NHS
Derbyshire Healthcare
NHS Foundation Trust

Meeting of the Board of Directors 26 April 2017

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NOTICE OF BOARD MEETING - WEDNESDAY 26 APRIL 2017
TO COMMENCE AT 1.00 PM IN TRAINING ROOMS 1 & 2
CENTRE FOR RESEARCH & DEVELOPMENT, FIRST FLOOR,

	TIME	AGENDA	ENC	LED BY
1.	1:00	Chair's welcome, opening remarks, apologies for absence and declarations of interest	**-**	Caroline Maley
2.	1:05	Service Receiver Story	**-**	Carolyn Green
3.	1:30	Minutes of Board of Directors meeting held on 1 March 2017 Matters arising – Actions Matrix	**A** **B**	Caroline Maley
4.	1:40	Acting Chair's Update	**-**	Caroline Maley
5.	1:50	Acting Chief Executive's Update	**C**	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY				
6.	2:05	Integrated Performance and Activity Report	**D**	Mark Powell/Claire Wright/Amanda Rawlings/Carolyn Green
7.	2:20	Position Statement on Quality	**E**	Carolyn Green
8.	2:30	Equality Delivery System2 (EDS2)	**F**	Amanda Rawlings
9.	2:40	Board Committee Assurance Summaries and Escalations *(minutes are available on request)*: Safeguarding Committee 24 February, Mental Health Act Committee 3 March, Audit & Risk Committee 13 March, Quality Committee 9 March, People & Culture Committee 15 March 2017	**G**	Committee Chairs
10.	2:50	Measuring the Trust Strategy	**H**	Lynn Wilmott-Shepherd
3:00 B R E A K				
11.	3:15	Deep Dive – Acute Inpatients	**I**	Mark Powell
12.	3:40	Business Plan 2017-18	**J**	Lynn Wilmott-Shepherd
GOVERNANCE				
13.	3:50	Annual Review of Register of Interests Annual Review of Trust Sealings	**K**	Caroline Maley Sam Harrison
14.	3:55	Governance Improvement Action Plan Update	**L**	Sam Harrison
15.	4:10	Report from Council of Governors Meeting	**M**	Sam Harrison
16.	4:20	Closure of Board Assurance Framework 2016/17 Issue of Board Assurance Framework 2017/18	**N**	Sam Harrison

CLOSING MATTERS				
17.	4:30	Any Other Business	**-**	Caroline Maley
18.	4:35	2017/18 Board Forward Plan	**O**	Caroline Maley
19.	4:40	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	**-**	Caroline Maley

Questions that are applicable to the agenda, and at the Chairman's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.turner2@derbyshcft.nhs.uk

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

The next meeting will be held at 1.00 pm on 24 May 2017
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 Chairman's discretion.

DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday 1 March 2017

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4:40pm

PRESENT:	Caroline Maley	Acting Trust Chair
	Margaret Gildea	Senior Independent Director
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Maura Teager	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Executive Director of Finance
	Carolyn Green	Executive Director of Nursing & Patient Experience
	Dr John Sykes	Executive Medical Director
	Mark Powell	Acting Chief Operating Officer
	Amanda Rawlings	Director of People & Organisational Effectiveness
	Lynn Wilmott-Shepherd	Interim Director of Strategic Development
IN ATTENDANCE:	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary (Minutes)
For item DHCFT 2017/038	Michael	Service Receiver
For item DHCFT 2017/038	Bev Green	Service Improvement / Head Nurse Hartington Unit
For item DHCFT 2017/038	Bryan Plimmer	Occupational Therapist, Cherry Tree Close
For item DHCFT 2017/038	Alex Kerry	Occupational Therapy Student
For item DHCFT 2017/038	Hannah Lister	Occupational Therapy Student
For item DHCFT 2017/038	Carol Fordham	Occupational Therapy Assistant
For item DHCFT 2017/047	Claire Biernacki	General Manager - Neighbourhoods
For item DHCFT 2017/047	Julia Lowes	Service Manager
APOLOGIES:	Barry Mellor	Non-Executive Director
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
VISITORS:	John Morrissey	Lead Governor, Public Governor, Amber Valley South
	Gillian Hough	Public Governor, Derby City East
	Linda Langley	Public Governor Chesterfield North
	Kevin Richards	Public Governor South Derbyshire
	Melissa Castledine	Derbyshire Mental Health Alliance
	Danielle Sweeney	Observer from Deloitte

DHCFT 2017/037	**ACTING CHAIR'S WELCOME, OPENING REMARKS AND APOLOGIES** Caroline Maley opened the meeting and welcomed everyone. Apologies were noted from Barry Mellor and Samantha Harrison.
DHCFT 2017/038	**SERVICE RECEIVER STORY** Bev Green introduced Michael who had entered the Trust's services through the Radbourne Unit and was then cared for by the recovery team in Cherry Tree Close.

	Bryan Plimmer, occupational therapist from Cherry Tree Close and Alex Kerry and Hannah Lister who are occupational therapy students and Carol Fordham, an occupational therapy assistant also attended the meeting as they had all been involved in Michael's recovery. Michael told the Board how he had gradually progressed over the period of one year from feeling very low when admitted to the Radbourne Unit to his current position of normality. Michael described how he had been happy at the Radbourne Unit as all his meals were provided for him but when his condition improved and he moved to Cherry Tree Close he found it difficult caring for himself, preparing his own meals and socialising with people. He also found it difficult when periods of overnight leave in his own home commenced as he felt this stage had progressed at too fast a pace for him. Despite this Michael improved and settled into periods of home leave which made him realise he could do more things for himself at home and in the community. He started to take part in voluntary charity work and participating in the photography projects run by the Occupational Therapy team. Taking part in these activities encouraged him to re-engage his interest in cricket and he now feels more confident talking to people and socialising. When asked by Carolyn Green if there were any improvements that could have been made to the service he received, Michael said that the support he received at Cherry Tree Close was good. If he had gone straight home from the Radbourne Unit he would have felt isolated and this would have caused him to have very dark days. Michael thought that the preparation for progressing to overnight leave needs improving. Patients should be told what to expect so they can be prepared for this being quite difficult to undertake and be allowed to progress at their own pace. He also thought that people need to be made aware that they will have to cater for themselves in Cherry Tree Close and be given more support to look after themselves. Michael told the Board that being at Cherry Tree Close enabled him to recover at his own pace and get to the position he is in now. He felt he could not have done this without the support that the Trust gave him and was thankful to the staff who encouraged him to give different things a try. He believes it is important that staff get to know the people in their care and understand their interests as this will help patients engage in activities. . From the perspective of the OT team at Cherry Tree Close, Michael worked very hard. Once he knew he could do things for himself he engaged in activities and social events and it was his determination that helped him recover. Activities such as the photography group helped Michael and other service receivers suffering mental health problems to communicate easier because they had something in common. The Board congratulated Michael on his recovery and thanked him for raising the need for patients' interests and passions to be discovered and to agree recovery plans and the pace of leave periods. The Board also thanked the OT team for the support they gave to Michael and the other service receivers at Cherry Tree Close. **RESOLVED: The Board of Directors noted the effort made by the Occupational Therapy Team and the need to meet the expectations of service users at Cherry Tree Close.**
DHCFT 2017/039	**<u>DECLARATIONS OF INTEREST</u>** The Declaration of Interests register was noted.
DHCFT 2017/040	**<u>MINUTES OF THE MEETING DATED 1 FEBRUARY 2017</u>** The minutes of the previous meeting, held on 1 February were agreed and accepted

	subject to item DHCFT 2017/030 on Suicide Prevention Briefing being amended to show that over 50% of all clinical staff have now been trained in the nationally validated suicide awareness training and that further response training is being planned.
DHCFT 2017/041	**MATTERS ARISING AND ACTIONS MATRIX** Ifti Majid gave an overview of the current situation regarding last month's service receiver story and confirmed that a wheelchair had now been provided for this individual. The Board recognised that improved communication with carers and the client would have resulted in a better outcome and that joint working with Derbyshire Community Health Services (DCHS) had established the next steps and learning from this particular case. The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted on the actions matrix.
DHCFT 2017/042	**ACTING CHAIR'S VERBAL REPORT** Caroline Maley reported that during the last month she and other Board members had met with Southern Derbyshire Clinical Commissioning Group (SDCCG) in a 'Board to Board' meeting on 25 February when a positive exchange of views took place. A further meeting with SDCCG will be arranged so that discussions can continue. She also met with the chair of the Derby Teaching Hospitals NHS FT and with Helen Phillips from Chesterfield Royal Hospital and was pleased to hear that they have a positive opinion of our Trust. The new governor induction event took place in February and Caroline Maley was happy to see re-elected governors attending induction again. She also met with Lead Governor, John Morrissey and Gillian Hough the Chair of the governors' Governance Committee and she also attended the Governance Committee. Caroline Maley is planning to meet Dean Fathers from Nottinghamshire Healthcare next week and is looking forward to meeting a number of chairs from other trusts at meetings in London during March. **Voice of the service user community/third sector:** This discussion took place for the first time by the Board. Caroline Maley explained that she and Mark Powell had attended a public meeting at St Mary's House on 14 February when she and Mark had heard the concerns of people working in the voluntary group of services and third sector and she thought it would be good for the Board to consider how to work more closely with voluntary groups in their work; how to leverage their input and support in working for parity of esteem; and how they could support the Trust in conversations with the CCGs and discuss how to take this forward. The Board acknowledged that carer and service receiver groups have representatives that regularly attend the Quality Committee and that Derbyshire Mental Health Alliance work with people on the wards. These reciprocal relationships help the Trust to champion their voice and they do ours. Julia Tabreham asked if the Trust had a strategy for working with both the voluntary and community sector, especially as both these sectors are very different to each other. The Board discussed how these different areas require a different approach and agreed that a theme would be constructed to support both sectors that could also influence progress within our own organisation. The voice of the voluntary and community sector can be maintained through our Equality Delivery System2 (EDS2) work which will enable the Trust Strategy to connect with future service users. The Board agreed that this was a useful discussion and decided that the Executive Leadership Team (ELT) will discuss and propose the way forward for our partnerships

