with the wider Healthcare community in compiling a Derbyshire Wide Estate Strategy and ensuring best use is made of all premises		Completed through the STP	LW	31/03/19
Amplifying colleague voice through action		Local staff engagement events planned	SD	31/03/19

Milestone	RAG	Update	Owner	Target
Ensuring preparedness for the next Care Quality Commission (CQC) visit. Estates to ensure compliance files are current		Complete	SD	31/03/19

Communications and Involvement
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
To determine best value options for graphic design support into the organisation.		To be reviewed by ELT	AS	31/03/19

Milestone	RAG	Update	Owner	Target
To develop a comprehensive understanding and record of the Trust's stakeholder engagement activities.		Process underway	AS	31/12/18
To identify key stakeholders and prioritisation in order to deliver the Trust strategy.		Identification taken place - prioritisation continues	AS	31/12/18
Undertake a brand audit to asses the Trust's current reputation amongst stakeholders		Scheduled for October	AS	31/12/18
Development of a new extranet, to replace the existing Trust website and intranet.		Website due to launch in November, following which specification will be developed for new intranet	AS	31/03/19



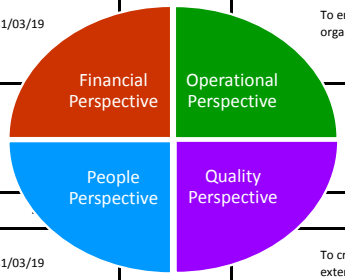
Milestone	RAG	Update	Owner	Target
Develop and implement a new programme of staff engagement. Implement system to capture staff engagement feedback. Identify key themes from staff engagement and ensure appropriate response		New programme developed and in implementation. Key themes being captured and due for future analysis at People and Culture Committee	AS	31/10/18

Milestone	RAG	Update	Owner	Target
Development of a new Trust-wide Communications Strategy and associated policies		Communication strategy being submitted to People and Culture Committee in October for sign off. Policies have already been approved.	AS	31/10/18

Legal Affairs
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
To optimise external legal use to achieve value for money by rationalising legal services to one provider wherever possible [or to rationalise legal services to one framework thus ensuring consistent costs across the various departments that access legal services].		In the final stages of rationalising providers	AC	31/03/19

Milestone	RAG	Update	Owner	Target
To ensure that the Accessing Legal Advice Policy is fully embedded in the organisation		Well embedded	AC	31/03/19

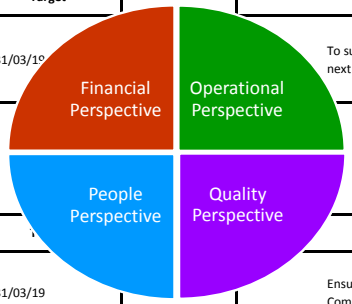


Milestone	RAG	Update	Owner	Target
To create a self-sustaining internal system of knowledge to minimalize external legal expenditure.		Some gaps where areas for improvement has been identified	AC	31/03/19

Milestone	RAG	Update	Owner	Target
To create a self-sustaining internal system of knowledge to minimalize external legal expenditure.		Some gaps where areas for improvement has been identified	AC	31/03/19

Governance
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Maintain an effective and streamlined governance structure, which releases indirect savings and ensures financial sustainability		Governance calendar for 18/19 reflects a streamlined governance arrangements. Frequency of meetings reviewed and reduced	SH	31/03/19



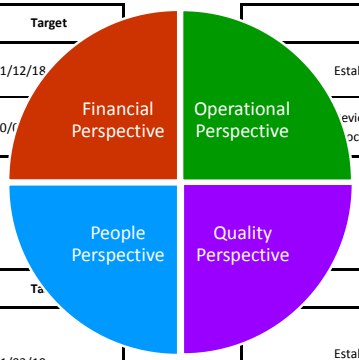
Milestone	RAG	Update	Owner	Target
To sustain and embed governance improvements in preparation for the next external well-led framework review		Report to Board in November on actions arising from the latest well-led review.	SH	31/12/18

Milestone	RAG	Update	Owner	Target
Ensure that there is good governance practice embedded throughout the organisation		Internal audit underway to review divisional goverance/accountability arrangements.	SH	31/03/19

Milestone	RAG	Update	Owner	Target
Ensure continued improving effectiveness of Board and Board Committees		Year end effectivenes reviews and surveys planned for Jan-March 2019.	SH	31/03/19

Contracting and Business Development
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Implement revised governance processes for 2019/20 contract negotiations		Currently testing IT solution before rolling out	L.W-S	31/12/18
Quarterly reconciliation of contracts with invoices and increased rigour of uplift		Monthly contract meeting with finance and review of income	JS	30/



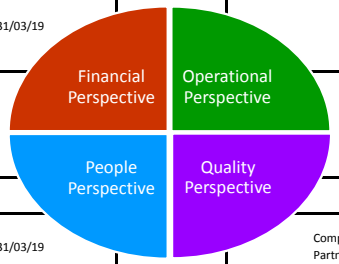
Milestone	RAG	Update	Owner	Target
Establish permanent second Business Development Manager Post		Business case for additional permanent BDM case not approved	JS	30/06/18
eview the Contract Negotiation Protocol and contractual governance ocesses		CCG consultation and contract management structure not confirmed.	JS	30/06/18

Milestone	RAG	Update	Owner	Ta
Continue development of Business Bytes programme to support organisational development – roll out specific programmes to certain staff groups, expand topics, market internally to improve uptake		Business bytes programme to be relaunched - bespoke training has been delivered to clinical teams	JS	31/03/19
Develop a suite of best practise guides and templates for the intranet (i.e. business case development)		Team capacity reduced	JS	30/09/18

Milestone	RAG	Update	Owner	Target
Establish internal web based contract systems – finalise roll out of online contract database and initiate development of reporting module		Team capacity reduced	JS	31/03/19
Options developed for alternative contractual governance frameworks in Sustainability and Transformation Plan (STP) environment		No STP direction on contract frameworks	JS	30/09/18

Procurement
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Procurement re-org. plan proposed and under consideration		Not approved by Execs	RH	31/03/19
3 year Procurement Work Plan completed and continuous monitoring of cost reduction opportunities through use of Purchase Price Index and Benchmarking (PPIB) and emerging Future Operating Model (FOM)		0	RH	31/03/19



Milestone	RAG		Update	Owner	Target
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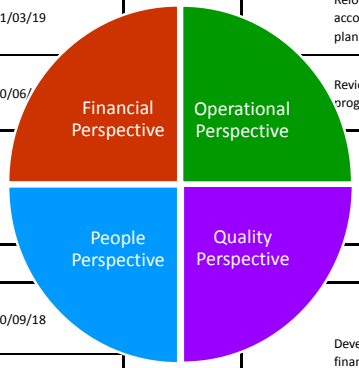
Milestone	RAG	Update	Owner	Target
Continued development of Purchasing Team to provide greater support to the organisation		New staffing structure agreed by ELT on 15th October	RH	31/03/19

Milestone	RAG	Update	Owner	Target
Completing the CQC action plan and the preparedness plan for next year – Partnership section completed and kept up to date as required		0	RH	31/03/19

Programme Assurance
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Work across the Trust to create and deliver a re-current cost-improvement-plan		90% achievement rate.	JW	31/03/19
Further development of Programme Assurance process generating leadership and accountability		Process has been improved with further improvements planned.	JW	30/06/



Milestone	RAG	Update	Owner	Target
Relocate team to Kingsway House base following series of moves to accommodate wider estate strategy. Including Contracts and STP in the plan		Office reloaction completed.	JW	30/06/18
Review team structure and job descriptions to ensure fit for purpose programme office delivery and assurance function		On schedule for review.	JW	30/09/18

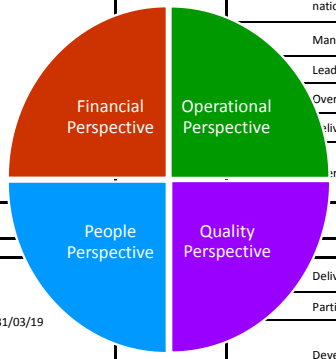
Milestone	RAG	Update	Owner	Target
Develop co-production approach to continuous improvement process		Approach developed and incorporated into the Quality Strategy, CQI and annual planning cycle.	JW	30/09/18
Team development for sustainable capability relating to CQI		CPD plans are progressing and on track.	JW	30/09/18

Milestone	RAG	Update	Owner	Target
Develop Continuous Quality Improvement (CQI) methodology to support financial sustainability		Discussions progressing in September with Exec Team around effective monitoring and control of CQI.	JW	30/09/18

Nursing and Quality
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Support the achievement of CQUINs		Q1 main contract CQUINs submitted as required, all achieved aside from expected challenge around physical health	DTh	31/03/19

Milestone	RAG	Update	Owner	Target
Support Area Service Managers (ASMs) in their understanding of and delivery of Commissioning for Quality and Innovation National Goals (CQUINs)		In partnership with Heads of Nursing and individual CQUIN leads	DTh	31/03/19
Engage operational colleagues in the delivery of the Schedule 4 Quality Contract		Support offered as and when required	DTh	31/03/19
Provide training on the reporting of incidents, including serious incidents, ensuring they are accurate and promoting a culture of candour		Training is ongoing, including in Team bases	DTh	31/03/19

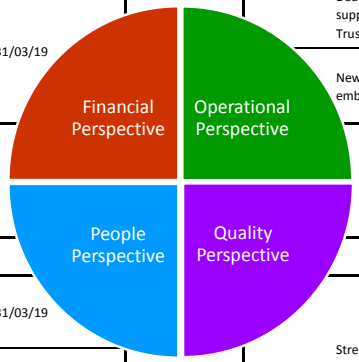


Milestone	RAG	Update	Owner	Target
Ensure the Trust meets its legal duties around Safeguarding Children & Adults		New "Working Together 2018" document is being reviewed by Safeguarding Children's Board from a multi-agency perspective. Proposed changes not yet mandated.	TN	31/03/19
Ensure the Trust meets its legal duties around Infection Prevention & Control		2017/18 Annual report submitted to Quality Committee. No significant changes.	RM	31/03/19
Ensure the Trust meets its legal duties around the Mental Health Act and Mental Capacity Act		Assumed Green	KB	31/03/19
Ensure the Trust meets its legal duties around Health & Safety		0	CG	31/03/19
Report on the Schedule 4 Quality Contract to the Clinical Commissioning Groups (CCGs)		All submitted as required at the current time, no concerns raised by commissioners after Q1	DTh	31/03/19
Oversee the reporting process and submit CQUIN evidence to the CCG and NHS Improvement (NHSI)		Completed for Q1	DTh	31/03/19
Oversee the Trust position on Patient Safety and Mortality, submitting committee reports and national data as appropriate		0	RW	31/03/19
Manage, respond and report appropriately to all complaints that come to the Trust		Assumed Green	AR	31/03/19
Lead on our carer involvement work		Assumed Green	WS	31/03/19
Oversee and manage the Datix incident reporting system		Ongoing	RK	31/03/19
eliver the annual Quality Report		Data being gathered over the year	DTh	31/03/19
rsee the annual Quality Visit programme		Current programme coming to an end for this year, awards to then be decided	DTh	31/03/19

Milestone	RAG	Update	Owner	Target
Deliver the Quality Improvement Strategy for the Trust		Implementation plan in place	DTh	31/03/19
Participate in the national patient safety campaign 'Sign up to Safety'		0	RW	31/03/19
Develop a structure to demonstrate our position around NICE Guidelines and promote their use		NICE Steering Group is established, some initial challenges around mapping our alignment to NICE	DTh	31/03/19
Improve level of Datix reporting		Next 6 monthly NRLS due end of September which will allow comparison with other similar MH trusts.	RK	31/03/19
Engage with the NHS Staff Health and Wellbeing agenda for the Nursing & Quality Team		Managed via supervision and appraisal	DTh	31/03/19
Offer leads for each CQUIN and enable teams to succeed		All CQUINs have an operational lead and an aligned Head of Nursing	DTh	31/03/19
Revise the Quality Visit programme – to a new model		New model is established and delivered	CG	31/03/19
Design a new Quality Improvement strategy and define agreed methodology toolkit that can be used		QI Strategy signed off by Quality Committee	CG	31/03/19

People Services
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
Create and deliver a recurrent cost improvement plan		No CIP applied to People Services	CS	31/03/19
Achieve agency ceiling		Continued work focussed on Medical agency spend through Medical Director and Head of People Resources	CS	31/03/19



Milestone	RAG	Update	Owner	Target
Joined up recruitment processes that reduce time to recruit		Trajectory on track to achieve target by end of 18/19	CS	31/03/19
Dedicated Bank for Derbyshire Healthcare NHS Foundation Trust supported by Derbyshire Community Health Services NHS Foundation Trust		Complete	CS	31/03/19
New structure to provide HR support to divisions e.g. Business partners embedded in services providing strategic advice and support		New Divisional People Leads (DPL) in place with defined portfolios as of 1st Sept 18	CS	31/03/19

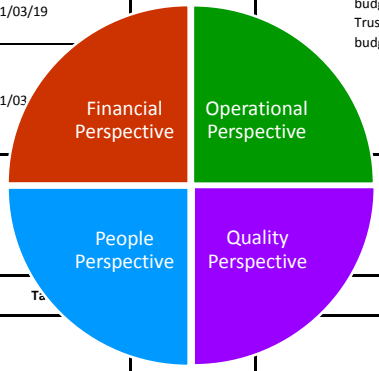
Milestone	RAG	Update	Owner	Target
Amplifying colleague voice through pulse check feedback and staff survey results		Staff survey 18/19 starts Monday 24th September and pulse check closes of Sunday 23rd September	CS	31/03/19
Promote Staff Forum and attendance across DHCFT, feedback and outcomes published		Complete	CS	31/03/19
Promote Equalities Forum		Work ongoing	CS	31/03/19
Effective Appraisal process		New appraisal process proposal has been to ELT in September. Further work to be done	CS	31/03/19
Attract, develop and retrain strategy		Complete	CS	31/03/19
Flexible career pathways		Work ongoing	CS	31/03/19

Milestone	RAG	Update	Owner	Target
Strengthened employee relations team, reducing length of investigations and improving outcomes		As of August 2018, 36 open employee relations cases with a target to complete within 50 days. Continued work between Employee Relations and Staffside to review disciplinary policy and procedure.	CS	31/03/19
Developing empowered and compassionate leaders through Leadership Development Programme. Team Derbyshire Healthcare, Talent Management and succession planning		Leadership Development Programme in draft form to be finalised by the end of October.	CS	31/03/19

Finance
Plan on a Page Update

Milestone	RAG	Update	Owner	Target
To support the delivery of the short term and long term financial plans		Financial plans submitted to NHSI of which are being managed in year. Forecasting to deliver those plans. Will be completed with the conclusion of year ends. On track to deliver.	RL	31/03/19
Provide information on expenditure and accurate forecast information		Information is being provided to budget holders, ELT, TMT, F&P and Trust Board	RL	31/03/19
Contribute and support the Costing Transformation Programme - on-going development of Patient Level Information and Costing Systems (PLICS)		This is on-going working towards the mandatory deadline	KP	31/03

Milestone	RAG	Update	Owner	Target
Continue to provide a responsive service to budget holders and senior managers across the Trust to enable them to effectively manage their budgets		Information is being provided to budget holders, ELT, TMT, F&P and Trust Board	RL	31/03/19



Milestone	RAG	Update	Owner	Ta
Provide information and support to managers to support the delivery of the 2018/19 efficiency programme		Information is being provided to managers. Cost avoidance schemes are being reported to PAB	RL	31/03/19

Milestone	RAG	Update	Owner	Target
Involvement in the National Costing Transformation Programme groups		This is on-going working towards the mandatory deadline	KP	Ongoing

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors - 6 November 2018

Deloitte Well-Led Framework Review Phase 3 Recommendations Progress Update

Purpose of Report

To present an update on progress with agreed actions to address recommendations arising from the Phase 3 Deloitte review of the Trust's governance arrangements assigned to the Committee for 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 NHSI 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 was broadly in line with our own self-assessment. 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 31 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.

Following discussion with Board members these were assigned to Board Committees to take oversight and to receive assurance on progress with the recommendations. Details were agreed with respect to lead Executive Director, operation Committee (where relevant) and the operational oversight Committee (either TMT (Trust Management Team) or ELT (Executive Leadership Team)) to ensure that there would be pace and progress to address the recommendations raised. The forms developed also outline how each Committee is to be assured on progress and how action taken will be sustained and embedded.

The forms summarising the recommendations made, actions and scope proposed to address, and proposals for assurance reporting were presented and agreed by Board Committees during March and April 2018.

The attached forms provide a six monthly update on progress which have been scrutinised and RAG ratings reviewed at Board Committees during September/October. Comments arising from discussion at these meetings are shown in red text. The exceptions are the two recommendations which are for Board oversight, and which are presented direct to the Board. The unconfirmed RAG ratings are shown in italics for these recommendations.

Progress on all recommendations was discussed at the Executive Leadership Team on 15 October 2018. Discussion focussed on the position of progress rated Amber and Red and is reflected in the update summaries below.

A summary of the position of the recommendations is as follows:

Recommendation	Current Position
1: Strategy	This recommendation was rated Green and complete in April 2018 and confirmed at the October 2018 meeting. Further assurance of a sustained approach to business planning in terms of implementing planning in teams and measurement of success will be taken forward as part of annual planning for 2019/20 and as a result of the Board's current work on reviewing the Trust Strategy
2: Annual Planning	This was presented to Finance & Performance Committee in March 2018 and agreed as Green-Complete and endorsed in October. The form highlights plans to enhance and further embed wider involvement in business planning in the 2019/20 planning process
3: Risk Assurance/ Escalation Report	This was RAG rated Green-Complete for March, July and October meetings of the Audit & Risk Committee. The high/extreme operational risks were successfully reported as part of the BAF reporting round for issue 2 and this will continue on a six-monthly basis
4: Risk Management Training	RAG rated Amber in March, and Green-Complete in July and October by the Audit & Risk Committee. The tiered management programme has been effectively developed and the form outlines a planned update of future operational and

	assurance reporting against uptake and evaluation feedback
5: QIA Process	This was agreed as Green-On Track in March 2018 and agreed as Green-Complete (by the June 2018 deadline) at the Quality Committee held on 9 October. This reflects the relaunch of the QIA process and confirmation of the ongoing review of this process by the Quality Committee. The Committee discussed and greed format of future reporting required
6: Staff Objectives	Agreed as Amber rated in March 2018. Discussion at ELT (15 October) focussed on the delay in developing the Trust's revised appraisal process, which was due to awaiting national direction relating to implementation of the pay deal. ELT have discussed and agreed a draft appraisal document which will now be circulated to groups for consultation prior to implementation. PCC in October 2018 agreed the proposal that the rating remains as Amber, with an amended delivery date of April 2019 to reflect that all plans are in place but not yet delivered.
7: Sharing Learning	This was agreed as Green-On Track in April 2018 and then agreed as Green-Complete at Quality Committee on 9 October, reflecting that the Executive Serious Incident Group has been operational for several months and has identified and effectively shared learning from serious incidents. The Committee requested that future SIRI reports should evidence learning from cases and subsequent change in practice. It was requested that a summary of learning including analysis of themes should be presented to the Quality Committee in March 2019 (single page report)
8: Datix Training	RAG rated Amber in March and Green (On Track) in July and October 2018 (Complete). Targeted training continues and there is an ongoing programme of promotion and awareness. An overview of training uptake will be presented to the Committee in March 2019
9: IPR	It is proposed that this recommendation moves from Green-On Track status as at March 2018 to Green-Complete given the review of metrics, the successful aligning of metrics to strategic objectives, and clear trajectories included in the report, as well as evidence of ongoing review and development of the report
10: Data Quality	RAG rated Green-On Track in March 2018 and agreed that this rating should remain at October 2018 Audit & Risk Committee meeting, as actions are scheduled to be complete by the end of October deadline. This comment was initially proposed for oversight by the Finance & Performance Committee who did so at their meeting on 26 March 2018. Later discussion by Board members agreed that actions responding to this comment should fall under the remit of the Audit & Risk Committee. An update report on the achievement of Recommendation 10 on data quality will take place at the extraordinary Committee meeting taking place on 4 December to incorporate the management response from the internal audit follow up on data quality which will presented at the same meeting
11: Improvement Methodology	This was agreed as RAG rated Red at the March 2018 Finance & Performance Committee meeting and proposed to shift to Amber rating at the September meeting. Although acknowledging the approval of the Quality Improvement

	Strategy by the Trust, the Committee confirmed that the status should remain as Red pending further clarification on approach across the Trust to be presented to the Committee in December 2018. Please note that this is a comment arising from the Deloitte report, not a formal recommendation, however it is acknowledged as a priority area for the Trust to take forward, to include focus on leadership development areas of the proposed actions
12: Staff Views on Data	Response to this comment was agreed as Red RAG rating in March 2018 and July 2018. Following update and discussion at Finance & Performance Committee in September 2018 it was agreed to move this to Amber rating. This reflects the progress made by the EPR Clinical Reference Group by the June 2018 deadline, but noting that there is further work to progress and embed actions. As this is a comment rather than a recommendation the Committee agreed that they would take assurance from wider reporting to the Committee relating to IM&T developments and response to related CQC inspection findings. It was proposed that Green-Complete status will be achieved once there are mechanisms in place to collect staff feedback and set appropriate action planning for validated statements

Specific comments/additions to the forms reflecting Committee debate as outlined above are highlighted in red type on the forms themselves.

In terms of progress:

9/10 recommendations are agreed RAG rated Green (eight completed and one on track – within timeframe). *(NB Two are proposed Complete pending review by Board)*.

The recommendation listed as Amber relates to the development of the Trust's appraisal process. This is currently out to consultation and the People & Culture Committee confirmed at their meeting on 22 October that confirmation of implementation of the plans as outlined, to include assurances that this process is robust, has engaged staff and ensures staff objectives may be set appropriately, would deem the action as Green-Complete (April 2019).

Of the two Comments in the report, one is RAG rated Red and one is RAG rated Amber (as detailed below):

The one Red rated response relates to the comments regarding the Trust's progress and implementation of continuous quality improvement. This position was discussed and clarified at ELT on 15 October, where it was confirmed that a training needs analysis, implementation plan, and list of projects where the methodology had been implemented would be produced to evidence progress in this area. This would form part of agreed reporting to Finance and Performance (December 2018).

One area listed as Amber is the comment relating to staff feedback regarding the electronic patient record. The status has moved from Red to Amber over the past six months. The Trust is working to review current systems and include staff in future decision making on EPR systems. The Committee will receive further assurance as

part of its business as usual remit and once satisfactory additional reporting is received in December, outlining the frameworks to be taken forward, this response may be deemed Green and Complete.

Recommendation /Comment	Executive Lead	Board Committee (Exec lead)	Scheduled Timescale to complete	RAG rating March 2018	Board Committee Six Month Review	RAG rating October 2018
1. Strategy	Gareth Harry	Board (SH)	Apr 2018	Green Complete	06 Nov 2018	*Green Complete*
2. Annual planning	Gareth Harry	Finance & Performance (CW)	Apr 2018	Green Complete	18 Sep 2018	Green Complete
3. Risk assurance / Escalation report	Sam Harrison	Audit & Risk (SH)	Jul 2018	Green On track	04 Oct 2018	Green Complete
4. Risk management training	Carolyn Green	Audit & Risk (SH)	Apr 2018	Green Complete	04 Oct 2018	Green Complete
5. QIA process	Gareth Harry	Quality (CG)	Jun 2018	Green On track	09 Oct 2018	Green Complete
6. Staff objectives	Amanda Rawlings	People & Culture (AR)	Jul 2018	Amber	22 Oct 2018	Amber
7. Sharing learning	John Sykes	Quality (CG)	Sep 2018	Green On track	09 Oct 2018	Green Complete
8. DATIX training	Carolyn Green	Audit & Risk (SH)	May 2018	Green On track	04 Oct 2018	Green Complete
9. IPR	Mark Powell	Board (SH)	Oct 2018	Green On track	06 Nov 2018	*Green Complete*
10. Data quality	Mark Powell	Audit & Risk (SH)	Oct 2018	Green On track	04 Oct 2018	Green On Track

Status marked in italics reflects discussions pending

In addition to the ten recommendations highlighted in the Deloitte report there were two comments which we agreed to oversee progress upon as part of 'business as usual':

11. Improvement methodology	Gareth Harry	Finance & Performance (CW)	Dec 2018	Red	18 Sep 2018	Red
12. Staff views on data	Mark Powell	Finance & Performance (CW)	Jun 2018	Red	18 Sep 2018	Amber

Please note that the Executive Lead for the QIA Process has changed from Carolyn Green to Gareth Harry since the last reporting round to ELT/Board.

The agreed RAG rating for this process is as follows:

GREEN: Recommendation fully implemented to deadline with clear plans to embed/sustain. A rating of 'Green-On Track' may also be used to indicate that progress is being made to plan to meet a future deadline.

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

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

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

Assurances

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

Consultation

The Phase 3 report was considered at the Board Development Session held on 17 January 2018, Board meeting on 31 January and Executive Leadership Team on 12 February. The initial forms outlining scope of the actions, operational governance arrangements and respective leads we agreed at Board Committees in March/April 2018. Progress on all recommendations/comments was reviewed and scrutinised at ELT on 15 October.

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 – The actions outlined include activities which will individually be considered for impact on individuals with protected characteristics as part of operational planning.

Recommendations

Board is requested to:

1) Note and consider the level of assurance (RAG ratings) presented to the Committees in respect of progress with implementation of actions to meet the recommendation as outlined
2) Note the recommendations/comments where there is further work/assurance required and for relevant Executive Leads to confirm that this will be delivered to Committee deadlines
3) Agree for final reporting on these recommendations/comments in March 2019 which will draw upon evidence from a range of business as usual reporting on the issues related to the recommendations/comments.

Report prepared & presented by: **Sam Harrison**
Director of Corporate Affairs

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 COMPLETE**		

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	Gareth Harry	N/A	ELT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

The Trust strategy was refreshed to reflect the Trust's priorities and the new statement of vision and values. This was presented to the Board in March 2018. Measures of success were identified and agreed and will be reported to the Board on an annual basis. Ongoing measures of success have been reported in the revised Integrated Performance Report, which, in its new form has been reported to the Board since June 2018. The Business Plan for 2018/19 also picks up the measures at Trust and divisional levels.

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 has been providing 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:

The bi-monthly Divisional Performance Review meetings cover performance and business plan success measures. Where actions are off-track, mitigations have been put in place. Concerns are escalated to ELT through routine escalation reporting.

Deloitte Phase 3 Recommendation/Comment

Recommendation 2

RAG rate whether progress is on track for delivery to agreed timescales.	**Red**	**Amber**	**Green Complete**
Timescale:	**April 2018 COMPLETED**		

Vision, strategy and planning
Recommendation 2
Refresh the annual planning process to include more oversight and scrutiny from the executive team in the development of plans to ensure consistent quality across divisions. Progress of implementation should continue to be monitored quarterly through TMT and more routinely at Divisional meetings.

Board Committee	**Lead director**	**Operational Committee (if applicable)**	**Operational oversight Committee (TMT/ELT)**
Finance and Performance	Gareth Harry	TMT	ELT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

Business Plans were agreed and are in place for all Divisions and corporate support areas across the Trust. These have been reviewed by ELT and TMT to ensure consistency and that they reflect Trust-wide priorities and are consistent in terms of approach and quality. Plans have been overseen at Performance Review Meetings (held bi-monthly) and at Divisional meetings (held monthly). ELT have reviewed all areas, including corporate, on a quarterly basis. The first report closing off 2017/18 was presented in May 2018. Reports were made in July, with further reports scheduled for October, January and April. Board to review six monthly progress with Divisional/corporate area plans.

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 plans clearly outline the actions that are required and the completion date. Progress is being reported at TMT monthly and at the bi-monthly Performance Review Meetings, reported to ELT quarterly and the Board six monthly. If actions are not completed in a timely manner or if there are barriers to completion then TMT will be aware and can quickly escalate to ELT if necessary. Therefore two operational Committees are able to either solve issues or agree mitigating actions.

Board assurances will come from the scrutiny of both TMT and ELT and the timely resolution of barriers and/or mitigation of potential issues.