	within the voluntary sector and produce a report for the Board. It is clear that these groups welcome the Trust's involvement and Board members were urged to take part in further voluntary service meetings. **ACTION: ELT to consider the Trust's partnership strategy with the voluntary sector prior to a report being submitted to the Trust Board.** **RESOLVED: The Board of Directors noted the Acting Chair's verbal report and agreed that ELT will propose the way forward for partnerships within the voluntary sector.**
DHCFT 2017/043	**<u>ACTING CHIEF EXECUTIVE'S REPORT</u>** Ifti Majid, Acting Chief Executive, 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 our commissioners and feedback from the Trust's staff. Ifti Majid gave an overview of the key points contained in his report. He drew attention to the Policing and Crime Bill that has since become an Act of Parliament and the Board was pleased to note that this would be considered this month at the Trust's Mental Health Act Committee. Julia Tabreham felt this was a positive direction of travel and asked how confident the Board could be that the Trust's services are ready for this act. Ifti Majid responded that evolution is taking place to ensure the right model is in place. The Trust is working closely with the police and ambulance services and the Mental Health Act Committee will escalate any concerns it might have to the Board. Ifti Majid referred to the letter he had received from NHS England (NHSE) with respect to the operational planning and contracting round 2017/19 and confirmed that the Trust had replied to NHSE stating we are not certain that we will meet the five year forward view for mental health commitments. Ifti Majid believes that the details set out in the letter from NHSE are a real indication of their commitment to ensure that the five year forward view for people with mental health problems is transparently supported. It also provides real leverage to local providers to ensure CCGs are held accountable to local people for their commissioning decisions relating to mental health funding and services. Thanks were given to the South and City Early Interventions Team at St Andrew's House for their hospitality when Ifti Majid and Mark Powell met them recently. Ifti Majid was impressed with their willingness to adopt a solution focused approach to their service and was struck by their strategies for clear two-way communication processes so that Board messages and approaches arrive at team level and helps them to make decisions locally. Ifti Majid made the Board aware of a league table that had just been issued by NHSE containing benchmarking of mental health STPs (Sustainability Transformation Plan). The Trust is ranked twelfth in the UK in terms of delivery of mental health 'must do' indicators and parity and he considered this to be a very positive result. **RESOLVED: The Board of Directors noted the Acting Chief Executive's update.**
DHCFT 2017/044	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)</u>** Mark Powell, Acting Chief Operating Officer, opened discussions on the integrated overview of performance in workforce, finance, operational delivery and quality performance as at the end of January 2017. The Trust continued to perform well against many of its key indicators during January. The key theme continues to be one of ongoing staffing and activity pressure in many of

	the Trust's services. This is highlighted by the difficulty in achieving 100% Registered Nurse fill rates for day and night shifts on our inpatient wards. Although mitigated by extra nursing assistant cover this continues to be a concern which is being monitored continuously and he assured the Board that recruitment plans are being put in place to resolve these issues. Carolyn Green reported that quality performance focus has continued to address the issues arising from the Trust's recent Care Quality Commission (CQC) inspection report. There continues to be extensive activity across all service lines to focus on environmental, clinical, policy and organisational governance priorities and she was pleased to report that a number of the Trust's committees received assurance with regard to the CQC action plans. She also highlighted the need to improve rates in complaints responsiveness and she expects to see this improve now that increased review and performance monitoring is taking place. Claire Wright reported a broadly similar financial situation to the previous month with the key risk being agency spend against the NHSI ceiling. The BAF (Board Assurance Framework) for next year will include cost risks associated with agency spend along with our potential inability to mitigate this risk. She emphasised that this is because decisions made on agency spend will always prioritise the interests of patient safety and always override the NHSI ceiling. Claire Wright made the Board aware of extra regulatory pressure the Trust will be under. She expects the Trust will have to absorb emerging costs associated with recruitment and she stressed the need for the Board to be mindful of further potential financial risks. Amanda Rawlings reported that staff attendance remains a significant challenge to the Trust. Annual sickness absence rates are beginning to stabilise following a two year period of increase. Issues associated with workforce supply, along with recent actions taken to reduce agency usage were all reviewed at the February meeting of the People and Culture Committee. Amanda Rawlings was pleased to report that the Trust's vacancy rate has reduced slightly since last month due to increased recruitment. There is an ongoing focus on clinical vacancies which is supported by a detailed action plan which was also presented at the People and Culture Committee. This action plan focusses on how to attract people to the Trust and includes campaigns across the UK, incentive schemes and introducing overseas recruitment for hard to fill posts. The recruitment process continues to improve especially now that a new e-Recruitment system (TRAC) is in place which will enable managers and candidates to utilise a streamlined, interactive and responsive process, which will reduce or eliminate paperwork and unnecessary delays. Amanda Rawlings expressed concern about the effects of competition from other organisations that pay better rates to their staff. Caroline Maley asked if there was any indication of new supply into the market. In response Amanda Rawlings said education commissioning reductions in nursing opportunities and bursaries might have an effect but the uncertainties that BREXIT might have with workforce supply from outside of this country was also seen as a concern and she emphasised that good quality staff engagement and wellbeing of staff will be key to attracting new staff and improving staff retention. The Board was made aware of changes that will be made with regard to the way self-employed people work within the NHS and the introduction of new taxation rates that could incur further workforce costs due to people negotiating their rates. Mark Powell referred to the robust plans that are in place to improve recruitment and the work taking place within the People & Culture Committee to address immediate issues. He assured the Board that everything is being done to resolve staffing issues, not just in the short term but in 3 – 5 years into the future.

	The Board acknowledged that the content of this report showed that a significant amount of work had been addressed through the work of the Board Committees and took assurance that these key issues are discussed particularly within the People & Culture Committee. It was agreed that a further understanding of improvements that are expected to be made with regard to the level of performance will form a regular part of the IPR from April onwards. **ACTION: A further understanding of improvements that are expected to be made with regard to the level of performance will form a regular part of the IPR from April onwards** **RESOLVED: The Board of Directors considered the Integrated Performance Report and obtained a good level of assurance on current performance across the areas presented.**
DHCFT 2017/045	**<u>QUALITY POSITION STATEMENT</u>** Carolyn Green provided the Board of Directors with an update on the organisation's continuing work to improve the quality of services that are provided in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives. Carolyn Green informed the Board that the CQC had re-inspected secure and older adults services and was pleased to report that she had received an informal notification that the ratings of these services had improved. Carolyn Green drew attention to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) Safety Scorecard that had been developed in response to a request from the Healthcare Quality Improvement Partnership (HQIP) for benchmarking data to support quality improvement and assured the Board that quality improvement scoring would be followed up through the Quality Committee. Julia Tabreham as Chair of the Quality Committee mentioned the need for the Quality Leadership Teams to be supported so they can improve their specific clinical reference groups. She was pleased to see that mentoring and coaching has been offered to these specific groups which will result in them being supported so they can flourish. Claire Wright referred to the sudden unexplained deaths (SUD) data incorporated in the NCISH Safety Scorecard and wanted to make sure that when scrutiny of SUD takes place that the safety aspect is reinforced. John Sykes explained that this is a very explicit term used for an unexplained death and commissioners have confirmed that these incidences are very rare. He assured the Board of the strength of the scrutiny, practice and learning that takes place within the Serious Incident and Mortality Group which is closely monitored by the Quality Committee. **RESOLVED: The Board of Directors** **1. Received and noted the Quality Position Statement** **2. Gained assurance and information on the content of the Quality Position Statement.**
DHCFT 2017/046	**<u>BOARD ASSURANCE SUMMARIES & ESCALATIONS</u>** Assurance summaries were received from the Quality Committee held on 9 February and the People & Culture Committee held on 21 February. **Quality Committee:** Julia Tabreham reported that the Committee is functioning well but is due to lose the valuable experience of its previous Chair and Non-Executive Director member Maura Teager. Her level of clinical challenge will be missed and she wanted to

	thank Maura for the huge contribution she has made to the work of the Committee over recent years. The Committee was assured by the Emergency Preparedness Resilience and Response (EPRR) work on disaster recovery and congratulations were made to the team for this piece of work. The Committee escalated the following two items to the Board, both of which were noted: • Community Health Teams - risk to delivery, emerging potential patient safety issues and significant pressure on staff in the community health teams. • CQC Actions - significant risk to delivery and lack of assurance in CQC actions outside of the Trust's control in commissioning intentions. Concerns regarding the pipeline for financial investment have been relayed to commissioners and that it is not known what effect this will have on our CQC rating. **People & Culture Committee:** Margaret Gildea felt that all issues raised from the February meeting of the Committee had been very well aired by the Board at today's meeting. The Workforce Plan will be received by the Board in April and will enable discussion to take place on future supply and funding. Since the Board decided that only the assurance summaries are to be received at each meeting Caroline Maley made the point that that the summaries should state that minutes of these meetings will be available upon request. **ACTION: Assurance summaries are to include the declaration that minutes of these meetings are available upon request.** **ACTION: Workforce Plan to be submitted to the April Board meeting.** **RESOLVED: The Board of Directors received the Board Committee Assurance Summaries and Escalations.**
DHCFT 2017/047	**<u>DEEP DIVE - NEIGHBOURHOODS</u>** Claire Biernacki and Julia Lowes from the neighbourhood team joined the meeting and provided the Board with an in depth review of the growing pressures faced by the community teams. This report set out some of the risk mitigations and end results which Claire Biernacki highlighted to the Board. She emphasised that the neighbourhood team has a strong awareness of how difficult things are and the pressure they are under. GPs are also under so much pressure they are referring anyone they believe has a mental health problem and Claire Biernacki explained how she was trying to create capacity working with primary care so people can be managed before they get to the threshold of our services. She stressed that commissioners are aware of the gap in resource to deliver appropriate levels of care co-ordination but there is no additional resource to close that gap. In 2015/16 commissioners funded a quarter of the deficit identified at that time, however the rise in rates of referral and other pressures meant that this additional resource had limited impact. The impact of pressure on the neighbourhoods impacts other services such as IAPT, CAMHS, Crisis etc. as to how they can get people flowing into our services. All these services are feeling the impact. Discussion centred on how long people are waiting to be seen. It would appear that this varied and depended on whether beds were available and in some cases there is a 3 – 5 month wait. The team is very aware of people's needs and where they are being referred from and will prioritise people on the waiting list. Amanda Rawlings asked whether

	people who wait 3 – 5 months deteriorate and what effect this had on carers and families and the cost to the community. Claire Biernacki explained that there are levels within the waiting lists and there is also a 'waiting well' policy which works capably but is under significant stress. The significant number of caseloads that the team has to manage was discussed. Large caseloads impact on clinical capacity to provide effective, efficient and good quality treatment, they also impact on the stress levels of workers and this is reflected in sickness levels, staff survey feedback and staff turnover rates. Carolyn Green proposed to work with the neighbourhood team to develop an improvement plan that will result in reducing caseloads. Mark Powell wished to assure the Board that a planning process to reduce this risk mitigation is already in place through the Contract Management Board and the Trust's Management Team (TMT). The Board committed to support the neighbourhood team to mitigate this risk and reduce bureaucracy and decided on the following actions: **1) Detailed mitigation plan to be prepared to show there are assurance mechanisms in place defined through TMT to ELT to Quality Committee and then the Board.** **2) Assurance model to be put in place around CPA, waiting lists and "waiting well" procedure which will be monitored through Quality Committee, TMT and ELT** **3) Contract team to continue to lobby commissioners for more resources for community workers linked with the STP. This will be reported through the Finance & Performance Committee** **4) Ifti Majid will write to Andy Gregory acknowledging the level of risk on the community teams and the need for improved commissioning** **5) Ifti Majid will write from the Board to the neighbourhood teams attaching the deep dive report** Carolyn Green informed the Board that the Safeguarding Committee met last week and 'red rated' the risk of the allocation of care co-coordinators to safeguard children from harm. This is a residual action that has not yet been resolved and she asked that Andy Gregory responds to this risk when he replies to Ifti Majid's letter. This was a very comprehensive report that showed the daily decisions that the teams have to take. The Board recognised the level of risk the neighbourhood team is carrying. Their work is very much valued and the Board applauded the inventive way in which the team resolves issues. **RESOLVED: The Board of Directors:** **1) Considered the content of this paper** **2) Agreed to formally address the level of risk on the community teams and the need for improved commissioning community with commissioners**
DHCFT 2017/048	**<u>GOVERNANCE IMPROVEMENT ACTION PLAN (GIAP)</u>** As described in the GIAP Governance and Delivery framework, the Board has overall responsibility for ensuring that the GIAP is delivered. In the absence of Sam Harrison, Mark Powell presented this report to provide Board members with an update on progress on the delivery of the GIAP, including the identification of tasks and recommendations that are off track.

	The Board noted the progress made against each recommendation and as well as issues that were raised through the Board Committee Assurance Summaries. The Board was pleased to note that there were no recommendations rated as red "off track". The recommendations that have some issues and were amber rated were reviewed and noted as follows: • **Core 3 - Clinical Governance - ClinG1 *(Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums)*:** There is still some progress to be made with this recommendation and it is hoped this can be completed before the May deadline. • **Core 6 - Roles and Responsibilities of Board Members - RR1 *(Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions)*:** this recommendation remains as having some issues pending assurance from Remuneration and Appointments Committee The Board scrutinised the blue forms and the following comments were noted: • **PC3 *(Supplement the current mechanisms to engage with staff through the inclusion of more informal activities across both clinical and corporate areas. Develop clearer reporting of information and trends from these activities in order to triangulate with other information, for example, through the CEO report and Quality Position Statement)*:** The Board felt satisfied with the evidence provided by the People & Culture Committee that the Board and senior management are engaging with staff and passed this recommendation. • **PC4 *(Prioritise the development of the People Strategy and ensure the agenda and focus of the newly formed People and Culture Committee is clearly aligned the Trust's overall strategy)*:** The Revised People Plan captures actions and priorities for 2017 and was submitted to the January 2017 People & Culture Committee meeting and approved. The Board was assured that the People Plan is now embedded in the organisation and forms the basis of the agenda for the People & Culture Committee and passed this recommendation. • **GClinG3 *(Increase the effectiveness of the Quality Committee by ensuring clear alignment of the committee with the quality strategy and associated objectives, and ensuring a clear focus on seeking assurance)*:** The Quality Committee is now much more focussed on strategic priorities and the CQC. The Committee's forward work plan has been developed to cover all areas of the Quality Committee terms of reference and the agenda has been structured according to CQC domains and covers topics to support the delivery of the quality strategy and is cross referenced against quality priorities. The Board passed this recommendation. • **WOD1 (DR34 *Define and agree a process to regularly monitor the consistent application of HR policies and procedures for the full range of Employee Relations cases):*** The employment relations paper, submitted to the January People and Culture Committee provided sufficient evidence of completion of actions and provided the Board with assurance that this action could be signed off. • **WOD1 (CQC1 *the Trust must ensure HR policies and procedures are followed and monitored for all staff)*:** The People & Culture Committee obtained evidence that training and adherence to procedures had taken place and passed CQC1. This resulted in the Board being assured that this action could be signed off.

- **WOD4** ***(As part of its review programme, the Trust may wish to consider a mandatory programme for line managers in order to embed the revised policies and procedures)*****:** The People & Culture Committee felt satisfied that all HR policies are up to date. A training programme has been rolled out and policies are being complied with. The Board passed this recommendation.

- **WOD7** ***(The trust should monitor the adherence to the grievance, disciplinary, whistle-blowing policies and the current backlog of cases concluded)*****:** The People & Culture Committee was satisfied that systems are in place that focus on governance and was assured that people now understand the Whistleblowing Process. The Board passed this recommendation.

- **WOD8** ***(The Trust should continue to make improvements in staff engagement and communication)*****:** The Staff Engagement Group has driven the progress of this action and People & Culture Committee was satisfied that the right mechanisms are now in place. The Board passed this recommendation.

- **CQC2** ***(The Trust should continue to proactively recruit staff to fill operational vacancies)*****:** The Board heard that a lot of debate took place during the February meeting of the People & Culture Committee and it was agreed that this recommendation could be passed as sufficient progress had been made. The Board passed this recommendation.

- **PC2** ***(Develop and undertake a clear programme of work around culture, utilising the expertise of other NHS Trusts in the Local Health Economy, and where necessary beyond, to inform the programme of activities)*****:** Mark Powell informed the Board that the People & Culture Committee did not feel sufficiently assured to pass this recommendation and asked that a clear programme of work be evidenced to enable a blue form to be submitted to the next Board meeting. The Board looked forward to receiving the assurance that this action can be closed at the next meeting on 29 March.

Amanda Rawlings wished it to be recorded that six Board members attended the February meeting of the People & Culture Committee and scrutinised the GIAP recommendations the Committee has oversight for.

The report provided the Board with assurance of the delivery and risk mitigation from Board Committees and Lead Directors. Having reviewed the detail contained in the blue forms the Board felt satisfied that that strict scrutiny of all the GIAP recommendations had taken place and sufficient evidence had been provided to show that actions had been completed and that the above recommendations could now be closed and archived. The Board was also pleased to hear that a Communications programme is being developed to ensure staff are aware of the completion of the GIAP recommendations.

The pipeline of GIAP recommendations was noted and the Board acknowledged that this would be adjusted to take into account the scheduling of the Extraordinary Board Meeting that will take place in private session on 29 March.

RESOLVED: The Board of Directors:

1) Noted the progress made against addressing GIAP recommendations
2) Discussed and noted the areas rated as 'some issues'
3) Formally approved the 10 blue forms as presented and confirmed they provided assurance of completion, namely:

- **PC3**
- **PC4**
- **PC5**
- **ClinG3**

	• **WOD1** • **WOD3** • **WOD4** • **WOD7** • **WOD8** • **CQC2** **4) Noted the GIAP recommendations approval pipeline and its role in supporting effective oversight of progress** **5) Agreed that no further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting**
DHCFT 2017/049	**2016/17 BOARD FORWARD PLAN** The forward plan was reviewed and will be carried forward to next year. Carolyn Green asked that the Equality Delivery System2 (EDS2) be captured in the forward plan and was assured that this was scheduled for April in the 2017/18 forward plan that will be received at the April Board meeting. **RESOLVED: The Board of Directors noted the forward plan for 2016/17.**
DHCFT 2017/050	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK OR GIAP** Level of risk on the community teams and the need for improved commissioning within community services is to be included in the BAF deep dive schedule of risks.
DHCFT 2017/051	**MEETING EFFECTIVENESS** The Board agreed there have been some good discussions on the Trust's key issues and enough time was devoted to discussions. Mark Powell was pleased that the Community Team was able to discuss the risk associated with the neighbourhoods. The level of detail contained in the report gave a good opportunity for discussion and it is clear that the team benefitted from putting the paper together. Significant progress has been made with the GIAP and this was seen through the engagement of the Board Committees in this process. Discussion on the IPR took place regarding further evolution to further enhance the triangulation. However the Board fully recognised the successful progression in integrated reporting. Today's meeting was observed by Danielle Sweeney from Deloitte who commented that the meeting was well planned; the agenda was very transparent. It was good to hear the service receiver story and she was pleased to see an effective deep dive take place in public session. There was strong governor attendance and she made positive comments with regard to Board member challenges and she observed clarity in the actions agreed and decisions made.