Details of how changes/actions are to be sustained:

Divisional Management meetings have operational oversight of actions. TMT has ensured the work is being completed and ELT is now overseeing this. Board and Committee forward plans include regular reporting of progress.

A new process for Business Planning, encouraging bottom-up identification of risks, opportunities, investments and quality improvement and cost improvement schemes, will be in place over the Autumn, in time for the 19/20 planning process. This proposal is in development with Divisional leadership teams and will be agreed by ELT in early Autumn.

Deloitte Phase 3 Recommendation/Comment

Recommendation 3

RAG rate whether progress is on track for delivery to agreed timescales.	**Red**	**Amber**	**Green COMPLETE**
Timescale:	**July 2018 COMPLETE**		

Management of risks, issues and performance
Recommendation 3
Expand the existing Risk Assurance and Escalation Report so that information on mitigating actions is included for all open high and extreme-rated risks. This report should be received by the assurance Committees alongside the BAF, and also by the Board (for information) on a six-monthly basis.

Board Committee	**Lead director**	**Operational Committee (if applicable)**	**Operational oversight Committee (TMT/ELT)**
Audit & Risk Committee	Sam Harrison	N/A	ELT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

Reporting on mitigating actions against all open and high and extreme rated risks will be included in Board reporting six monthly to both highlight key operational risks and also reiterate links to BAF risks. This will be presented alongside issue 2 and issue 4 of the BAF. The report will be reviewed by ELT (June 2018) and Audit and Risk Committee (July 2018) prior to presentation to the Board (in September 2018)

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')

Assurances will be presented to the Board to highlight key operational risks, to reiterate links to the BAF and also provide assurance against mitigating action for all high and extreme rated risks.

Details of how changes/actions are to be sustained:

This work will form part of the established cycle of BAF review and update during the year which includes review by individual Executive Directors, ELT, Audit and Risk Committee and the Board. This will be reviewed in the annual BAF /risk management audit as part of the annual internal audit programme.

Deloitte Phase 3 Recommendation/Comment

Recommendation 4

RAG rate whether progress is on track for delivery to agreed timescales.	**Red**	**Amber**	**Green Complete**
Timescale:	**April 2018**		

Management of risks, issues and performance
Recommendation 4
A tiered risk management training programme should be developed for all Trust staff

Board Committee	**Lead director**	**Operational Committee (if applicable)**	**Operational oversight Committee (TMT/ELT)**
Audit & Risk Committee	Carolyn Green	Senior Assurance Support (SAS)	TMT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

The Training Group considered this recommendation at their meeting on 20 March. Many elements are already being effectively undertaken and a clear programme has been followed to roll this out by 30 September 2018, with the exception of the bespoke e-learning package which has had some technical difficulties which are planned to be resolved by the end of October. Recording of all uptake of training is noted in ESR (Electronic staff Record). An overview of risk management training will be reviewed by SAS in December.

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')

Assurances including uptake, rollout and effectiveness will be presented to the Audit and Risk Committee as part of future annual reporting on progress against the implementation of the Risk Management Strategy.

Routine reporting for the current year is to be included in the training report to People and Culture Committee and the Risk and Assurance manager is working with Education and Development leads to incorporate this.

Details of how changes/actions are to be sustained:

Ongoing reporting of tiered risk management training will form part of routine management oversight of TMT and SAS and audited annually as part of BAF/risk management internal audit. Details of training uptake will be provided for assurance as part of reporting to the Committee in March 2019.

Deloitte Phase 3 Recommendation/Comment

Recommendation 5

RAG rate whether progress is on track for delivery to agreed timescales.	**Red**	**Amber**	**Green Complete**
Timescale:	**June 2018**		

Management of risks, issues and performance
Recommendation 5
Review and relaunch the QIA process for CIPs with a focus on ensuring that it is flexible enough to be relevant to schemes of various scales. The process should be clearly communicated to all managers and the Director of Nursing and Quality and Medical Director should sign off all schemes. Schemes which are risk-rated Amber and Red should be signed off by the Quality Committee.

Board Committee	**Lead director**	**Operational Committee (if applicable)**	**Operational oversight Committee (TMT/ELT)**
Quality Committee	Gareth Harry	N/A	ELT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

The review of the QIA process was undertaken and discussed by ELT. A report encompassing 2017/18 QIAs undertaken was presented to Quality Committee in May 2018. Implementation has been led by the Director of Business Improvement and Transformation and has included briefing to all relevant staff. The process is understood by all CIP programme leads and sponsors and has been working in practice through the Programme Assurance Board. Both the Medical Director (MD) and Director of Nursing (DoN) have Red-rated CIP proposals based on QIAs submitted. These have been subject to further iterations until both MD and DoN are assured that quality impacts are mitigated or minimized.

The forward plan for the Quality Committee has been amended to ensure that QIAs are reporting at least twice per year.

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 proposed twice year report to Quality Committee will outline that full and robust QIA processes have been undertaken to review all relevant schemes. Reporting will outline all schemes with focus on those risk rated Amber and Red. The first of these reports was submitted and discussed by the Quality Committee in August. Future reporting was requested to take a dashboard format to encompass the last rolling three years' schemes.

Details of how changes/actions are to be sustained:

Overview of QIA processes forms part of Quality Committee remit and terms of reference.

Deloitte Phase 3 Recommendation/Comment

Recommendation 6

RAG rate whether progress is on track for delivery to agreed timescales.	**Red**	**Amber**	**Green**
Timescale:	**October 2018 Update – Completion by April 2019**		

Management of risks, issues and performance
Recommendation 6
All staff need to have meaningful annual objectives which are monitored through a quality appraisal process. Once the Trust strategy has been refreshed, all objectives should be linked to this.

Board Committee	**Lead director**	**Operational committee (if applicable)**	**Operational oversight committee (TMT/ELT)**
People and Culture Committee	Amanda Rawlings	n/a	ELT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

An end to end review of the appraisal process has now been completed. We hoped to have this completed by the end of July 2018, but this has taken a little longer as we have been checking in on the requirements that we will need address as part of the Agenda for Change Pay Deal. We have been through two iterations in the development phase and expect we will made further tweaks as we move to consult with staff and leaders. The new process aligns individual objectives to organisational strategic objectives. Once the consultation is complete we will start training with staff and leaders on the new process in readiness for launch in April 2019.

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 reporting to the People and Culture Committee will aim to provide assurance that the appraisal process has been robustly reviewed to incorporate the principles of aligning individual objectives to organisational corporate/strategic objectives. Assurance will be provided that consultation with staff has taken place with confirmation that the new process has been overseen by ELT.

The Staff survey will help gauge staff feedback on the effectiveness of the appraisal process.

Details of how changes/actions are to be sustained:

Focus on delivery of an effective appraisal process is part of the People Plan on which progress is reported to People and Culture Committee as part of its annual work programme.

Deloitte Phase 3 Recommendation/Comment 7

RAG rate whether progress is on track for delivery to agreed timescales.	**Red**	**Amber**	**Green Complete**
Timescale:	**September 2018**		

Learning, continuous improvement and innovation
Recommendation 7
The Trust should seek to supplement the current mechanisms in place to share learning throughout the Trust for example through the use of increased oversight at TMT and at Divisional COAT and Directorate meetings

Board Committee	**Lead director**	**Operational Committee (if applicable)**	**Operational oversight Committee (TMT/ELT)**
Quality Committee	Dr John Sykes	Executive SIG	ELT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

An Executive Serious Incident Group (SIG) has been established to identify themes/trends to inform practice development and commission further analysis where indicated. Specific projects are referred to TMT for consideration. The Operational SIG will monitor action plans and escalate to the divisional COAT and Directorate meetings as necessary. The Mortality Group will analyse data from NHS Digital and individual case reviews as they become available. Findings will be reported to the Quality Committee as part of the Serious incident/Mortality report but without the Cause of Death (from NHS Digital) individual mortality reviews can only come to tentative conclusions and usually assurance in the absence of concern.

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')

A Serious Incident/Mortality Report is presented to every Quality Committee. It will be refocussed on 'learning the lessons' supported by 'Practice Matters' publication. TMT will receive specific projects, e.g. the 'Healthy Consultant Caseload' proposal and the Peer Review of Homicides. Operational SIG will escalate to divisional COAT and directorate meetings as necessary. The Committee requested evidence of this escalation in practice as part of the update on this recommendation in March 2019.

Details of how changes/actions are to be sustained:

Individual actions will be subject to compliance checking and quality improvement cycles. Action plan completion is monitored by the SI office and summarised in regular reporting to Quality Committee. Sharing learning will be included in the remit of Executive SIG and the terms of reference of the group are to be reviewed to incorporate this.

The Committee requested that future SIRI reports should evidence learning from cases and subsequent change in practice. A summary of learning including analysis of themes was requested for the Quality Committee meeting in March 2019 (single page report).

Deloitte Phase 3 Recommendation/Comment

Recommendation 8

RAG rate whether progress is on track for delivery to agreed timescales.	**Red**	**Amber**	**Green COMPLETE**
Timescale:	**May 2018 COMPLETE**		

Learning, continuous improvement and innovation
Recommendation 8
Further work is required to ensure that staff are encouraged to utilise Datix to capture incidents appropriately and to ensure that all are aware of the need to review and provide feedback in a timely manner.

Board Committee	**Lead director**	**Operational Committee (if applicable)**	**Operational oversight Committee (TMT/ELT)**
Audit and Risk Committee/People and Culture	Carolyn Green	N/A	TMT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

The importance of the use of Datix is covered in the e-learning package, enhanced focus at induction and has been promoted through staff communications. Targeted training and awareness raising has been and will continue to be undertaken in teams where there is low reporting. Staff survey outcomes have been reviewed and teams identified who may require further explanation and support with respect to training, and managers encouraged to feedback to staff from incidents that are reported.

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')

Reports to the People and Culture Committee will provide assurance on uptake on levels of training. Also targeted training will take place where there is low reporting and where identified in staff survey outcomes. The Audit and Risk Committee will receive details of promotional activity, shared learning and training uptake in the annual review of implementation of the Risk Management Strategy.

The CQC inspection report (due end September 2018) will be reviewed to provide assurance of staff awareness and understanding of reporting and feeding back on incidents, and also to further identify any areas requiring targeted support. Details of targeted support to teams were noted and an overview is to be provided for the March 2019 meeting of activity throughout the year.

Details of how changes/actions are to be sustained:

Ongoing programme of staff communication and targeted training. Sustained change will be evaluated as part of annual BAF/risk management audit. An overview of training uptake will be provided as part of assurance to the March 2019 Audit and Risk Committee meeting.

Deloitte Phase 3 Recommendation/Comment

Recommendation 9

RAG rate whether progress is on track for delivery to agreed timescales.	**Red**	**Amber**	**Green Complete**
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. Six months and ongoing.

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.

Deloitte Phase 3 Recommendation/Comment

Recommendation 10

RAG rate whether progress is on track for delivery to agreed timescales.	Red	Amber	Green On track
Timescale:	October 2018		

Reporting
Recommendation 10
Reiterate the processes for data quality, ensuring all required aspects are in place. Also introduce data quality kite marks for key metrics reported in the Committee and Board IPR.

Board Committee	Lead director	Operational Committee (if applicable)	Operational oversight Committee (TMT/ELT)
Audit and Risk	Mark Powell	TMT	ELT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

ELT discussed the scope of this recommendation and considered this alongside feedback from the data quality internal audit carried out earlier in the year. Work has involved review of the data quality policy and broader framework and focus on effective implementation. Data quality kitemarks have been added for the January 2018 Integrated Performance Report (IPR) onwards on selected metrics (regulatory measures).

As defined by KPMG, the policy and procedures have been updated and ratified by Information Governance Group. Data Quality Kitemarks have been introduced into the Trust NHSi Dashboard for the operational indicators.

A regular programme of indicator testing has been implemented based on the significance of the indicators identified within the Data Quality Priority Framework.

The top 10 indicators were tested in May 2018 and a report produced capturing the results.

The testing will be expanded to include confirmation by those who enter the information that it reflects the performance of the teams.

Management response to recommendations arising from the internal audit have been agreed including oversight of Data Quality by the Audit and Risk Committee. Response to the findings of the Deloitte review included a Board Development session covering Data Quality – which was undertaken as a combined session on review of the IPR in July 2018.

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')

Board Development session on data quality and IPR undertaken July 2018. Audit and Risk Committee will focus on effective data quality policy and ensure Board member understanding of the Trust's data quality framework.

An update report on the achievement of Recommendation 10 on data quality will take place at the extraordinary Committee meeting taking place on 04 December to incorporate the management response from the internal audit follow up on data quality which will be presented at the same meeting.
Details of how changes/actions are to be sustained:
Developments in data quality will form part of ongoing review of the integrated performance report. Follow up of internal audit will also confirm completion and embeddedness of required actions. This is underway and outcome of this follow up audit will be presented to provide further assurance to the Committee (due to review by the Committee on 4 December) when any further assurance reporting will be identified.

Deloitte Phase 3 Recommendation/Comment

Comment 11

RAG rate whether progress is on track for delivery to agreed timescales.	Red	Amber	Green
Timescale:	**December 2018**		

Learning, continuous improvement and innovation
Comment 11
Improvement Methodology: Whilst work in this area is ongoing, we understand that the Trust are planning to develop their own in house approach, rather than implement one of the recognised schemes in use in other organisations. It is planned that this will include a strong focus on the development of staff and leaders across the organisation in order to develop skills in this area. In support of this, there are also plans to review the approach to leadership development to include a focus on developing the skills for continuous improvement as outlined in the People Plan next steps.
No specific recommendation has been raised as action is already being undertaken by the Trust in this area.

Board Committee	Lead director	Operational Committee (if applicable)	Operational oversight Committee (TMT/ELT)
Finance & Performance	Gareth Harry	N/A	ELT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

The comment required the Trust to develop an in-house approach to quality and continuous improvement and that it should include a strong focus on the development of staff and leaders in order to develop skills in these areas. To address this comment, the Trust agreed to put a Quality Improvement Strategy in place and to have an Implementation Plan for the delivery of the strategy. The Implementation Plan would have a particular focus on the empowerment and development of frontline teams and leaders to develop their skills and approaches to improvements in quality, efficiency and effectiveness of their services.

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')

In April 2018, the Quality Committee agreed a new Quality Improvement Strategy. In August, the Quality Committee agreed an Implementation Plan. The Strategy and Implementation Plan established that quality improvement, processes of continuous improvement and cost improvement plans were to be combined in a single approach.

The agreed Implementation Plan included a communications plan and outlined how the programme would be launched via inclusion in Trust wide leadership events, COAT agendas and Trust Medical Advisory Committee.

Continuous Quality Improvement (CQI) will be embedded into the existing transformation programme, which will focus on bottom-up improvement schemes involving the Trust's

clinical and non-clinical workforce. These processes report to Programme Assurance Board and, by escalation, to ELT.

CQI methodologies and tools, such as SPC, Lean, Carter, Red2Green etc. will be made available to teams and support will be provided from the Transformation Team to enable their use.

Following consideration at Finance & Performance Committee in September, the Committee decided to retain the RAG rating for this Comment as Red, rather than Amber as proposed. Committee felt that they were not yet assured that progress had been made on the leadership development areas of the proposed actions.

In July, the People & Culture Committee agreed a new Management and Leadership Development Strategy, which included the commitment to "Provide all leaders with knowledge of quality improvement methods and how to use them at all levels".

Details of how changes/actions are to be sustained:

The Trust's Business Planning processes, CIP programme development processes, its COAT and TMAC and the development of a specific Quality Improvement Oversight Group will embed CQI into the Trust's processes.

Deloitte Phase 3 Recommendation/Comment

Comment 12

RAG rate whether progress is on track for delivery to agreed timescales.	Red	Amber	Green
Timescale:	**June 2018**		

Reporting
Comment 12
Staff views on data and information

Both clinical and non-clinical staff we spoke with at various levels described the IM&T team as responsive and helpful. There are, however, many frustrations with the electronic patient record (EPR) systems in use. In particular:

- Different systems are in place, which can slow staff down when trying to access information. A review of this remains ongoing;
- Staff described some systems as difficult to use (e.g. being logged off unexpectedly, being unable to access systems when working remotely with patients and being unable to log observations) which can cause safety concerns;
- Some staff have struggled to adapt to the new safety planning requirements in the EPR, and therefore may not be using appropriate functionality (the executive team is sighted on this);
- Data from social care is not included and there are no linkages to local acute trusts' systems (an STP workstream is focussing on data integration); and

We understand that an EPR clinical reference group has been established to address some of these concerns, with a re-procurement exercise planned for 2018. This should provide an opportunity to further address some of the issues described above.

No recommendation raised due to the establishment of the EPR clinical reference group and also the re-procurement exercise due to commence in 2018.

Board Committee	Lead director	Operational Committee (if applicable)	Operational oversight Committee (TMT/ELT)
Finance and Performance	Mark Powell	Clinical Reference Group (CRG) & TMT	ELT

Brief description of scope and proposals to address recommendation ('any additional information to be appended as required')

An EPR clinical reference group was established to take forward issues relating to EPR systems and ensure developments are reviewed by clinical colleagues and that issues in relation to safety planning are addressed through reporting to Quality Committee. Operationally, the CRG group reports to TMT and through to ELT.

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')

It is proposed that F&P receive assurance reporting on the progress of the FSR CRG, to include how staff views on data and information are to be taken forward with clear plans outlined.

- An initial report on the Full Service Record (FSR) Clinical Reference Group was presented to TMT in July 2018 and a further update is scheduled for October 2018. The purpose of the group is to support, develop and maintain the effectiveness of the FSR by liaising with clinicians and promoting the full use of the FSR. Work undertaken by the group so far in 2018 has continued to be directed at Reducing the complexity and repetitive recording in key fields

on the system. An action plan has been developed and includes visits to other sites who implement PARIS.

- Future reporting from the FSR CRG will incorporate further recommendations as highlighted in the CQC inspection report (September 2018) relating to PARIS. It is anticipated that work to address this recommendation will be taken forward as part of the response to CQC recommendations and reporting will be developed to align with the Trust's CQC response.

- A report was submitted to F&P in July relating to wider proposals on the Electronic Patient Record.

- There are proposals within the Trust to establish the role of Chief Clinical information Officer. The role is being clarified, and has arisen from national recommendations (Watcher report) and will aim to ensure clinical engagement and leadership on the overall IM&T agenda. ELT have had initial discussions about this role, and are supportive of this in the Trust and are exploring how this can be best taken forwards.

- The Trust is working to review current systems and include staff in future decision making on EPR systems. The Committee will receive further assurance as part of its business as usual remit and once satisfactory additional reporting is received in December, outlining the frameworks to be taken forward, this response may be deemed Green and complete.

Details of how changes/actions are to be sustained:

This will be outlined as part of the action planning developed by the CRG and wider response to CQC feedback.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 November 2018

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

Purpose of Report

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

Executive Summary

- There continue to be eleven risks are currently identified in the BAF for 2018/19.
- Since Issue 2 of the BAF, the risk ratings of two risks are proposed to be revised:
    - Risk 18_19 4d *Flow of patients,* is proposed to increase from high risk to extreme risk
    - and Risk 18_19 3b *Influencing Joined Up Care Derbyshire*, is proposed to decrease from high risk to moderate risk
- It was recommended to the Mental Health Act Committee on 7 September 2018, that Risk 18_19 1b *Compliance with the Mental Health Act/Mental Capacity Act* be reduced from high to moderate due to progress made. However following discussion and debate the Committee agreed to retain the risk as high until a further audit of community team compliance with the MCA (Mental Capacity Act) is completed. If compliance continues to increase, the Committee agreed the risk should be reduced.
- It had been proposed through executive review, Executive Leadership Team (ELT) scrutiny and Audit and Risk Committee oversight, that Risk 18_19 2a E*ngagement with our workforce* should be decreased from high to moderate risk to reflect the wide ranging engagement framework and activity underway. However, following presentation of an engagement update to People and Culture Committee on 23 October 2018, the Committee challenged the proposed reduction and recommended that the risk should remain as a high. Although outside of usual BAF management and update process, it is recommended that this risk therefore remain as high, pending presentation of further assurance at the next People and Culture Committee meeting.
- Further revisions have been included to Risk 18_19 1a *Failure to provide safety and quality standards* arising from Board discussion on 2 October 2018, with reference to gaps in assurances identified in relation to compliance with implementing recommendations from NHS Resolution and potential decommissioning of psychodynamic psychotherapy services. Actions to address these gaps will be further detailed in the next iteration of the BAF.

- These changes will result in the BAF containing: three risks rated as extreme risk, seven risks as high risk, and one risk as moderate risk

- The focus has continued on ensuring appropriate actions to mitigate risks are identified and to scrutinise, evaluate and challenge risk ratings. It continues to be the expectation that completion of identified actions will result in reduced risk ratings and we continue to work with Executive Leads to ensure appropriate mitigating actions are identified with timeframes and milestones for delivery.

- The Deloitte phase 3 Well Led governance review recommendation to expand the BAF to include information on mitigating actions for all high and extreme rated operational risks was included in Issue 2 of the BAF. In line with the agreed action this level of detail will be included again in Issue 4 of the BAF.

- The Deep Dive programme is on track. ELT have reviewed the Deep Dive format and a template presentation is now available for Executive Leads to ensure consistency of approach.

- The BAF risks for the responsible Board Committee continue to be presented at the start of each agenda in order to drive the Committee agenda. Reflection of any required changes to the BAF, following discussion of agenda items, remains as a standing item.

- The following feedback from the CQC review 2018 identified that the Board knew its most significant risks and how to monitor and manage them. The Board assurance framework was described as:

    - *very good with clear accountabilities and oversight. Good examples were given of the board assurance framework driving agendas and priorities for both the board and governance sub-committees. Gaps in control, and the mitigating actions to address them, were very clear and informative, and the actions taken were detailed and updated regularly. We found that the trust took a cautious approach to changing its red ratings to amber or green, so all risks appeared red even when significant mitigating action had occurred.*

  Lack of pace in improvements to some services as described in the draft CQC report will be reflected on during the next cycle of discussions with Executive Leads

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

Individual Executive Directors – during September 2018. Further minor revisions included following review of every BAF risks at each Board Committee and final consultation with individual directors during late Oct 2018

Executive Leadership Team – 17 September 2018

Audit and Risk Committee – 04 October 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 and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	x

Actions to Mitigate/Minimise Identified Risks

Specific elements within each BAF risk and associated actions continue to be addressed by the relevant lead Executive Director in taking forward. Examples include: clear policies and procedures in place to ensure equality of access in all recruitment processes as outlined under Risk 18_19 4a (retain, develop and attract); all Trust policies having an equality impact assessment attached which are reviewed and updated at each policy review; information regarding the lack of capacity for autism assessment identified in Risk 18_19 1a is being shared with the commissioners with a request for them to undertake an equality impact assessment on the commissioning decisions.

Recommendations

The Board of Directors is requested to:

1. Agree and approve this third 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 amended risk ratings, that is to increase risk 4d to extreme risk and decrease risk 3b to moderate risk, as proposed by the Executive Leadership Team and supported by the Audit and Risk Committee

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

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

Rachel Kempster
Risk and Assurance Manager

Board Assurance Framework

Third 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 third formal presentation of the Board Assurance Framework to the Board for 2018/19.

1) Overview and movement of risks 2018/19

A summary of all risks currently identified in the 2018/19 BAF is shown below. This is added to 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)	HIGH (4x4)	HIGH (4x4)		
18_19 1b	Failure to provide full compliance with the Mental Health Act (MHA) and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)		
18_19 1c	Failure to develop systems and processes to deliver physical health care for patients	Medical Director	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)		
18_19 1d	Failure to redesign the Care Programme Approach processes	Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)		
18_19 2a	Risk that we do not engage our workforce to experience aims and values of the Trust	Director of People and Organisational Effectiveness	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)		
18_19 3a	Delivery of financial plan	Director of Finance	EXT (4x5)	EXT (4x5)	EXT (4x5)		
18_19 3b	Failure to influence Joined Up Care Derbyshire	Director of Business Improvement and Transformation	HIGH (4x4)	HIGH (4x4)	MOD (3x4)		
18_19 4a	Unable to retain, develop and attract staff in specific teams	Director of People and Organisational Effectiveness	EXT (4x5)	EXT (4x5)	EXT (4x5)		
18_19 4b	Failure to gain confidence of staff re the electronic patient record	Chief Operating Officer	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)		
18_19 4c	Unable to introduce new workforce models and provide training to reskill staff	Director of People and Organisational Effectiveness	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)		
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)	HIGH (4x4)	EXT (5x4)		

It is proposed that changes be made to the risk ratings of the following risks

BAF ID	Risk title	Change	Rationale
18_19 3b	Failure to influence Joined Up Care Derbyshire	Decrease likelihood from 4 (likely) to 3 (possible). Reduction in risk rating from HIGH to MODERATE	Attendance at all eight PLACE alliance meetings. DHCFT able to work in partnership with CCGs to be able to agree a reset MHIS which delivered £2million pounds of investment savings. This has avoided the need for widespread decommissioning of core services.
18_19 4d	There is a risk that the Trust will not improve the flow of patients through our services	Increase likelihood from 4 (likely) to 5 (almost certain). Increase of risk from HIGH to EXTREME	Increased out of area placement of patients. Pressure on acute service pathway

2) Deep dives 2018/19

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

The current plan for BAF Deep Dives for 2018/19 is shown below. Those that have been completed are highlighted:

Risk ID	Subject of risk	Director Lead	Committee
18_19 1a	Safety and quality standards	Carolyn Green	Quality Committee July 2018 Completed
18_19 1b	MHA/MCA Compliance	Dr John Sykes	Mental Health Act Committee: September 2018 Completed
18_19 1c	Physical healthcare compliance	Dr John Sykes	Quality Committee September 2018 Completed
18_19 1d	CPA approach	Carolyn Green	Quality Committee November 2018
18_19 2a	Staff engagement	Amanda Rawlings	People and Culture Committee October 2018
18_19 3a	Financial plan	Claire Wright	Audit and Risk Committee (Finance and Performance Committee) January 2019

Risk ID	Subject of risk	Director Lead	Committee
18_19 3b	Influence 'Joined Up Care Derbyshire'	Gareth Harry	Finance and Performance Committee September 2018 Completed
18_19 4a	Staff retention, recruitment and development	Amanda Rawlings	Audit and Risk Committee (People and Culture Committee) July 2018 Completed
18_19 4b	Electronic Patient Record	Mark Powell	Quality Committee December 2018
18_19 4c	Workforce model and training to reskill staff	Amanda Rawlings	People and Culture Committee December 2018
18_19 4d	Improve flow of patients	Mark Powell	Audit and Risk Committee (Finance and Performance Committee) December 2018

A power point presentation including guidance on contents for deep dive presentations has been reviewed and circulated to all Executive Directors.