The next meeting of the Board held in Public Session will take place at 1pm on Wednesday, 26 April 2017.

The location will be Training Rooms 1 and 2
Research and Development Centre, Kingsway, Derby DE22 3LZ

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - APRIL 2017			Enc B
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
11.1.17	**DHCFT 2016/007**	Integrated Performance Report	Mark Powell	Mark Powell will circulate a draft of changes made to the IPR to Board members for comment in advance of April, this will include KPIs taken from the single oversight framework.	26.4.2016	Revised IPR will be submitted to April Board meeting and will include KPIs taken from the single oversight framework.	Green
11.1.17	**DHCFT 2016/010**	GIAP Update	Amanda Rawlings Sam Harrison	Monitoring and reporting to form part of forward planning for the People and Culture Committee and will be incorporated into the Committee's annual work plan for 2017/18	1.3.2017	Monitoring and reporting of GIAP is captured in People & Culture Committee's forward plan. Amanda Rawlings will also incorporate the GIAP into the terms of reference where relevant ready for them to be reviewed at April People & Culture Committee meeting.	Green
1.3.17	DHCFT 2017/044	Integrated Performance Report	Mark Powell	A further understanding of improvements that are expected to be made with regard to the level of performance will form a regular part of the IPR report from April onwards	26.4.2017	Revised IPR agreed at Board Development session on 12 April.	Green
1.3.17	DHCFT 2017/046	Board Assurance Summaries & Escalations	Sue Turner	Assurance summaries are to include the declaration that minutes of these meetings will be available upon request	26.4.2017	Agenda now states that minutes of meetings are available upon request.	Green
1.3.17	DHCFT 2017/046	Board Assurance Summaries & Escalations	Amanda Rawlings	Workforce Plan to be submitted to the April Board meeting	26.4.2017	Now deferred to May meeting	Yellow
1.3.17	DHCFT 2017/047	Deep Dive Neighbourhoods	Mark Powell	Detailed mitigation plan to be prepared to show there are assurance mechanisms in place defined through TMT to ELT to Quality Committee and then the Board	26.4.2017	Mitigation plan developed and presented to TMT on 24 April.	Green
1.3.17	DHCFT 2017/047	Deep Dive Neighbourhoods	Mark Powell Carolyn Green	Assurance model to be put in place around CPA, waiting lists and "waiting well" procedure which will be monitored through Quality Committee, TMT and ELT	26.4.2017	This will be addressed as part of the mitigation plan in action above.	Green
1.3.17	DHCFT 2017/047	Deep Dive Neighbourhoods	Lynn Wilmott-Shepherd	Contract team to continue to lobby commissioners for more resources for community workers linked with the STP. This will be reported through the Finance & Performance Committee	26.4.2017	Tranferred to F&P. Scheduled on F&P agenda for 22 May meeting.	Green
1.3.17	DHCFT 2017/047	Deep Dive Neighbourhoods	Ifti Majid	Ifti Majid will write to Andy Gregory acknowledging the level of risk on the community teams and the need for improved commissioning	26.4.2017	Letter sent to A Gregory 6 March 2017	Green
1.3.17	DHCFT 2017/047	Deep Dive Neighbourhoods	Ifti Majid	Ifti Majid will write from the Board to the neighbourhood teams attaching the deep dive report	26.4.2017	Neighbourhood Teams have now received the March Board deep dive report.	Green

Resolved	**GREEN**	9	90%
Action Ongoing/Update Required	**AMBER**	0	0%
Action Overdue	**RED**	0	0%
Agenda item for future meeting	**YELLOW**	1	10%
		10	100%

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors 26 April 2017

Acting Chief Executives 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. 31 March saw the release of the Next Steps on the 5 Year Forward View by NHS England and NHS Improvement. The document clear defines 4 key priorities for the coming year:

   - Deliver financial balance across the NHS
   - Improve A&E performance
   - Strengthen access to GP and primary care services
   - Improve cancer and mental health services.

   With respect to improving performance in A&E the key change is an increase in the speed with which improvements are required. By September this year 90% of patients will be treated in 4 hours (up from 85% currently) and the setting of a 95% standard from 2018. The document also describes requirements associated with using the £1billion social care budget money to reduce DTOCs in association with local authorities, implement comprehensive front door clinical streaming and focus on improving patient flow.

   It is positive to see the document clarifying the future role of STPs. It clarifies that STPs will not replace the accountability of individual Organisations but will be in addition having clear governance and 'support chassis' to enable effective working. The document describes the journey all STPs (now called Sustainability and Transformation Partnerships) should aspire to through development towards an Accountable Care System (all organisations, commissioner and provider, working under a formal shared partnership/contract agreement binding aims and outcomes together) then potential on to an Accountable Care Organisation. The document recognises this is many years away but ultimately is a single Organisation in a defined area responsible for the delivery of all care and treatment. The document goes on to identify a 10 point plan to increase efficiency:

   - Free up 2000 to 3000 hospital beds - Using the extra £1bn awarded to adult social care in the last budget hospital trusts "must now work with their local authorities, primary and community services to reduce delayed transfers of

care."

- Further clamp down on temporary staffing costs and improve productivity - Trusts are set a target of cutting £150m in medical locum expenditure in 2017/18. NHSI will require public reporting of any locum costing over £150,000 per annum.

- Use the NHS' procurement clout - All trusts will be required to participate in the Carter Nationally Contracted Products programme, by submitting and sticking to their required volumes and using the procurement price comparison tool.

- Get best value out of medicines and pharmacy - NHSI support trusts to save £250m from medicines spend in 2017/18 by publishing the uptake of a list of the top ten medicines savings opportunities, and work with providers to consolidate pharmacy infrastructure.

- Reduce avoidable demand and meet demand more appropriately - NHS provider trusts will have to screen, deliver brief advice and refer patients who smoke and/or have high alcohol consumption in order to qualify for applicable CQUIN payments in 2017/18 and 2018/19.

- Reduce unwarranted variation in clinical quality and efficiency - trusts to improve theatre productivity in line with get it right first time (GIRFT) benchmarks and implement STP proposals to split 'hot' emergency and urgent care from 'cold' planned surgery clinical facilities for efficient use of beds.

- Estates, infrastructure, capital, and clinical support services - The NHS and Department of Health are aiming to dispose of £2bn of surplus assets this parliament, following recommendations from the Naylor review (referenced later in my Board report).

- Cut the costs of corporate services and administration - NHSI is targeting savings of over £100m in 2017/18, from trusts consolidating these services, where appropriate across STP areas. NHSI is also establishing a set of national benchmarks.

- Collect income the NHS is owed - The Government has set the NHS the target of recovering up to £500m a year from overseas patients, twenty trusts will now pilot new processes to improve the identification of chargeable patients.

- Financial accountability and discipline for all trusts and CCGs - Outlines the operation of control totals - 70% of the STF will again be tied to delivery against control totals. Provider trusts not agreeing control totals will lose their exemption from contract fines. From August 2017 CQC will begin incorporating trust efficiency in their inspection regime based on a Use of Resources rating. Trusts missing their control totals may be placed in the Special Measures regime.

It is not clear at present how these extra requirements will be monitored though I anticipate an increase in ad hoc reporting and use of the regular performance meetings all Trust now have with NHSI. In addition to the general requirements above

that apply to all Trusts, there are a number of mental health specific requirements:

- An extra 35,000 children and young people being treated through NHS-commissioned community services in 2017/18 compared to 2014/15
- NHSE to fund 150-180 new CAMHS Tier 4 specialist inpatient beds, rebalancing beds from parts of the country where more local CAMHS services can reduce inpatient use.

- 74 24-hour mental health teams at the Core 24 standard, covering five times more A&Es by March 2019 (Our Liaison teams already meet this standard in the south and some specific funding received will add a small number of staff to the liaison team in the north meeting the standard there)

- An extra 140,000 physical health checks for people with severe mental illness in 2017/18.

These requirements will be enabled by:

- Expanding the mental health workforce – 800 mental health therapists embedded in primary care by March 2018, rising to over 1500 by March 2019.

- Reform of mental health commissioning so that local mental health providers control specialist referrals and redirect around £350m of funding.

- Clear performance goals for CCGs and mental health providers using the new national mental health dashboard

The Executive team are working to understand the impact of these requirements both the general requirements and the mental health specific KPI's. this will be reported through to Finance and Performance committee and the national dashboard will form part of the revised integrated performance report to ensure Board has oversight of the tool used nationally to monitor Derbyshire's performance

2. During March Sir Robert Naylor's independent report into NHS Property and Estates was published. The review set out to develop a new NHS estate strategy, which supports the delivery of specific Department of Health (DH) targets to release £2bn of assets for reinvestment and to deliver land for 26,000 new homes. The general consensus is that the current NHS capital investment is insufficient to fund transformation and maintain the current estate. It is estimated that STP capital requirements might total around £10bn, with a conservative estimate of backlog maintenance at £5bn and a similar sum likely to be required to deliver the 5YFV. This could be funded through property disposals, private capital (for primary care) and from HM Treasury. However, the NHS needs to develop a robust capital strategy to determine the final investment requirements through the STP plans. The review was predicated on widely accepted assumptions that the NHS estate is not currently configured to maximise benefits for patients or taxpayers. It considered:

   - The size of the opportunity – building on the Carter Report on efficiency

   - The mix of incentives and sanctions required for delivery

- How to strengthen capacity and capability across the system

The review makes 17 recommendations that include:

- Setting up of a new National NHS Property Board
- Greater use of benchmarking to ensure STP property plans achieve the required performance prior to agreeing capital requests
- Disposals will not be recovered centrally but will be used to support delivery of STP plans
- Primary care facilities must meet the vision of the five year forward view
- Land vacated by the NHS should be prioritised for the development of residential homes for NHS staff where there is a need
- NHSE and NHSI must work together to deliver a robust capital investment plan by summer 2017.

The requirements of this report that impact on our Trust will be factored into the regular estate updates presented to Board and F&P Committee.

3. The Royal College of Psychiatrists has published a report led by trainees into morale and training within psychiatry. Junior doctors have recently begun to be referred to as ‘canaries in the mine’ (not a great term) but descriptive in it suggests that how junior doctors (and other trainee grade staff) are feeling gives us early warning signs as to how the bulk of NHS staff are feeling in the system as a whole. The report paints a positive picture of what can be addressed, many of the recommendations are about being good employers and good educationalists. Ensuring that the basic needs of trainees are met, protecting time for educational activities and communicating effectively about expectations. I consider it vital that as a Trust we consider carefully the recommendations of this report. We are aware of the pressure nationally on recruiting psychiatrists and it is my belief that through being and exemplar training and placement organisation we become a much more attractive employer for all our staff.

When asked what trainees value most I was struck by the similarity to what all our staff tell us is important to them. The report makes a number of recommendations broken into two sections Core Commitments and Desired Commitments. The Core commitments include:

- All trainees must receive their minimum of 1 h supervision per week with their psychiatric supervisor as stipulated in the curriculum
- All trainees must receive a minimum of one teaching session per week provided through a local programme or on a recognised MRCPsych course
- All trainees, where applicable, must receive timely allocation of psychotherapy cases with protected time for clinical sessions and supervision
- All higher specialty trainees must receive a minimum of two sessions per week (pro rata for LTFT), agreed with their educational supervisor or training programme director, to pursue their special interests. This may include clinical, educational, research or leadership and management activities

I would recommend that as a Board we accept these commitments in full tasking Dr John Sykes and Dr Vishnu Gopal (Director of Medical Education) to report current compliance and proposed action plan to full compliance through to People and Culture Committee.

The report can be seen attached as appendix 2.

Local Context

4. In light of the Next Steps on the 5 Year Forward View requirements around STP governance the process in Derbyshire has started to fill programme leads posts that will support the review and delivery of the business case components that make up the STP. The importance of these roles is enhanced by the ongoing serious financial pressures our local CCGs are facing and the need to deliver high impact transformational change in a co-ordinated way across the health and social care system.

5. As part of the Trusts response initially to the Lord Carter review and requirement to improve local efficiency and latterly in response to the Next Steps of the 5 year Forward View we have commenced work to enter into a jointly delivered People and Organisational Effectiveness function, initially with Derbyshire Community Health Services NHS FT (DCHS) but with the expectation that the number of organisations involved will grow over time. For the avoidance of doubt this arrangement is separate to the integration work between the two Trusts and would have gone ahead regardless of that work. The new service will consist of 7 component parts:

    - Business Partners
    - Employee Relations
    - Staffing Solutions
    - Workforce Information
    - Workforce Development

- Health and Safety
- Equality and Diversity

Each of these 7 components has a service specification that has been developed and agreed by the Executive Team as supporting the ongoing requirements of our Trust and importantly building on and embedding the significant improvements that have been made as part of the Governance Improvement Action Plan. The service change will be delivered in two phases over the next 3 months, phase 1 being to work with senior staff effected by change to create the new functions leadership structure then phase 2 will be to move remaining staff into posts within the structure and TUPE all staff into DCHS. This process will be governed through the People and Culture Committee and the new service will be subject to performance review and contract monitoring in line with all 'outsourced' services.

6. Derby City Healthwatch have completed a review of 421 attendees at A&E in the City. The review showed that one of the major causes of attendance at A&E was lack of availability of a GP appointment - 1in 4 of people who were spoken to cited that as the reason for attending. This was a significant worsening in the City from the last review in 2015. Interviews with attendees at A&E also showed that awareness of other sources of treatment in the City was poor.

7. On 31 March I attended a Regional Health Education England event to launch the new national mental health workforce strategy. The Mental Health 5 Year Forward View and Future in Mind have described deficits in skills and competences of existing mental health teams, which hinder their ability to deliver the most effective interventions for their service users. The expansion and transformation ambitions of the Five Year Forward View are expected to require approximately 14,000 FTE additional staff to be working in 12,000 new posts across the priority areas. This increase in staff needs to be viewed in the context of significant pressures already on staffing numbers in core services and leaver/turnover rates significantly higher than Acute Trusts. The Department of Health and Arm's Length Bodies including Health Education England, NHS England and NHS Improvement have agreed that the focus of this strategy and the workforce interventions during the period should be primarily focussed on expanding the workforce in the priority areas.

   The strategy describes ways in which barriers to transformation can be overcome through concerted effort and collaboration. It describes ways to build skilled, knowledgeable and competence based teams in order to minimise the 'capability' gap (the skills required to deliver care) and enable teams to deliver high-quality, NICE-concordant care. It is further categorised by five "pillars" which describe areas of workforce interventions in order to meet the 'capacity' gap (how many people are required to deliver care). High level actions for bodies at a national level are described which will drive implementation at local, regional and national levels, as well as proposals for measuring success.

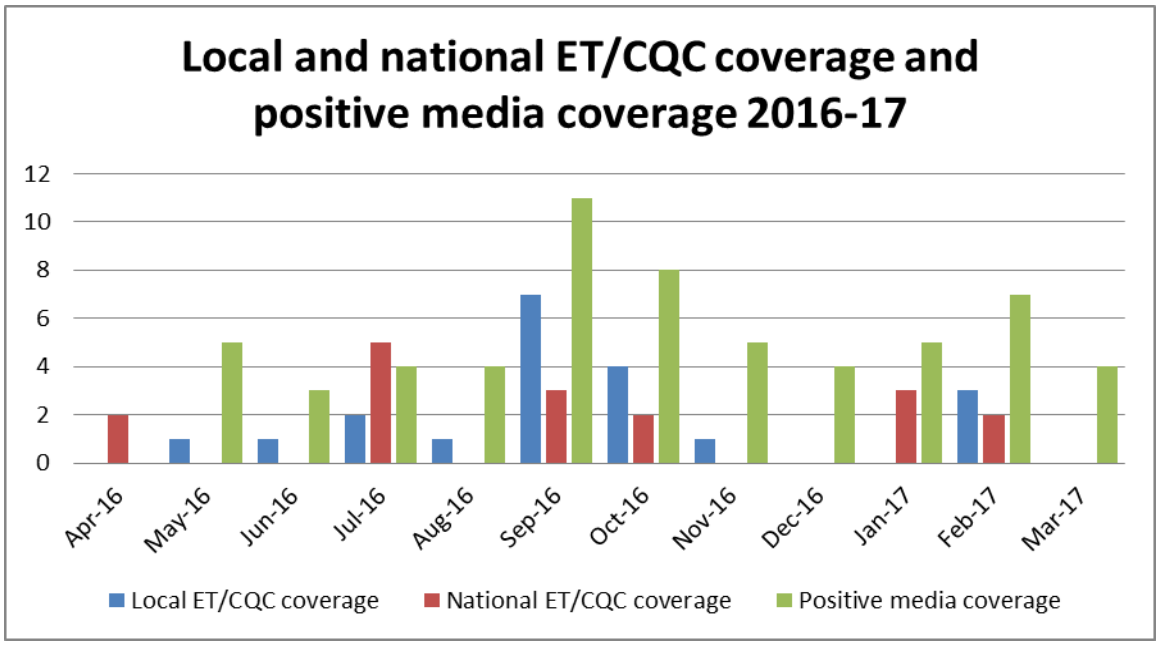
   I will continue to be part of the oversight group across the Midlands and East Region.

Within our Trust

8. On 17 March I attended the Trust's BME staff network Annual Conference. This was a well-attended event that was facilitated by Rasheed Ogunlaru. I was particularly

impressed with how our colleagues adopted a positive can do approach to supporting improvements and the openness with which staff shared their experiences, concerns and thoughts about where improvements have already been made. The outcome of the day was a re-invigorated Mission and Vision for the network and clear set of objectives. I also requested the group are clear about what support is needed from the Trust (a wish list). A write up of the day by Harinder Dhaliwal is included as appendix 1. I can confirm that all requested support including a ring fenced budget has been provided and further more as discussed on the day all Executive Team members have agreed to act as 'Reverse Coaches' working with staff members from all our Regards groups, shadowing them to find out what it is like to be a member of a protected group working in our Trust.

9. The graph below shows the media coverage we have received as a Trust during 2016/17 relating to our CQC results and the aftermath of the complex employment tribunal in 2015. It also includes positive media stories the Trust has had reported to show the balance. From the graph it is clear to see that negative media coverage began to reduce in the second half of last year and even at the points of higher local and national coverage we still were having more positive stories picked up than negative.