Summary Board Assurance Framework Risks 2018/19 - Issue 3.2

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	MODERATE (3x4)
Strategic Objective 4.Operational Delivery			
18_19 4a	There is a risk that the Trust will not be able to retain, develop and attract enough staff in specific teams to deliver high quality care	Director of People and Organisational Effectiveness	EXTREME (4x5)
18_19 4b	There is a risk that the Trust will fail to gain the confidence of staff to maintain a modern and effective electronic patient record system	Chief Operating Officer	HIGH (4x4)
18_19 4c	There is a risk that the Trust will be unable to meet the needs of patients by not introducing new workforce models and provide sufficient training to reskill staff.	Director of People and Organisational Effectiveness	HIGH (4x4)
18_19 4d	There is a risk that the Trust will not improve the flow of patients through our services	Chief Operating Officer	EXTREME (5x4)

Board Assurance Framework Risks 2018/19 v 3.2

Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

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

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

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Acute pathway overwhelmed with demand with excessive bed occupancy which is impacting on staff morale and ability to provide essential care.	Implement 100 day improvement plan [ACTION OWNER:COO]	30/11/2018	Implementation plan in place, and actions have started to be completed. Improvements have commenced in bed occupancy, staffing and support. Following this will be to implement CQC improvement plan.	High
Fully implemented quality priorities and Quality Improvement Strategy	Roll out of actions in relation to the current quality priorities and Quality Improvement Strategy including a training needs analysis and full implementation plan [ACTION OWNER: DBI&T]	30/11/2018	Quality priorities are required outcomes of quality visits, programme commenced to be completed by Oct 2018. Full training needs analysis in development.. Quality Improvement ELearning now available. Implementation plan for Quality Improvement Strategy commenced.	Medium
Commissioner commitment to invest in mental health, children's services and learning disability services. Role of primary care models underdeveloped in Derbyshire.	Commissioner lobbying and provision of evidence to support need to increase funding or to provide an alternative strategic plan [ACTION OWNER DON]	31/12/2018	2018 CQC comprehensive inspect states that 3 service lines do not have enough staff to meet domain compliance requirements. CQC report shared with commissioners to inform their priorities and business planning.	Low
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]	31/12/2018	Recruitment of community forensic team underway, team to be in place by Dec 2018 Neighbourhood staff in place. Recruitment of crisis staff completed.	Low
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]	31/01/2019	Staff recruited. Use of PICU substantially increased for acute core services. This will be reviewed as part of the 100 day improvement plan. Travel for patients requiring out of area PICU bed is being raised as a quality and a patient experience concern. Exploration of alternative solutions is in design. Up-date on progress planned for Jan 2019	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 DBI&T]	31/01/2019	Delayed due to other clinical IT priorities.	High ↑
Fully embedded Clinical and Operational Assurance Teams	Embed CPD and complete development work for COATs [ACTION OWNER COO]	30/11/2018	Further review required of some COAT's to improve rigour and effectiveness	High ↑
Gap in knowledge and competence in relation to treatment of autism and support	Implement clinical quality improvements as identified in Schedules 4 and 6 in autism treatment during	31/12/2018	Training uptake increasing. Staff knowledge and capability improving. New HEE MIND educational materials available and being reviewed	Low ↓

in complex cases	2018/19 [ACTION OWNER DON]			
Lack of capacity for autism assessment services and non-compliance with the statuary autism act which recommends assessment within 12 weeks	Quality improvement mapping to understand referrals. Sharing this information with commissioners to undertake an equality impact assessment on commissioning decisions [ACTION OWNER DON]	30/11/2018	A review of achievements against the statutory Autism Self-Assessment Framework is in design with a framework to be published in Nov 2018. Trust is not compliant with recommended standards due to commissioning gap. This has been escalated to Board and to commissioners (via QAG) in September 2018	High ⇧
Clinical buy in to review NICE guidelines	To be evidenced through compliance with quality priorities assessed during Quality Visit programme [ACTION OWNER DON]	30/11/2018	NICE Steering Group to oversee results from Quality Visit programme with respect to compliance with NICE	Low ⇩
Full compliance with Trust strategy to be 'smoke free'	Further develop improvement plan with ward teams to prevent smoking on inpatient wards to reduce risks of potential fire if smoking in undesignated areas [ACTION OWNER DON]	30/11/2018	Fire officer and FRESH committee working on safety improvements to ensure staff feel safe and confident to challenge smoking in ward areas safely and effectively. Impact monitored through incident reporting processes. E-burn implementation in place. Exploring pilot of E-cigs/vaping in NHS settings.	High ⇧
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
2018 CQC comprehensive inspection has identified a deterioration in the safety domain across 3 service: adult acute, older people community and learning disability community	Extensive CQC action plan to be developed 'bottom up' with required evidence per area being established at the outset. [ACTION OWNER DON]	31/12/2018	Warning Notice signed off 05/09/2018. All actions plans developed and reviewed by core services with assurance checks led by Nursing and Quality Directorate. Currently on track for delivery of actions with auditable evidence.	High
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]	31/01/2019	Further success achieved against Q4 17/18 target. Quality and financial plan to be realigned as a result. 2018/19 milestones are continuation of previous year, A&E repeat attenders target already improved.	Low
Lack of clinical strategies with Divisional areas.	Develop new clinical strategies for recovery and enablement, substance misuse and Co- existing substance misuse and then Eating Disorders [ACTION OWNER DBI&T]	31/12/2018	New policy and clinical strategy model over- rides original plan. New clinical strategy development model in design	Medium
Evidence to support sexual safety of patients is maintained across inpatient areas	Identify issues re sexual safety of patients in inpatient areas and develop a plan to improve where gaps are identified [ACTION OWNER DON]	30/11/2018	Two papers on environment and improvement work achieved have been drafted and circulated to ELT. To be considered by the Safeguarding Committee Nov 2018.	Medium
Full compliance with safe use of medicines, with breaches still continuing to be identified.	Improvement plan in place to deliver compliance with medicines management code, including implementation of the Medicines Optimisation Strategy [ACTION OWNER MD]	Completed	Implementation plan for Medicines Optimisation Strategy approved by Quality Committee October 2018	Achieved
Achievement of required levels of compliance with mandatory and role specific training	Increase compliance with mandatory and role specific training requirements [ACTION OWNER COO]	31/12/2018	Some deterioration in performance and concerns re key safety training. Recommendation of additional monitoring at TMT	High ⇧
Evidence of compliance with recommendations from NHS Resolution in relation to suicide related claims	Implement requirements from NHS Resolution reviews of suicide-related claims to help prevent future harm. Implement recommendations and provide assurance [ACTION	31/12/2018		Medium

	OWNER MD]			
Potential lack of continuity of psychotherapy services following CCG launch of consultation to fully decommission	Complete a Quality Impact Assessment process in line with any QUIPP scheme to disinvest from mental health services and respond to consultation. [ACTION OWNER DON and MD]	31/12/2018		High

Board Assurance Framework Risks 2018/19 v 3.2

Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

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

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Improvement in practice and recording made in inpatient areas yet to be made in community settings	Focused workplan for improving compliance in community team with development of relevant guidance and documentation [ACTION OWNER MD]	31/12/2018	Re-audit completed. Reported to the MHA Operational Group Aug 2018 and MHAC Sept 2018. Improving compliance, plan to re-audit in 3-4 months.	Medium
Comprehensive training to support	Develop and implement comprehensive training plan to	31/12/2018	Trajectory of 3 yearly training confirmed to MHA Operational Group	Low

application of MHA and DoLs	support application of MHA and DoLs. [ACTION OWNER MD]		Aug 2018 and presented to MHAC Sept 2018. Improved position. Review again at next MHAC Dec 2018.	⬇
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]	31/12/2018	Monitoring of rapid tranquilisation improved due to developments in the FSR. Real time feedback to clinicians not possible without electronic prescribing. Regular reporting to MHA Operational Group. Electronic prescribing in procurement.	Medium
Consistent approach to management of Associate Hospital Managers (AHM's)	Develop a plan to ensure a consistent approach is implemented with respect to recruitment, job descriptions, appraisal, offers of appointment and training for AHM's [ACTION OWNER MD]	31/12/2018	Proposal considered by ELT and MHA Operational Group Aug 2018. Final plan agreed by MHA Committee Sept 2018 and discussed with AHM's at meeting with NED's following Sept MHAC.	Low ⬇
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]	31/12/2018	Plan to use CQC portal functionality to follow up these actions agreed by MHAC Sept 2018, together with paper presenting current position. Quarterly reporting to MHAC to be included in forward plan.	Low ⬇
Potential breaches of Section 136 waiting times. (Due to reduction in length of time a person can be held in a S136 suite under the new Police and Crime Bill).	Raise at Board level with escalation to Commissioners [ACTION OWNER MD]	Complete	This risk is impacted on by the difficulties accessing CAMHS/learning disability and PICU places. Issue escalated through ELT to Board.	Achieved

Board Assurance Framework Risks 2018/19 v 3.2

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:
18_19 1c			21289

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

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

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

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

Assurances on Controls (internal):	Positive assurances on Controls (external):
Programme of physical health care related audits and associated action plans	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	Develop a physical health care tile on PARIS to record in a single place all physical health care related information, initially focused on LESTER Tool compliance [ACTION OWNER MD]	31/12/2018	Physical health care tile being developed in PARIS Play with input from clinical and IT staff. Specific physical healthcare section now within PARIS. Number of clinical teams testing elements of this for usability and data integrity. Recording of physical health care observations in 136 suites developed as paper form. To be created in PARIS as part of above process.136 suite operational policy review underway	Medium
Trust led physical healthcare monitoring	Expand Derby pilot of physical health care monitoring	31/12/2018	Funding and job descriptions identified for 4 HCA's, a co-ordinator and	Medium

following initiation of medications	clinics to Chesterfield [ACTION OWNER MD]		a clinical lead, currently out to advert. Training and competency framework being developed and team will use new EPR LESTER tool. Initially the team will cover Chesterfield, Amber Valley and Derby City with a plan to roll out further once proof of concept has been achieved and capacity issues further explored.	
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]	31/12/2018	Physical health in mental health e-learning (LESTER), in place for just over 12 months. As of August 2018, compliance as at 63.9%. Monitored through CQUIN delivery group. Assistant Director for Public and Physical Healthcare supports escalation. Recent technical issues now resolved. Delirium training delivered to old age wards. Being rolled out to nursing homes. CRH providing some additional resuscitation training at Hartington Unit and are exploring simulation training. Trust is part of national learning set	Medium
Gaps in communication with GP practices re awareness of SMI cohort leading to potential gaps in physical healthcare monitoring	Continue to work with GP practices to ensure SMI databases are maintained and kept up to date [ACTION OWNER MD]	31/12/2018	Audit of SMI registers undertaken during Q4 17/18 demonstrated 91% compliance with required information shared with GP's. 2018/19 CQUIN requires defined process across Trust, workplan for Derbyshire agreed with Commissioners and public health. Quarterly meetings in place to monitor progress. Solution agreed with IT/IG for our access to primary care summary care records	High
Specific process and training to manage sepsis, in line with national guidance	Review the current infection control policies to ensure information around the identification and management of sepsis, and other high profile infections, are in line with current national guidance and best practice	31/12/2018	Sepsis policy in development with intention to roll out alongside NEWs2. This will replace existing DEWs framework	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Consistent monitoring and recording of physical healthcare standards across inpatient and community settings	Develop automated compliance checks and audits in PARIS [ACTION OWNER MD]	31/12/2018	Develop compliance report for key areas- 136 assessment, admission, community 1st contacts in addition to CQUIN requirements to be presented at TMT	High
Consistent implementation of the LESTER tool	Scope the implementation of a module in PARIS to enable local teams to receive early notification of patients commencing medication to enable monitoring to be put in place [ACTION OWNER MD]	31/12/2018	Trigger notifications to clinicians involved in a patient's care being developed based on diagnosis to instigate use of LESTER tool. Scoping of implementation of E-prescribing remains underway. Specification and interface issues being explored with development team and CIVICA. Medical director and EPR CRG chair working to identify if section in clinical letters can be subject to word search and this trigger alerts.	High

Board Assurance Framework Risks 2018/19 v 3.2

Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

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

	Design and redesign training methodology using experts by experience and carers[ACTION OWNER DON] Continual audit of compliance and outcomes., connecting to recovery and enablement strategy.[ACTION OWNER DON] Adopt a learning and scrutiny culture in supervision that reviews the adequacy and meaningfulness of CPA in supervision [ACTION OWNER DON] Embed CPA monitoring into COAT practice and include routinely on compliance and clinical audit programme.[ACTION OWNER COO]	30/11/2018 Completed 31/12/2018 31/12/2018	Carers quality improvement lead assessed knowledge of people currently in in- patient care on CPA. Findings being fedback into redesigned training being co-produced with experts by experience. Findings from community audit of CPA and safety plan reviewed by COAT and reported to July 2018 Quality Committee. Completed Audit of case files, improvement trajectory for supervision is in place and will continue with increased monitoring pending review of the Mental Health Act Findings from community audit of CPA and safety plan will be reviewed by COAT at regular intervals, and monitored at TMT. Performance monitoring against the code of practice standards in final agreed policy. Operational teams to develop implementation strategy, performance monitoring schedule and implement clinical standards.	
Compliance with revised policy	Develop and implement audit of compliance over an 18 month period [ACTION OWNER COO]	31/12/2018	Automated audit will be developed against ten core standards. Will require monthly submissions by service managers to ensure scrutiny and compliance.	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Delivery of improvement plan	Production of a 'deep dive' on the improvement plan with evidence of implementation and reporting structures in place [ACTION OWNER COO]	30/01/2019		Medium

Board Assurance Framework Risks 2018/19 v 3.2

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

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

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

Key controls:

Preventative – Team Derbyshire leader's events to engage leaders. Ongoing wider engagement activities for all staff
Detective – Management and leadership questions from staff survey, staff survey engagement questions. 'Ifti on the Road' programme
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 Feedback from Quality Visits Planned oversight of implementation of leadership development strategy to People and Culture Committee (as part of People Plan)	Staff Survey (limited assurance) 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 and management development strategy to include: management development; leadership development; coaching and mentoring, reverse mentoring. [ACTION OWNER DPOE]	30/11/2018	Leadership and Management Development Strategy developed and agreed. Wider organisational involvement plan with priorities for 2018/19 agreed by ELT and PCC Aug 2018. Implementation plan due end Sept with priorities identified. ELT and PCC monitoring implementation	Low ⬇

Further development to embed and coordinate wider engagement activity, including capturing feedback from all engagement activities	Range of activities are in place including Staff Forum, Team Derbyshire Healthcare Leaders events, team briefing, raising concerns, director/CE visits etc. to provide opportunity to engage with staff. Continuing implementation and evaluation of effectiveness to be undertaken including review of feedback captured from all engagement activities. [ACTION OWNER DPOE/DCA]	30/11/2018	Assessment and tracking of effectiveness of the range of activities in place underway. Progress was reported to People and Culture Committee June 2018, 'deep dive' planned for Oct 2018 PCC. Board in Sept 2018 received update on pulse check progress and staff survey implementation. Update on progress due back to ELT Sept 2018. Pulse check opened 3rd Sept and staff survey commences end Sept 2018. Team brief developed following feedback from staff.	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]	30/11/2018	Staff survey and pulse checks analysed. Plan in place to work with 10 least engaged teams by Sept 2018, to improve staff survey participation rates and overall engagement score. Staff survey action plan to include 'you said: we did' examples	Low ⬇
Staff awareness and ownership of Trust vision and values	Refreshed Trust strategy, vision and values to be cascaded through Trust and reinforced by staff communication, branding and role modelling from senior leaders. Promotion of examples of positive behaviours in practice to be disseminated and example of this happening in practice celebrated. Ensure staff are aware of what behaviours/practice is not acceptable and how to report this. [ACTION OWNER DPOE/DCA]	30/11/2018	Refreshed Trust Strategy, vision and values cascaded throughout Trust and reinforced through Team Brief, staff magazine and screen saver on Connect. Staff Forum up and running. Challenging and focusing on issues staff want to be discussed. Staff Conference arranged for Sept 2018 Work now underway to develop a set of expectations for staff whilst working in the Trust, led by HR and Communications managers. Work re bullying and harassment underway.	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]	30/11/2018	Leadership and Development Strategy and priorities identified. Updates planned for ELT Sept 2018 and PCC Oct 2018. To be costed in line with affordability. Individual seconded to leadership and development manager post from EMLA. Post is back out to substantive recruitment.	Medium
Staff responses on morale and health and wellbeing questions in staff survey	Address hotspot areas and wider trust actions to address [ACTION OWNER DPOE]	30/11/2018	Providing active support to individuals and teams where highlighting high levels of sickness absence. ELT to receive a paper on 17th Sept on range of staff support processes we believe will enhance what we can offer to staff.	Medium

Board Assurance Framework Risks 2018/19 v 3.2

Strategic Outcome 3. Financial sustainability

Principal risk:

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

Impact: Trust becomes financially unsustainable.