The Board should note that the number of articles doesn't always accurately convey the impact of the coverage; some Derby Telegraph articles about the employment tribunal, for instance, were on the front page in the early part of the year and were extensive. Our communications team seeks to examine the influence these articles have had on people's attitudes about the Trust (i.e. the outcome of this negative and positive publicity). Throughout this period we have continued to generate positive news on our social media channels (Facebook, YouTube and Twitter) which allow us to communicate directly with audiences.

10. As I have previously reported, during December and January we received further visits to our Low Secure Service, Older Adults In-Patient Services, Children's Service and Learning Disability services. The formal results of those inspections are now available

on the CQC website and whilst they will be reported in more detail in the Quality Report in the Board I am delighted in three of the four areas domains were upgraded meaning that both Low secure Services and Older Adult Services have been regraded in entirety to requires Improvement. This is a great achievement by all staff concerned in such a short time. In addition I had a letter in march from James Mullins (CQC) to inform me that the warning notices applied to the Trust after the comprehensive inspection in June last year have been lifted in full – again testament to the hard work of staff at all levels within the Organisation.

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

(Board) Assurances

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

Consultation

- The report has not been to any other group or committee

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

Equality Delivery System

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 feedback 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 regionally have the potential to have an adverse impact on people with protected characteristics (REGARDS).

Five Year Forward View
This report details a number of outline plans that should improve access to and outcomes of healthcare. It is essential we collect the correct data on the newly defined initiatives to ensure the access and outcomes for protected groups are at least no worse than other parts of the population. I would expect this to be reviewed as part of implementation plans and monitored through ongoing EDS2 reviews for new service areas.

Naylor Report
There is a potential that this could impact on experience and access for protected groups. If we are reviewing, moving and closing estate we need to ensure that all plans do not

make it harder for people who are less mobile (in its broadest sense) to get to or get into our services. This will be mitigated as any proposed estate changes in the Trust in response to this report will be specifically equality impact assessed.

Mental Health Workforce Strategy
It is good to see that the strategy makes specific reference to upskilling staff to improve outcomes for people from protected groups and to consider ways of attracting more people into the workforce from protected groups however it doesn't make reference to retention, promotion and representation of staff from protected groups within mental health workforce and so this is something we will develop locally as part of the Boards 6 key priorities

Recommendations

The Board of Directors is requested to:

1) Note the contents of the update
2) Accept the Core Commitments of 'Supported and Valued', Royal College of Psychiatrists, tasking People and Culture Committee to monitor ongoing progress.

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

Appendix 1

Annual Conference
Friday 17th March, 2017 9am to 4.30pm Centre R & D, Kingsway

BME Network Annual Conference -Strategy– Development – Coaching – Team-working.

This initial report gives a brief outline of the annual BME Staff Network annual conference. A full report and evaluation will be produced by Harinder Dhaliwal, Assistant Director for Engagement & Inclusion over the coming weeks. This session was facilitated by Rasheed Ogunlaru, experienced life, corporate and business coach / broadcaster and author of Soul Trader – Putting the Heart Back into Your Business.

Please note that the author has tried to use phrases used by the BME network colleagues to capture and do justice to the feedback and discussions taking place during the session

The event was promoted widely across the Trust and senior leaders were asked to nominate/encourage attendance from BME staff in their respective areas to maximise the 'BME voice', staff engagement and representation across the occupations.

Ifti Majid, Acting Chief Executive, champions the BME Staff Network attended the event and shared his commitment to equality and diversity. He listened to the lived experience of BME staff in the Trust and actively participated in the discussions, including the benefits of network, SWOT analysis and action planning. This was included in his weekly Friday email to all staff. A 'we need list' has been included at the end of the document as requested by the Acting CEO to share as part of his update to the Board.

The BME Staff Network dovetails into Trust staff engagement meeting/mechanisms, supports staff survey action plan, Equality Delivery System2, Workforce Race Equality Standard (WRES), and delivery of corporate Equality action plan (via Equality Forum and People & Culture Committee).

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Aims of session:

- An empowering strategic, coaching and planning session to help progress the BME Network, members and supporters.
- Build your personal, career, leadership, team and people skills.

Outcomes:

- Energised, self-empowered, engaged, proactive BME Staff
- Strategic Road Map – mission/purpose, vision, objectives and action plan and steps for the BME network

- Dovetailing with Workforce Race Equality Standard Action Plan and Equality Delivery System (EDS2).

Key headlines and points

Mission: To achieve open and fair access to opportunities, development and progression to ensure equality in career outcomes.

Vision:

- Representation, having a voice and visibility (to be heard, seen and listened to).
- BME staff and wider staff reporting positive working experience and environment. Ensure BME people no longer feel bullied.
- Diverse, skilled, talented and experienced workforce providing quality service based on individual need.
- To have a happy and healthy workforce and community.
- Equality and fairness - recognition by Trust and accessibility.

Objectives (no particular order at this stage - these will be developed into a SMART action plan:

- Accountability from the Board and network – mutual expectation to live the Trust values and a place where you can be yourself (identity), feel valued and sense of belonging. BME people no longer feel excluded or bullied.
- To grow the BME network by (% tbc)
- Equality performance, meeting equality legislation, CQC regulations and benchmarking for equality progress – to support the trust assess and feed into EDS2 annual grading, WRES action plan and staff survey.
- To track BME progression compared to non-BME groups and provides solutions to address gaps and barriers.
- To act as a reference group for on matters of diversity and access
- To support Equality Impact Risk Analysis and annual quality audit of EIRA to ensure fair application and outcomes of policy and decisions (equal quality of access, experience and outcomes).
- To have a BME member of staff on (% tbc) on shortlisting, recruitment panels and disciplinary hearings.
- Accessibility – widen access and visibility across the trust to raise profile of BME staff
- Equity at all levels - to ensure the proportionate levels/percentage of staff is representative across all the bands/levels not just Trust representation compared to overall Derbyshire population (skewed by medical workforce and need to look at Derby City and Derbyshire as populations are different). Review against baseline readings and build on these to show progress.
- Increase the positive staff experiences with the Board prioritising BME staff engagement.

- Positive action and access for staff at lower bands – generating greater access for training and development.
- Talent management and succession planning –increase pool and identification of potential BME leaders (particularly bands 7 and 8 for acting up roles etc.) to ensure fair access and progress to senior leadership roles.
- BME workshop and dialogue with board/senior leaders and reverse coaching programme
- Celebrate Black History Month and other key events.

We need list (as requested by Acting CEO)

BME Staff Network – £30K dedicated resources and specific cost centre to:

- Fund refreshments for monthly meetings
- Consistent administration to plan, support note taking and promote network.
- Development of events as per objectives and action plan above.
- To support annual EDS2 and EIRA quality audit
- Time to chair meetings
- Protected time for BME staff to attend from across the Trust and backfill if required to support release of staff.
- Annual BME Staff Network conference and workshops.
- Development programme for BME people that is specific to individual needs, such as attending conferences and sharing with network, leadership, coaching, secondments and acting up.
- Celebrate diversity events such as Black History Month.

Report sponsor: Ifti Majid, Acting Chief Executive.

Report prepared by:
Harinder Dhaliwal,
Assistant Director Engagement & Inclusion
20 March, 2017

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Supported and valued?

A trainee-led review into morale and training within psychiatry

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The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).

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Foreword

The Royal College of Psychiatrists is a charity and membership organisation which exists to improve the lives of people with mental illness. It is also the professional body responsible for setting and raising standards for the education and training of psychiatrists within the UK. The delivery of education and training, however, is the responsibility of local education providers and local education and training boards. Despite this divide, it is vital that we work collaboratively and support each other to ensure that all psychiatric trainees, wherever they may be based, receive the highest quality training possible.

The College strongly believes that the highest standards of patient care are delivered by energetic, motivated and well-rested doctors who have a good work–life balance. Unfortunately, in the context of the recent Junior Doctor Contract dispute in England, which saw unprecedented industrial action, it became clear that there are deep-seated concerns about the lives of modern junior doctors which reach far beyond contractual arrangements.

Although the Royal College of Psychiatrists does not get involved in terms and conditions of employment, we continue to support our talented, committed and dedicated junior doctors, who deliver high-quality care in challenging circumstances, and the education and well-being of psychiatrists are very much our core business.

The College has a proud tradition of involving psychiatrists in training in all of the work of the organisation through the Psychiatric Trainees' Committee (PTC). We have continued to use every means at our disposal to support our psychiatric trainees, working with the PTC throughout this review into morale and training in psychiatry.

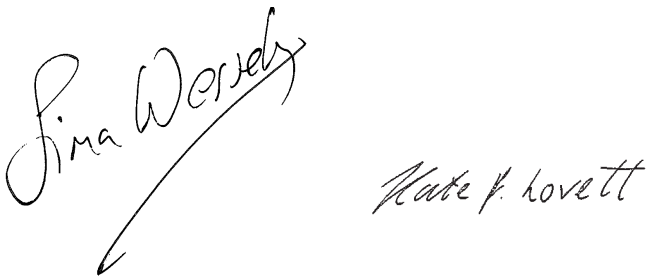
Junior doctors have recently started to be referred to as 'canaries in the mine', i.e. as an early warning system in a National Health Service (NHS) under strain. It is therefore with immense gratitude that we would like to thank the PTC for undertaking the painstaking work of gathering feedback from trainees throughout the four nations of the UK.

Many of this report's findings make for hard reading; however, it is of immense importance to policy makers, chief executives, medical directors and educationalists within psychiatry and other medical specialties.

The report paints a positive picture of what can be ameliorated – much of this is simply about being good employers and good educationalists. Ensuring that the basic needs of trainees are met, protecting time for educational activities and communicating effectively about expectations: these must not be considered to be controversial.

- We will call on all heads of school to monitor access to supervision, protected teaching, psychotherapy and special interest sessions to inform the quality assurance of training.
- We will work with partners at Health Education England to improve the Annual Review of Competence Progression (ARCP) process and agree national standardisation of ARCP requirements.
- We will recognise and understand the pressures of modern life and deliver greater access to flexibility in training and give trainees more autonomy over their careers.
- We will write to and monitor local educational providers to implement enhanced junior doctor forums, with clear lines of accountability to the Board, addressing key issues surrounding trainee morale.
- We will continue to lobby government for parity of esteem with physical health services and for improved health and social care funding.

Mental health is at the forefront of a revolution. It is starting to receive much needed government commitment to investment and reform through the *Five Year Forward View for Mental Health*. If we are to realise the vision that this sets out, and build a world-class NHS, we will need a fully recruited, well-trained mental health workforce that is clinically led. Tomorrow's consultants are today's trainees. We ignore them at our peril.



Professor Sir Simon Wessely, President, RCPsych
Dr Kate Lovett, Dean, RCPsych

Introduction

It is often said that patients are at the heart of everything we do, and that is true – but, equally, we must support, value and care for our workforce. Given the overwhelming evidence that good staff morale leads to better patient outcomes, we must not forget to be compassionate and respectful towards ourselves and our colleagues. If we take care of each other, then the rest will follow.

However, the NHS is suffering. Staff morale, and particularly that of junior doctors, is far from satisfactory. With declining morale and higher levels of stress, depression and burnout, we should all be concerned. We are experiencing negative organisational cultures in which the good will of staff, on which much of the NHS relies to function effectively, is being eroded. Too often, front-line clinicians feel that they are neither valued nor listened to by hospital management and policy makers.

These concerns cannot go unaddressed. There are increasing problems with retention and rota gaps. If we do not act now, we stand to lose a tranche of dedicated clinicians. We will compromise our profession and contribute to a decline in care that will have a negative impact on not just our patients but on society as a whole.

It is with this in mind that the PTC, which represents and supports more than 3500 psychiatric trainees across the UK, has initiated a review into morale and training within psychiatry. Our key priority was to engage with trainees across both core (CT1–CT3) and specialty (ST4–ST8) training. We wanted to provide them with the opportunity to freely express their views and act as a vehicle through which even the quietest voice could be heard at the highest level. We wanted to understand what makes a difference to trainees, and what makes them feel supported and valued.

We hope that this review and our recommendations will provide a stimulus for improvement both locally and nationally, resulting in meaningful change to the lives of psychiatric trainees and a culture within the NHS that supports and values its staff

Our focus groups and survey

We modelled our review on the Listening into Action approach. Developed as a simple, practical and outcome-oriented vehicle to engage with staff, it would, we felt, provide a realistic picture of what mattered most and enable us to create a meaningful starting point for change.

Through a series of regional focus groups, we engaged with every division of the College across the UK. This approach maximised our ability to interact directly with trainees. Each focus group concentrated on three key lines of enquiry, highlighting what trainees thought was currently working well and what steps we could take to improve in the future.

For each line of enquiry, there was the opportunity to record individual thoughts before breaking into small groups to reach a consensus on the three issues participants felt were most important to them. At the end of the focus groups, individual responses were collected, along with the groups' top three issues for later analysis.

Question 1
In your area, what do you **value most** about your training and how does this have a positive impact on your morale?

Question 2
Please explain what **immediate changes** you think would improve your work–life balance and training and help you feel more supported and valued.

Question 3
Please explain what **long-term changes** you think would improve your work–life balance and training and help you feel more supported and valued.

Key lines of enquiry

As a follow-up to our focus groups, we conducted a short survey open to all psychiatric trainees for a 1-week period in March 2017. This was designed to provide quantitative data on key areas highlighted by the focus groups. We received a total of 302 responses, and our findings are incorporated into this report.

Engagement

In total, divisional representatives of the PTC organised, led and analysed more than 2000 views from 268 trainees. Twenty-eight focus groups were held across all 11 regional divisions of the College between June 2016 and January 2017. Locations were chosen to maximise accessibility for as many trainees as possible.

Given the geographical disparity and spread of psychiatric trainees, the limited resources of the PTC and a budget dependent solely on the generosity of local trusts, health boards and schools of psychiatry, this was a remarkable achievement.

The exact number of focus groups ranged from one to four within each region, and groups were open to all psychiatric trainees. They were advertised through various local and national platforms. Attendees represented a mix of both full-time and less-than-full-time (LTFT) trainees, and included all subspecialties and a spread of both core (64%) and specialty (34%) trainees (the same proportional split as for trainees in core and specialty training nationally).

International Congress

1 Northern and Yorkshire (3)
2 North West (2)
3 West Midlands (2)
4 Trent (2)
5 South West (1)
6 South Eastern (1)
7 London (3)
8 Eastern (4)
9 Scotland (4)
10 Wales (1)
11 Northern Ireland (4)

Locations of our focus groups

What do psychiatric trainees value most?

Following a thematic analysis of more than 750 responses to our first key line of enquiry, the factors valued most by psychiatric trainees in their work life and training were clearly identified.

We know that what counts most towards our happiness and well-being is our health and relationships; our review cements this finding. Despite the widely perceived loss of a firm structure within medicine and the feeling of isolation sometimes experienced within psychiatry, it is evident that we should be proud of the unique relationships that exist across multidisciplinary teams and throughout the medical hierarchy, which are clearly compensating for this.

Nearly half of all responses indicated that trainees valued their supervision time, the support of their seniors and peers, and the opportunity to work collaboratively as part of a multidisciplinary team. Building further on this, we know that reflective space is essential for processing emotional distress, professional development, resilience and well-being. While many specialties are trying to build this into training, we are fortunate to have this already within psychiatry through Balint groups; the evidence for their importance to trainees shone through in our review.

It is also clear that trainees value flexibility and autonomy within their training, that protected time for teaching and special interest sessions is vital, and that true satisfaction with one's work comes from delivering direct patient care. This is only possible with manageable case-loads allowing individuals to work and care to their full potential

What changes will improve work life and training?

Facilities
24-hour appropriate provision of working and rest facilities, including hot food and drink

Clinical support
Appropriate provision and access to phlebotomy, electrocardiography, pharmacy and physical healthcare support

Career autonomy
Greater equity and access to flexibility in training, study leave and considerate placement allocation, providing trainees greater autonomy over their careers

Information technology
Appropriate support, access and availability of IT, including mobile working and pathology services

Non-clinical support
Integrated secretarial support and timely remuneration of salaries, expenses, study leave and locum fees

RCPsych and PTC support
Increased engagement, transparency and communications

Rota management
Ergonomic rotas co-designed with trainees that are issued in a timely fashion (minimum 12 weeks notice) and accommodate pre-existing leave arrangements

Training requirements
Access to and availability of all training requirements, including clear ARCP support

Investment
Parity of esteem and improved investment in the health and social care

Recommendations and desired commitments

Psychiatric trainees must feel supported and valued. Based on the views collected through this review, our evidence has led us to propose specific core recommendations and desired commitments that we feel will have the biggest impact on improving psychiatric trainees' work–life balance, morale and quality of training.

Many of our recommendations build on pre-existing College guidance but are re-emphasised to strengthen their importance, as trainees are experiencing variation in how the guidance is implemented locally.

We believe that:

- core recommendations *must* be met in all situations
- desired commitments *should* be aimed for wherever possible.

It is the joint responsibility of the College, schools of psychiatry, local education providers and trainees themselves to pro-actively ensure that these requirements are met and maintained.

Core recommendations

> With regular, meaningful and protected supervision where my consultant is interested in me as an individual, I function better professionally and personally; he knows me and he values me

Supervision

23% of trainees do not receive regular weekly supervision

All trainees must receive their minimum of 1 h supervision per week with their psychiatric supervisor as stipulated in the curriculum

Protected teaching

Only 80% of trainees receive weekly protected educational time

All trainees must receive a minimum of one teaching session per week provided through a local programme or on a recognised MRCPsych course

Psychotherapy

24% of trainees do not receive protected time for psychotherapy, and only 53% feel they receive timely allocation of a psychotherapy case

All trainees, where applicable, must receive timely allocation of psychotherapy cases with protected time for clinical sessions and supervision

> Dedicated support and protected time for special interest sessions encourages me to advance my professional development and fulfil my potential

Clinical

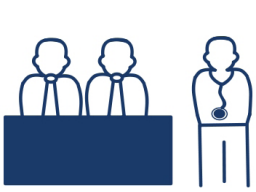
Teaching

Research

Leadership and management

All higher specialty trainees must receive a minimum of two sessions per week (pro rata for LTFT), agreed with their educational supervisor or training programme director, to pursue their special interests. This may include clinical, educational, research or leadership and management activities

Desired commitments



ARCP

All trainees should receive clear ARCP guidance at the start of each training year which is standardised across the UK

Career autonomy

All trainees should be supported to have autonomy over their careers through consideration of their personal circumstances and career intentions

Enhanced junior doctor forums

All trainees should have access to an enhanced junior doctor forum with senior management that expands beyond contractual issues and feeds into continual improvement of training, working life and patient care

ARCP

The PTC has recently surveyed members on their thoughts and feelings about the ARCP process. This highlighted concerns that the ARCP process and the standards required to achieve a satisfactory outcome are inconsistent across the UK. Alongside supporting the national review currently being conducted by Health Education England, we urgently recommend national ARCP guidance be agreed and implemented by heads of school to ensure equity in psychiatric training standards across the UK.