Root causes:

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

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

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

Key controls:

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

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

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

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

information, quality information set against the financial performance evidencing whether we deliver services within our resources Use of Resources report to Trust Board meeting November 2018 evidences strategic approach to effective use of resources	reporting in Trust and no material losses have been incurred - 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)	Completed	Agency controls have led to reduced total agency expenditure and better adherence to capped hourly rates, but ceiling not achieved. Agency spend reduced from c£5m in 1617 to c£4m in 17/18 Trust vision/priorities: Financial sustainability – the leading indicators chosen are achieving agency ceiling and recurrent CIP Reported position at end of month 4 (31/7/18) is that we are under agency ceiling. Action closed, to be reopened if required.	Achieved
Cost control/Cost improvement – requirement for firm plans for full 18/19 CIP programme (and longer term pipeline of cost and quality improvement)	QIPP and CIP incorporated into the mental health STP workstream [ACTION OWNER DBI] Increased CIP meetings and project scrutiny, management action via PAB {ACTION OWNER – CEO] AIM: full CIP programme, quality assured. Updated PMO and associated structures with new Director Business Improvement and Transformation in place	31/03/2019	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. Discussions expanding to include greater focus on cost pressure as well as CIP schemes. Ongoing to end of financial year. PAB re-instated chaired by CEO and continues to meet. Full programme not yet completed but work continues. Executive Directors are further considering PAB and TMT roles in order to urgently shift the full focus to 19/20 planning and beyond. 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 (this indicator will be reviewed in strategy discussions given that it has now been met) and recurrent CIP	High

Board Assurance Framework Risks 2018/19 v 3.2

Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery.

Board Assurance Framework Risks 2018/19 v 3.2

Strategic Outcome 3. Financial sustainability

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

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

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of capacity and cohesion across clinical pathways	Transform clinical pathways to provide more joined up care (internal focus)[ACTION OWNER DBI&T]	31/12/2018	Trust attended at each of eight PLACE alliance meetings in Jul and Aug 2018. Trust representation at identified at	High

Board Assurance Framework Risks 2018/19 v 3.2

			organisational development workshops through Autumn.	
Delivery of 'Five Year Forward View'	Develop new clinical models for service delivery via Mental Health System Board (external focus). Work with commissioners to deliver Mental Health Investment Standard in developing new pathways and services [ACTION OWNER DBI&T]	31/12/2018	Work on rehabilitation pathway continues, including analysis of cohort in locked rehab beds. Scoping of use of public health well-being hubs as alternative to clinical interventions. Agreement with Commissioners on system wide savings to deliver mental health element of the CCG QIPP target.	High
Level of influence on system wide children's and urgent care QIPP schemes	Ensure Trust is actively participating in workstreams for children and urgent care [ACTION OWNER DBI&T]	31/12/2018	COO attendance at Urgent Care Strategy Board meetings. Meeting scheduled in Oct 2018 with children's commissioners to discuss system approach.	High
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery.
Compliance with Mental Health Investment Standard	NHS England monitoring of CCG's compliance with investment standard [ACTION OWNER DBI&T]	Ongoing monthly	Agreement with CCG on the reset MHIS in July 2018. Delivering system wide savings.	Low ⬇

Board Assurance Framework Risks 2018/19 v 3.2

Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of available staff in hotspot areas	Increase availability of staff in hotspot areas [ACTION OWNER MD/DPOE	30/11/2018	Focused work being undertaken via ELT and PCC on hotspot areas. Actions being taken to address the availability of staff through: reduction of sickness absences, increasing fill rate to vacancies, and increasing bank and agency fill rates where appropriate.	High
Workforce plan to include alternative workforce models both medical and nursing	Develop alternative workforce models for key hard to fill services where have been unable to attract suitable medical staff.	30/11/2018	Currently focused on Associated Nurses, NMP and ACP's. Two ACP's are progressing through recruitment process to start in September 2018. Medical Director to work with medical staff across	High

	[ACTION OWNER MD/DPOE] Continue to progress, in line with Year 2 of the Workforce Plan, nursing/AHP associates and apprenticeships.	 30/11/2018	the Trust around introduction of new roles and to develop a plan October 2018 LBR and Levy funding considered by ELT July 2018. Funding now being allocated out according to prioritisation plan	
Appeal of the trust as a place to work	Further develop multigenerational offer to attract staff for key national occupational shortages, and for development and retention of staff in key areas [ACTION OWNER DPOE] Develop a rotation role and programme across inpatient and community services in order to proactively manage the flow of workforce across these areas [ACTION OWNER DPOE/COO]	30/11/2018 30/11/2018	Work commencing between people services and operations. Development of a business case to give assurance around the gaps Flexible working offer needs further promotion, in-house bank being expanded. Rotation programme deferred due to high demand for recruitment and operational capacity	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
National funding sources to develop our workforce	Gain funding streams from Learning Beyond Registration (LBR), Apprenticeship Levy and STP funding for Mental Health [ACTION OWNER DPOE]	31/12/2018	LBR funding reduced for 18/19 by over 50%. Identifying offset against the levy and bids made into STP workforce to see how to support staff development. Update to PCC planned for Dec 2018.	High

Board Assurance Framework Risks 2018/19 v 3.2

Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

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

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Clear specification for improvements required	Develop clear specification of improvements required to PARIS, with project plan, and timeline to meet agreed scope. FSR CRG to develop plan and report	30/11/2018	Second scoping exercise completed, resulting in now three task and finish groups focusing on: physical health care, information flow, well-being plans and clerking in. Scoping work has been completed for one	Moderate

	back to the Finance and Performance Committee [ACTION OWNER COO]		of the groups, and the other two are nearing completion. Development wok has remained ongoing though out. Delivery is now depended on the capacity of the developers, but remains on track.	
Confidence of staff in using the FSR to enhance patient care	-Ongoing support and review from Clinical systems lead -Involve clinicians in the FSR CRG to seek opinion and advice. -Ensure focus is maintained on reducing complexity and number of templates and time taken to complete by staff [ACTION OWNER COO] -Identify medical clinical information officer to develop clinical involvement in PARIS [ACTION:MD]	Ongoing Completed 30/11/2018 Completed	Additional training sessions are being delivered in locations across the organisation. Increased number of clinicians now attending the FSR CRG (5) Task and finish groups outlined above have been developed in response to areas of highest concern from clinicians and requiring the greatest simplification and redesign. Job description approved by ELT. In process of recruitment.	High
Fragmented recording of physical healthcare information on PARIS	Remapping of physical healthcare health care recording and monitoring on PARIS [ACTION OWNER MD]	30/11/2018	Being progressed by task and finish group for physical health care as outlined above. Necessitated enhancements delivered on ongoing basis.	Moderate
Limited staff engagement with safety planning process	Developing the safety plan framework on PARIS in line with commissioner feedback to include a stepped approach to safety planning and review of the existing form [ACTION OWNER MD]	Completed	Safety plan development is on track. Developers have the new specifications are these are being built	Achieved
Too many locations on PARIS to record same information	-Rationalisation and reduction of clinical documents held on PARIS -Conversation of 'forms' to 'locations' to centralise similar clinical information in one place. -Increasing auto population of forms where relevant -Development of tiles to improve access to key information (Care planning/ physical health care/ safety planning [ACTION OWNER COO]	30/11/2018	The FSR CRG review the enhancement log at each meeting, rationalise actions and reviewed more complex actions with the staff proposing to clarify request. Necessitated enhancements delivered on ongoing basis. Number of actions aligned with actions identified through scoping exercise, so these will be subsumed in task and finish group work plans. New developments are paused to create capacity to develop the above.	High
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]	30/11/2018	Trust colleagues have visited another trust that uses Civica to establish what learning can be transferred to our own trust. Any positive learning is being reviewed at the CRG meeting. Trust actively engages with the wider user network on an ongoing basis as required.	Moderate

Board Assurance Framework Risks 2018/19 v 3.2

Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Workforce plan: Oversight of delivery via fully functioning strategic workforce groups. Leadership ownership of the plan with sponsors for introducing new roles	Reshape the strategic workforce group and education group membership. [ACTION OWNER DPOE]	30/11/2018	Year 2 workforce plan has been agreed. Investment into key roles such as Nursing Associates, Nursing Apprentices and ACP's agreed. ELT and PCC to track progress. New TOR for strategic workforce and education group drafted, supported by current participants. Now to reach out to new members.	Medium
Funding: Ownership across the leadership team to transform current gaps in supply to new posts. Trust and HEEM funding availability	Executive oversight at ELT to delivery and transformation. HEEM funding – bid for every available work stream [ACTION OWNER DPOE]	30/11/2018	Medical Director has a working group looking at 10 key actions and this includes alternative workforce models to address the medical gaps the trust has. PAB is overseeing the progress of this group.	High

Board Assurance Framework Risks 2018/19 v 3.2

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]	30/11/2018	ELT received training funding plan July 2018 to ensure funding focused on the key areas to delivery transformation. Update due back to ELT and PCC Nov 2018	Medium

Board Assurance Framework Risks 2018/19 v 3.2

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:
18_19 4d			21297

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

Key controls:

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

Directive – 'LEAN' based approaches to service change; Recruitment to key leadership posts in acute care i.e. Urgent Care Improvement Lead, Clinical Lead, 136 Clinical Lead, General Manager secondment, Clinical Director. Coaching support by Programme Assurance Office and Head of Programme Delivery

Corrective – Board reporting on Trust Strategy; Dementia Rapid Response Teams; In-reach to Ward 1; CAMHS home treatment model

Assurances on Controls (internal):	Positive assurances on Controls (external):
Update reports to Quality Committee and TMT on Neighbourhood Review progress Bed status dashboard Red2Green weekly tracker Community Caseload health tracker Monthly Integrated Performance Report to Board	CMHT Community Service Survey CQC 2018 comprehensive review (gaps in assurance)

Gaps in control:	Actions to close gaps in control:	Review due	Progress on action:	Risk to delivery:
Lack of clear Urgent and Emergency Care clinical model	Deliver 100 day plan. Plan focuses on delivering improvements to: clinical standards and re-energising clinical practice; improving clinical and operational leadership and staff engagement; redesigning and transforming service model; delivering and supporting staff; improving the physical environment. [ACTION OWNER COO]	31/10/2018	Fortnightly urgent care meeting led by COO to deliver 100 day plan, overseen by TMT. Clear measurable outcomes being developed, to be monitored weekly. Recruitment into key roles achieved. Paper to be presented to Board Oct 2018 re detailed progress against plan.	High

Lack of clearly defined clinical pathways [100 day plan]	Agree and implement clearly defined clinical pathways to ensure people are cared for by the right staff with the right skills for the right length of stay [ACTION OWNER COO]	30/11/2018	Multidisciplinary task and finish group, led by Urgent Care Improvement Lead and ACD, commenced to look at implementation plan to deliver clearly defined clinical pathways. Meeting arranged for 31/10/18 with Psychology leads for their input on a Trauma Informed Pathway.	High
High numbers of patients with length of stay over 50 days [100 day plan]	Identify causes of delayed discharges and review practice to ensure discharge process starts at point of admission in order to reduce length of stay. Work more closely with stakeholders such as social care to support reduction in length of stay. [ACTION OWNER COO]	30/11/2018	Thematic review underway to understood the root causes of delays in discharging long stay patients to then be able to exploit opportunities to the reduce their length of inpatient stay. Participate in the Out of Area Placements Improvement Collaborative from November 2018, is facilitated by NHSI. Acute in-reach process into local rehabilitation beds being set up to ensure bed optimisation across all our adult services.	High
High vacancy rates and and high levels of sickness absence in urgent care services [100 day plan]	Deliver bank fill rate of 80% for Radbourne Unit and CRHT [ACTION OWNER COO]	31/12/2018	Targeted support from other services to Radbourne Unit. Current bank fill rates between 73% and 87% across Radbourne Unit wards. Rolling program to recruit to bank to support staff wellbeing for those contracted staff that complete lots of bank shifts.	High
Increased use of health services by some high risk individuals	Improve packages for high intensity users of health services through projects supporting the acute care pathway [ACTION OWNER COO]	31/12/2018	High intensity users project (JET -Joint Intensity Team) team commenced. Training commenced and working through cohort of patients identified.	Moderate
Delayed discharges above specified lengths of stay	Bed optimisation project, including 'Red2Green' project implementation to increase flow in inpatient areas [ACTION OWNER COO]	31/12/2018	Red2Green continues to be undertaken across all wards, data being collated to evaluate impact. 100 day improvement plan in place and being delivered which will include a focus on further reducing lengths of stay. Renewed escalation focus on patients who have stayed in hospital over 50 days, evidence of impact.	High
High caseloads and long waiting lists in community based mental health teams	Complete Neighbourhood review, to ensure services are meeting commissioned needs in line with 'Joined Up Care Derbyshire' approach [ACTION OWNER COO]	31/10/2018	Neighbourhood review still in progress. Feedback from meetings with all Neighbourhood teams is being integrated to inform the revisions to the clinical model. Care Clustering is being used to support this work and help stratify the patient population	High
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery

Board Assurance Framework Risks 2018/19 v 3.2

Risk Assessment Matrix

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

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

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

Derbyshire Healthcare NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
Audit & Risk Committee – Meeting held 4 October 2018

Key items discussed

- Board Assurance Framework (BAF) Issue 3 reviewed.
- Progress against roll-out of the Risk Management Strategy and objectives for 2017/18 reported, including minor updates proposed to align with wider Trust arrangements.
- Progress report against implementation of internal and external audit recommendations.
- Report on Medical Annexe on actions taken to improve management oversight.
- Update on progress against the actions from Deloitte Phase 3 Well Led Framework Progress Review assigned to the Audit & Risk Committee for oversight.
- Review of learnings from 2017/18 Annual Report and Accounts/Quality Report Production.
- Quarter 2 Data Security and Protection Report including update on work of the Data Security & Protection (formerly Information Governance) Committee and Data Security breach monitoring.
- Internal Audit progress report setting out progress with internal audits to complete the programme prior to conclusion of the KPMG contract.
- Counter Fraud progress report covered issues of the latest Counter Fraud newsletter to staff, and update on work with estates, portering staff and People Services.
- External Audit progress report outlined work underway and planned relating to the 2018/19 financial statements. Report included details of national emerging issues relevant to the Trust.
- Confirmation received that Council of Governors at meeting held on 4 September approved the recommendation from the Bid Board and Audit and Risk Committee that Grant Thornton be awarded the contract for provision of External Audit services from 1 November 2018.
- Confidential session – discussed recommendations from the Bid Board who had issued and evaluated tenders for contracts for internal audit services and counter fraud services.

Assurance/lack of assurance obtained

- Significant assurance on the waiver reporting process, following a review of administration and oversight, and circulation of the updated Standing Orders/Standing Financial Instructions waiver register to Committee members in September.
- Significant assurance of the robust processes in terms of ongoing management of the BAF, and that risks presented had been scrutinised by individual Executive Directors, the Executive Leadership Team and relevant Committees.
- Significant assurance on the successful implementation of the Risk Management Strategy, noting evidence outlined relating to work towards meeting current objectives and actions identified for future years. This included strengthening and embedding reporting to divisional management, the Trust Management Team and the Executive Leadership Team.

- Outstanding internal and external audit recommendations relating to inclusion of fraud and bribery in medical contracts discussed. Significant assurance received on processes embedded within appraisal and job planning for medical staff. Significant assurance received on other completed actions.

- Significant assurance on progress made with implementation of the actions arising from the review of management arrangements within the Medical Annexe

- Significant assurance on progress with agreed actions to address recommendations arising from the Phase 3 Deloitte review of the Trust's governance arrangements assigned to the Committee for oversight.

- Significant Assurance that the lessons learned from the review of 2017/18 Annual Report and Accounts/Quality Report will be undertaken in initial planning sessions for next year's report in order to ensure continuous improvement.

- Significant assurance that the Data Security and Protection team is continuing to manage the data security environment and that this is reflected in the Risk Register.

- Significant assurance that all outstanding internal audit reviews would be completed for ELT review on 12 November and presented to the 4 December Committee meeting.

- Significant assurance on progress with counter fraud matters as outlined in report and noted plans in place for smooth transition to the new provider in December.

- Confidential session – full assurance of the robustness of procurement processes followed in the tender exercise for selection of a provider for the Trust's internal audit and counter fraud services. It was further noted that assurance had been outlined by the current internal audit and counter fraud services provider on preparations for a smooth transition to new provider.

Key risks identified

- BAF – increased risk for Patient Flow (4d) and decreased risk of BAF risks 2a and 3b were fully outlined and noted in the BAF report.

- Outstanding internal and external audit actions – risk arising from not including specific reference to fraud and bribery in medical contracts and agreed mitigating action in terms of routine review at appraisal and job planning.

- Data Security and Protection Report – acknowledged the risk for 2018/19 to the organisation of failing to meet the requirements of the new Data Security & Protection Toolkit (new IG Toolkit) particularly with regards to the mandatory data security training requirement.

Decisions made

- BAF – proposed amendments to the BAF were agreed (2a and 3b to move from High to Moderate, and 4d from High to Extreme) and approved that BAF be presented to the November Board. Agreed that the Deep Dive relating to Patient Flow (Risk 4d), which now fell to the Committee due to its Extreme rating, would take place at the 4 December meeting.

- Updates to the Risk Management Strategy approved. Agreed that the Strategy would be received by the Committee for further review in in December 2019.

- Internal and external audit actions – agreed to receive a report on best practice relating to the inclusion of a reference to fraud and bribery in staff contracts.

- Deloitte Phase 3 Well Led Framework Progress Review – agreed that an update report on data quality (recommendation 10) will take place at the extraordinary meeting on 4 December 2018. Agreed that final reporting on the Deloitte recommendations would take place at the Committee meeting in March 2019.

- Counter Fraud report - observed that a number of closed cases have been passed to the People Services team to consider and agreed that the Committee should receive confirmation that these are resolved.

- Confidential session – approved the recommendation from the Bid Board for the award of contracts for the provision of internal audit and counter fraud services to 360 Assurance.

Escalations to Board or other Committee

- None

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

Board Committee Assurance Summary Report to Trust Board
Quality Committee - meeting held 9 October 2018

Key items discussed

- Summary of Board Assurance Framework (BAF) risks for Quality Committee were reviewed
- Deloitte Phase 3 recommendations – confirmed
- CPA (Care Programme Approach) policy following learning from very serious incidents and independent investigations – scrutinised and accepted
- Quality Dashboard and CQC Factual Accuracy Report and Action Plan - scrutinised and accepted
- Formal Review of Physical Healthcare Strategy (tabled at September meeting)
- Summary from COAT meetings - verbal update
- First Draft of Neighbourhood Delivery Model – verbal update - delayed
- Serious Incidents Bi-monthly Report - reviewed and accepted
- Professional Strategies Annual Report Against Strategy – accepted - to be shared with People and Culture Committee
- Quality Assurance Group Summary Report - accepted
- Children's Risk Escalation Report - accepted
- Relapse Reduction (Quality Priority) - accepted
- EDS2 Update - accepted
- Development of Clinical Strategies - verbal update

Assurance/Lack of Assurance Obtained

- Formal Review of Physical Healthcare Strategy (tabled at September meeting) - limited assurance
- Serious Incidents Bi-monthly Report - significant assurance
- Children's Risk Escalation Report - limited assurance
- EDS2 Update - significant assurance

Meeting Effectiveness

- Well chaired and timely
- Some changes and delegation to other groups
- Forward plan reviewed

Decisions made

- Formal Review of Physical Healthcare Strategy (tabled at September meeting) - received limited assurance. Increase the BAF risks associated with limited implementation plan. Escalate to ELT,
- Serious Incidents Bi-monthly Report - remodel to monthly serious incident report and quartely serious incident report with summary from executive lead that will provide assurance on action taken and mitigate the issues raised and include any learning and how this had impacted upon practice.

- Quality Assurance Group Summary Report is to be submitted to TMT with exception only reporting to the Quality Committee

- Children's Risk Escalation Report - review Risk registers risk and consider for BAF – 1a on caseload for Health Visitors and CAMHS waiting time. Early monitoring and TMT operational action.

- Relapse Reduction (Quality Priority) - scheduled for future meeting, Direction of implementation endorsed

Escalations to Board or other committee

- Physical Healthcare escalated to Executive Leadership Team for increased executive action.

- CQC Inspection Report Action Plans - escalated to ELT to ensure the People Services team improve training capacity to meet demand. This is also escalated to the People & Culture Committee to ensure improved training compliance.

- People and Culture Committee for shared work on the principles contained within the Professional Strategy

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

Board Committee Assurance Summary Report to Trust Board
People & Culture Committee – Meeting held 23 October 2018

Key items discussed

- Matters Arising – Following on from previous PCC, the Committee requested a Deep dive into Sickness absence for Decembers PCC. Policy matrix reviewed and Communications Strategy added.

- Staff Story – Positive feedback received by the Committee following the account of previous NHS Graduate scheme member JA. Team were supportive and committed to providing a great learning experience for JA, he reflected on the positive culture he experienced in the Trust and his own development leading to a Business Manager post at United Lincolnshire Hospitals Trust.

- Review of BAF Risks – Recruitment and Retention – update re workforce modelling due at December PCC. Committee discussed the level of risk regarding staff engagement and agreed that the level of risk can be reduced following the proactive steps taken so far once the staff survey results are known and analysed. The level of risk can then be evaluated against that feedback.

- Deep Dive BAF Risk 2a Staff Engagement – Paper was well received by the Committee, covering all aspects of engagement, the Freedom to speak up Guardian role (FSUG),Team Brief, Team Talk, Facebook page and the first DHCFT staff conference. Discussion around the ongoing work re awards, work around refreshing the vison and values and DEED awards. Consultation has now started with staff across the organisation around the DHCFT "promise". Although NHS 70 activities were not captured in this report, there is a plan to review all the activities in January 2019 to illustrate how engagement feedback is captured across a variety of activities and events. This will include how we capture feedback following NED and Exec visits. The Committee questioned the level of communication regarding Team Brief and how and where this is delivered, concern that it is not disseminated widely enough. Freedom to Speak Up concerns raised and agreed there is more work to do here, discussed the expectations of the FTSUG (Freedom to Speak Up Guardian) role and concern that this can bypass management structures.

- Strategic Workforce Report and quarterly update on People Plan – The paper updated on national news i.e. Non EU update, Medical and Dental pay rise, Speak Up Month and an alternative to supernumerary status for Associate Nurses and then to a local level regarding the Talent Management proposal, a Disability and Wellness network across DHCFT, Zero tolerance to Bullying and Harassment and the People Strategy update. Discussion followed around how we can enable the "Maximising conversation" opportunities working with the Leadership academy and PA Consulting, to develop a proposal for the Trust to develop its approach to Talent Management which will link directly to the business plans for the Trust. Following discussion around the People Strategy update, the Committee wants to be able to see what the progress there is, what the transitions points are and how are they measured and what are the success measures. This will be brought back to the December meeting of the Committee to inform and update.

- Escalation Summary reports from the Committee's sub-groups:

  BME Network – WRES 2017/2018 continues to be tracked by PCC to close the gaps across the key indicators. Work is ongoing to look Disciplinary and Grievance polices to reflect those groups where there are protected characteristics. Recruitment and Zero

Tolerance to Bullying and Harassment work stream action plans updated against the WRES gaps. Dignity at Work policy engagement with the BME network and invites extended to staff side to further this piece of work.

JNCC (Joint Negotiating and Consultation Committee) – discussed the joint working between staff side and People Services policy review regarding tacking Bullying and Harassment in DHCFT. Discussed recruitment and retention hot spots across the Trust and what action is being taken, building more capacity across Band to reduce Agency spend. Agreement to train more staff side representatives for Job Evaluation training to help reduce delays and any backlogs. Key performance indicators re people metrics were discussed and agreement that in future People Performance report will also be shared with JNCC following submission to the Committee. Policies ratified: Health and Attendance Policy, Return to Work Form, Recruitment & Selection Policy. Grievance Policy and Procedures. Policies to be reviewed include: Sickness Absence Policy, Secondary Employment Policy, and Dignity at Work Policy, in light of the KPMG internal audit.

Mindful Health and Wellbeing Group - Group discussed sickness rates and the impact on recruitment and retention in hot spot areas and agreed an update eon sickness rates to be a regular report at this meeting. Discussed DNA's at Occupational Health and process in place to tackle this and flu update with clinics fully booked and more clinics to be made available.

Strategic Workforce Group – Increase in number of requests for student placements and the pressure on areas to accommodate this. Discussion around the Associate Nurse role and how this can be aligned to the Trust Nursing strategy and how further development is required at a national level to align to Mental Health services. Agreed to review the utilisation of the Apprenticeship levy to ensure this will be spent to support future service delivery.

- Deloitte Phase 3 Well Led Framework Progress Review: Appraisal Process update and New Appraisal Process –Timetable of progress to deliver a new appraisal process linked to pay progression as laid down in the newly revised NHS Terms and Conditions of service to be launched following further consultation and training in April 2019. The Committee approved the format of the new appraisal process and paper to go to wider consultation with TMT (Trust Management Team) and JNCC with final sign off back to ELT (Executive Leadership Team).

- Communications Strategy – To focus on five areas of priority : Internal communications and staff engagement, Developing our media profile and external reputation, Stakeholder engagement, Digital communications and Supporting delivery of the Trust Strategy, to be delivered over a three year plan 2018 - 21

- Workforce Supply and Hotspot Areas – assured that the pace of recruitment has progressed significantly, need to provide more focus with regard to the challenges of Medical Workforce recruitment and the medical model. Agreed that a further in depth report will be provided for December meeting. The Committee reiterated the positive progress made to date.

- Leadership and Management Strategy and implementation plan - update given regarding the Leadership Academy and how the monies may be shaped differently (East and West Midlands Academies merging). Keen to be able to measure the change when this is being delivered. Discussed the value of coaching and mentoring to support this programme.

- Staff Recognition and Reward Update Report - How reward works from organisational to individual level, refreshing the DEED scheme, how the Quality Awards will be managed, a consistent campaign for well-being and the importance of the relationship to the individual employee in reward and recognition. These values to be embedded in the Leadership development programme alongside the vison and values and the developing "Promise".

- Workforce Performance Report – next report is to investigate sickness reasons and teams with the highest level of absence and actions to be taken.

Assurance/lack of assurance obtained

- Staff Story – Significant ssurance was taken, positive feedback regarding the way in which this employee was accepted

- Review of BAF Risks – Red to moderate although the paper needed to provide more assurance. Committee took limited assurance at this point and will be able to access further assurance once staff survey results are known at the end of this year.

- Deep Dive BAF Risk 2a Staff Engagement - Not enough assurance to move this risk, agreement to leave as is and to review following results of the next staff survey due December and January 2019.

- Strategic Workforce Report and quarterly update on People Plan – Committee took significant assurance on paper, success factors to be reviewed.

- Escalation Summary reports from the Committee's sub-groups was noted
  - BME Network – could not take not overall assurance yet to deliver
  - JNCC – noted progress
  - Mindful Health and Wellbeing Group – noted progress
  - Strategic Workforce Group – significant assurance given on progress made

- Deloitte Phase 3 Well Led Framework Progress Review (blue form): Appraisal Process update and New Appraisal Process – timetable not concluded until March, reiterated this positive feedback development in timeline, significant assurance received.

- Communications Strategy – significant assurance was taken and that this is concentrating on the five areas outlined in the paper.

- Workforce Supply and Hotspot Areas – assurance given regarding the level of activity - significant assurance received

- Leadership and Management Strategy and implementation plan –significant assurance obtained on the direction of the plan

- Staff Recognition and Reward Update Report - significant assurance was taken

- Workforce Performance Report sickness – limited assurance, Committee to review with deep dive in December report.

Key risks identified

- Impact on service delivery, retention and key people metrics linked to sickness absence levels
- Ongoing Medical recruitment

Decisions made • Appraisal process approved in principle and further consultation to follow • Communications strategy approved • Approved the suggested focus areas for the next six months as outlined in the Communications and Staff engagement paper • Approved the implementation plan of the Management and Leadership strategy	
Escalations to Board or other committee • None identified	
Committee Chair: Margaret Gildea	**Executive Lead: Amanda Rawlings, Director of People Services & Organisational Effectiveness**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 6 November 2018

2018 Flu Campaign Update

Purpose of Report

The purpose of this paper is to update the Board on the current position in regards to the 2018 Flu Campaign

Executive Summary

In 2017 the Trust vaccinated 50% of frontline staff, an increase of 12% from the 2016 figure of 38%. The Flu CQUIN (Commissioning for Quality Innovation) for 2018 requires 75% of frontline staff to be vaccinated. The campaign is progressing well and board will be updated on the latest vaccination rates at the meeting.

Key successes so far include the pre-booking clinics and the roving vaccinator whilst there have been challenges around a PGD (Patient Group Direction) for non-frontline staff and vaccination for over 65s.

There has been a national requirement to complete a flu campaign self-assessment to ensure best practice guidelines are being followed. This is included within the paper. The Trust is rated green across all areas. The Board is asked to note that we have rated ourselves green for section D – incentives. The Executive Leadership Team (ELT) did not feel that staff should be incentivised to have their flu vaccination and believed many staff would not support this. ELT agreed that the approach would be to help staff to see that having a flu vaccination enables them to protect themselves, their colleagues and their patients/clients from the inflection.

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

Assurances

The Board can be assured that the Staff Wellbeing team has analysed the challenges from previous campaigns and addressed these in shaping the 2018/19 flu strategy, along with following national best practice guidelines. The campaign plans and updates have been taken through both the People & Culture Committee and Executive Leadership Team, receiving significant assurance.

Consultation

The campaign was designed following a review of the 2017 effort with lessons learnt integrated into the 2018 approach. This process involved getting feedback from staff and stakeholders across DHCFT.

Governance or Legal Issues

Vaccinating 75% of frontline staff is a requirement of the 2017-19 Wellbeing CQUIN.

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 take assurance on the progress of the flu campaign to date.

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

Report prepared by: **Jamie Broadley**
Staff Wellbeing Lead

2018 Flu Campaign Update

Background
the Trust vaccinated 50% of frontline staff, an increase of 12% from the 2016 figure of 38%.

The Flu CQUIN for 2018 requires 75% of frontline staff to be vaccinated.

This paper lays out the status of the current campaign, which is based on local lessons learnt and national best practice guidelines.

Current Position

During the first week of the campaign the Trust has vaccinated 273 frontline staff which equates to 12.9%.

This figure does not account for several peer vaccinator clinics that have taken place, where there is a lag in terms of returning and processing consent forms.

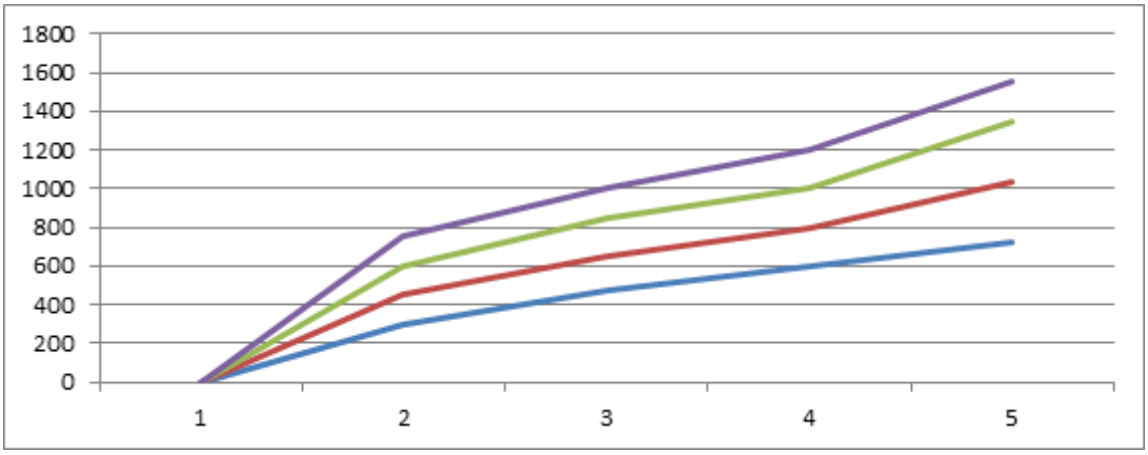
The figure can be broken down by service, as below:

Service	Headcount	Vaccinated	Vaccinated
383 Estates + Facilities	172	22	12.79%
383 Central Services	395	58	14.68%
383 Campus	630	66	10.48%
383 Neighbourhood	552	65	11.78%
383 Children's Services	388	25	6.44%
383 Finance Services	21	2	9.52%
383 Clinical Services Management	28	6	21.43%
383 Corporate Central	30	9	30.00%
383 Nursing + Quality	49	5	10.20%
383 Med Education & CRD	44	11	25.00%
383 Ops Support	76	17	22.37%

Modelling

In order to track progress throughout the campaign we have modelled the Trust's previous performance, in conjunction with regional community trusts to produce the following progress benchmarks and trend lines.

Month	35%	50%	65%	75%
Sep	0	0	0	0
Oct	300	450	600	750
Nov	475	650	850	1000
Dec	600	800	1000	1200
Jan	726	1036	1347	1555



Key Successes

The most significant addition to the 2018 campaign was the pre-booking clinics, which were initially targeted to frontline staff. All of these have now sold out with positive feedback about the ease of the system. Queues for clinics have been lessened with DNA (did not attend) rates also being significantly reduced thanks to the detailed location information on the 'tickets' and the reminder email circulated prior to the clinics.

After the initial run of these clinics we have been able to identify hotspots where further clinic availability is required and have deployed our roving vaccinator to run drop in clinics at these sites through this week. Peer vaccinator vaccination uptake has also increased with positive feedback on the ease of access.

The next stage of the campaign will now be a shift towards reactive drop in clinics and vaccination at events, team meetings and training sessions, utilising our roving vaccinator. This will be a data driven process with uptake monitored regularly to identify hotspot areas.

Key Challenges

The first key area of challenge has been in ensuring the PGD utilised by the Trust covers the vaccination of non-frontline staff. The PGD issued nationally covers the vaccination of frontline healthcare workers, however it is common practice for trusts to amend this in order to cover non-frontline staff. It took until the second week of the campaign for the amended PGD to be put in place. This created some initial confusion over who was eligible for vaccination, however the situation has now been rectified and communications issued accordingly.

The other key challenge is in the suitability of the vaccine for any staff aged over 65. We have procured the quadrivalent vaccine this year, in order to comply with NICE (National Institute for Health and Care Excellence) guidance for the flu campaign. This vaccine provides increased protection for recipients but is not recommended for over 65s. Instead they are recommended to access the trivalent vaccine through their GP, as per the national Public Health flu campaign. This has not been communicated extensively which led to a couple of staff aged over 65 not being able to be vaccinated at a clinic that they have attended. This situation has been further exacerbated by a shortage of trivalent vaccines at GPs and pharmacies.

We are exploring the possibility of procuring some trivalent vaccines for staff over 65 however there may be significant delays associated with this. In the meantime further communications have been issued to raise awareness of the recommendations, manage expectations and signpost affected staff to their nearest appropriate vaccination.

All of these points will be included and expanded in a thorough lessons learnt paper for People and Culture Committee on conclusion of the campaign.

National Assurance

To provide assurance to NHSI (NHS Improvement) on the design and progress of the campaign we have been asked to complete the following self-assessment. We are rated green for each area, demonstrating that the campaign plan follows national best practice guidelines.

A	**Committed leadership**	**Trust self-assessment**	**Evidence**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.		Data capture for vaccine declines through survey in line with national guidance.

A	Committed leadership	Trust self-assessment	Evidence
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers		QIV received
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt		Paper received significant assurance People & Culture Committee
A4	Agree on a board champion for flu campaign		Amanda Rawlings providing campaign updates
A5	Agree how data on uptake and opt-out will be collected and reported		Workforce Information team compiling data from consent forms and surveys
A6	All board members receive flu vaccination and publicise this		Board flu vaccination scheduled for6 November
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives		Flu campaign planned through MHWG (Mindful Health and Wellbeing Group) which covers all representatives
A8	Flu team to meet regularly from August 2018		Bi-monthly flu coverage in MHWG throughout the year.
B	**Communications plan**	**Trust self-assessment**	**Evidence**
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions		Initial frontline staff email detailed the key reasons for vaccination. Mythbusting information a key part of comms campaign.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper		Initial clinic run promoted ahead of campaign with opportunity to pre-book slots. Drop in clinics promoted for large events and training. Mobile vaccinator attending team meetings and other hotspot areas.
B3	Board and senior managers having their vaccinations to be publicised		As above
B	**Communications plan**	**Trust self-assessment**	**Evidence**
B4	Flu vaccination programme and access to vaccination on induction programmes		All inductions covered

B	Communications plan	Trust self-assessment	Evidence
B5	Programme to be publicised on screensavers, posters and social media		3 phases of comms campaign each with associated materials launching 1st week in October
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups		Weekly reporting schedule to all groups agreed
C	**Flexible accessibility**	**Trust self-assessment**	**Evidence**
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered		Top down organisation of flu vaccinators to ensure representation in each area.
C2	Schedule for easy access drop in clinics agreed		October clinic schedule published at start of September.
C3	Schedule for 24 hour mobile vaccinations to be agreed		Peer vaccinators able to cover shifts where required.
D	**Incentives**	**Trust self-assessment**	**Evidence**
D1	Board to agree on incentives and how to publicise this		As in previous years agreed on no-major incentives, instead messages focused around 'the right thing to do'.
D2	Success to be celebrated weekly		Uptake % shared weekly and promoted through Connect

Next Steps

The Staff Wellbeing Team will provide weekly reporting to Executive Directors on a Friday throughout the campaign.

This data can be broken down by service and team to identify hotspots, into which we can deploy our roving vaccinator, increasing uptake by improving access to the vaccine.

Feedback on the campaign and approaches taken within it are being captured throughout and will form the basis of a thorough lessons learnt paper to be presented in early 2019.

2018-19 Board Annual Forward Plan

Exec Lead	Item	1 May 18	5 Jun 18	3 Jul 18	4 Sep 18	2 Oct 18	6 Nov 18	4 Dec 18	5 Feb 19	5 Mar 19
		23 Apr	25 May	25 Jun	24 Aug	24 Sep	29 Oct	26 Nov	28 Jan	26 Feb
SH	Declaration of Interests	X	X	X	X	X	X	X	X	X
CM	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X	X	X	X
CG	Actions and learnings from patient stories	X				X		X		X
CM	Board Forward Plan (for information)	X	X	X	X	X	X	X	X	X
CM	Board review of effectiveness of meeting	X	X	X	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE										
CM	Chair's Update	X	X	X	X	X	X	X	X	X
IM	Chief Executive's Update	X	X	X	X	X	X	X	X	X
MP/CW	NHSI Annual Plan - timing to be confirmed						X			
JS	Data Security and Protection - annual declaration									A
AR	Staff Survey Results and Action Plan									X
AR	Equality Delivery System2 (EDS2) & Workforce Race Equality Standard (WRES) Submission	A			X				X Benchmarking report	
AR	Pulse Check Results and Staff Survey Plan				X					
SH	Corporate Governance Framework							A		
SH	Trust Sealings	X				X				
SH	Annual Review of Register of Interests	A								
SH	Board Assurance Framework Update	X			X		X		X	
SH	Raising Concerns (whistleblowing) and Freedom to Speak Up Guardian Report			X					X	
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance - Confidential - Mental Health Act Committee - Quality Committee - Safeguarding Committee - People & Culture Committee	X	X	X	X	X	X	X	X	X

2018-19 Board Annual Forward Plan

Exec Lead	Item	1 May 18	5 Jun 18	3 Jul 18	4 Sep 18	2 Oct 18	6 Nov 18	4 Dec 18	5 Feb 19	5 Mar 19
SH	Fit and Proper Person Declaration	X								X
MP	Emergency Planning Report (EPPR)					A				
SH	Board Effectiveness Survey									X
SH	Report from Council of Governors Meeting (for information)		X		X	X		X	X	
SH	Review of Policy for Engagement between the Board & COG									A
SH	Board Development Programme									A
GH	Business Plan 2017-18 Monitoring						X			X
GH	Measuring the Trust Strategy	X								
GH	Clinically Led Strategy Development									X
SH	Well Led Recommendations - update report on Phase 3 Deloitte recommendations - close out March 2019						X			X
IM	Race at Work Charter							X		
OPERATIONAL PERFORMANCE										
CG, CW, AR, MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	X	X	X	X	X	X	X	X	x
QUALITY GOVERNANCE										
CG	Quality Report (Incorporates Strategy and assurance aspects of Quality management) Quarterly publication of specified information on death in Jan/Mar/Jul/Oct/Feb/Apr			X	X	X	X	X	X	x
CG/JS	Safeguarding Children & Adults at Risk Annual Report					A				
CG	Annual Looked After Children Report					A				
CG	Control of Infection Report			A						
JS	Annual report on Re-validation of Doctors including NHSE Returnon Medical Appraisals sign off by Trust Chair			A						
CG	Annual Review of Recovery Outcomes						A			
AR	Flu Self Asssment						A		Update	
JS	NHS Resolution Recommendations							X		

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

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

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

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

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