Career autonomy

Supported by plans from Health Education England, we recommend that trainees should have greater access to flexibility in training and autonomy over their careers, including:

- placement allocations
- study leave
- in-programme developmental opportunities
- out-of-programme activities and
- LTFT working.

We believe that we can be at the forefront of valuing trainees by extending this recommendation beyond consideration of health issues and caring responsibilities to embrace the personal circumstances (including travel time from home) and/or career intentions of all trainees. This approach has the potential to reduce burnout and develop well-rounded psychiatrists with a high level of job satisfaction, an improved work–life balance and the ability to deliver better patient care.

Enhanced junior doctor forums

Dominating our review were a range of issues that were perpetuated by poor communication between trainees, senior doctors and management.

These included, but were not limited to:

- rota designs
- available facilities and clinical support
- non-clinical support
- better integration of physical and mental healthcare.

In England, it is now a requirement of the junior doctors' 2016 contract that junior doctor forums are established at every local education provider.

We recommend, in line with British Medical Association guidance, that it is essential to expand beyond the remit set out within the new contract, and that enhanced junior doctor forums should be established across all local education providers within the four nations.

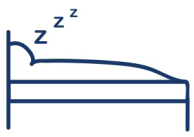
They should be overseen at director level (which in England must be the relevant director with responsibility for managing the 'guardian of safe working hours') and sponsored by a senior independent director providing accountability to the board. There should also be an established mechanism for feeding back to the local school of psychiatry.

The facilitation of enhanced junior doctor forums provides a unique opportunity to improve communication with senior management. We firmly believe that if implemented and engaged with effectively, this will lead to the resolution of many concerns and, as we have seen through engagement with our review, allow trainees to officially voice their concerns, feel empowered and feel that their seniors care about their development.

Two-thirds (66%) of trainees do not receive their rota within the current target of 6 weeks notice prior to commencing their placements

25% of trainees do not have access to a hot drink 24/7

Only 53% of trainees have access to a quiet reflective space with IT access 24/7



Only 32% of trainees have access to a private and comfortable area to nap 24/7

77% of trainees do not have access to a hot healthy meal 24/7

The NHS and parity of esteem

Evidence of the pressures currently facing the NHS was unmistakably palpable within our review. Similar to concerns highlighted by many other specialties, psychiatric trainees are concerned about recruitment and retention of not just psychiatrists, but the entire mental health workforce. Combined with rising demand for healthcare, trainees are clearly experiencing a system felt to be underfunded and overstretched.

Specifically, within mental healthcare, we find that there is still much to achieve if we are to approach parity of esteem with physical health services in the UK. There was a clear call for better physical and mental health integration, in terms of both training and service delivery. We cannot continue with a system where a choice must be made between two doors. We must create a single point of access for patients where both their physical and mental health needs can be addressed.

Although recent attention from the government on mental health services is welcomed, we continue to support our College, partners and patients in lobbying for greater funding, equality and access to the highest quality mental healthcare possible for all our patients.

Conclusions

We believe that psychiatric training is a privilege, and that the quality of training and opportunities we receive exceeds that in many other specialties. To maintain this advantage, we must learn from the evidence gathered within this review by acting on the issues raised.

We must expand on areas of good practice, and at the same time ensure that we provide equitable training opportunities throughout the UK. If these efforts are focused effectively, making use of the genuine desire to collaboratively improve the quality of psychiatric training that we believe exists, the future of psychiatry can be strengthened.

We were touched by the expressions of gratitude from trainees towards their seniors and their multidisciplinary colleagues throughout the focus groups. We would like to thank all those who work every day towards an environment where trainees feel supported and valued. We believe that, through these close supportive relationships that are valued so highly, we can continue to provide the personalised approach that makes psychiatric training so unique and, in many cases, exceptional.

The PTC will continue to drive improvements in the quality of training and in supporting and valuing each other. However, the real power of this review is in you. We all have autonomy over our behaviour and, on the basis of our findings, we implore you to make a difference. Through the power of marginal gains, even the smallest of changes can make a big difference.

It is up to all of us to reflect on this and be ambassadors for the profession. We must be a visible and credible presence where every contact counts, where effective role modelling and compassionate leadership allow us to work collaboratively, and where we can improve training so that we all feel supported and valued.

> There are lots of great things about psychiatric training, but improvements can be made. I hope this will inspire real change

Response from the College

We welcome this crucial piece of work by the PTC and are wholeheartedly committed, as ever, to engaging with trainees, directly improving training where we can, and strongly influencing others when direct change is outside our control.

We are delighted that the support of seniors and the training opportunities provided within psychiatry – such as supervision, protected teaching and special interest time – are valued so highly. However, it is clear that this is implemented with varying success across our four nations, and that there are a whole range of other factors raised in this review affecting the morale of our trainees.

We are saddened, although not surprised, to hear that for some of you the management of your rota and the on-call situation is decreasing your morale to the point of making you want to resign. We know that we have a high attrition rate between core and higher training, and that there is much to improve upon.

Your voices have been heard. We thank you for all that you do, and we commit to engaging with you in an ongoing conversation about how we can make your lives better. We will be monitoring for improvements, and will not stop until you all feel supported and valued.

You said: Our core recommendations *must* be met in all situations.

We will: Call on all heads of school to monitor access to supervision, protected teaching, psychotherapy and special interest sessions to inform the quality assurance of training.

You said: National ARCP guidance should be agreed and implemented by heads of school to ensure equity in psychiatric training standards across the UK.

We will: Work with partners at Health Education England to improve the ARCP process and agree national standardisation of ARCP requirements.

You said: Trainees should have greater access to flexibility in training and autonomy over their careers.

We will: Recognise and understand the pressures of modern life, and deliver greater access to flexibility in training and autonomy over your careers.

You said: Enhanced junior doctor forums should be established, across all local education providers within the four nations, which expand beyond the remit set out within the new contract.

We will: Write to and monitor local education providers to implement enhanced junior doctor forums, with clear lines of accountability to the provider Board, addressing key issues surrounding trainee morale.

You said: The system is underfunded and overstretched and we must approach parity of esteem with physical health services.

We will: Continue to lobby government for parity of esteem with physical health services and improved health and social care funding to improve the lives of people with mental illness.

Professor Sir Simon Wessely, President, RCPsych
Dr Kate Lovett, Dean, RCPsych

Acknowledgements

We would like to thank all trainees who attended our focus groups throughout the UK and took part in our survey as part of this review, Nikki Cochrane and the wonderful support staff at the Royal College of Psychiatrists, our College Officers, and all those who have shown generosity throughout the consultation period to help facilitate our focus groups.

In particular, we would like to acknowledge the following members and colleagues of the PTC, who were instrumental in the success of this project and helped facilitate local focus groups.

London

David Codling

Northern and Yorkshire

Bushra Azam

John Alderson

Soumaya Nasseer el din

Rosalind Oliphant

Eleanor Romaine

North West

Antonio D'Costa

Asghar Khan

Nilika Perera

Alex Till

Sally Wheeler

West Midlands

Saba Mattar

Kathryn Milward

Matt Tovey

Tara Walker

Trent

Charlotte Blewett

Christina Kelly

Beth Masterson

South West

Andy Brannac

Susan Howson

Karl Scheeres

Vicky Thom

South Eastern

Tarek Zghoul

Eastern

Meda Apetroae

Suzy Bassim

Felix Clay

Shevonne Matheiken

Rhianon Newman

Prasanna Rajbhandari

Baljit Upadhyay

Scotland

Tahir Ali

Andrew Bailey

Hannah Driver

Andrew Lawton

Alan Spratt

Wales

Rebecca Lendon

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Northern Ireland

Colin Gorman

Maggie Kelly

Graeme Young

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Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 26 April 2017

Integrated Performance Report Month 12

Purpose of Report

This paper provides Trust Board with an integrated overview of performance as at the end of March 2017. The focus of the report is on workforce, finance, operational delivery and quality performance.

Recommendations

The Board of Directors is requested to consider the content of the paper and consider their level of assurance on current performance across the areas presented.

Executive Summary

The Trust continued to perform well against many of its key indicators during December. This Executive Summary provides an overview of the some of the key issues during the month, assurance in a number of challenged areas and a forward view of some future risks and/or issues Board members need to be aware of.

Quality Performance

From a Quality perspective in relation to physical restraint and prone restraint, there have been particular instances reported around the use of illicit drugs and in response to the smoking ban. However, much of the increase can be attributed to thirteen of the incidents of prone restraint in the month relating to one person, who was refusing medication and needed to receive this intra-muscularly.

With regard to Complaint responses and outstanding actions. This is a known area of concern. We have appointed two Investigation Facilitators who will be starting in the coming months, and part of their time can be used to support improvement in this area.

We currently show reasonably strong performance for the percentage of people with a current risk assessment (FACE or Safety Plan). As the FACE tool is no longer used from this month, we can predict a potential reduction in this compliance, bearing in mind the current performance around Safety Plans alone

Operational Performance

Overall performance remains relatively stable, with all but two of the new activity based Single Oversight Framework indicators being achieved.

There are a number of areas where performance remains variable, with further detail provided in the main body of the report.

Key areas of note are as follows;

Challenges remain in relation to achieving Priority Metric compliance by the end of the financial year.

Incomplete waits for Early Intervention in Psychosis RTT Within 14 Days is a concern. A number of vacancies have resulted in a service capacity gap. This gap means that the 50% referral to treatment target has not been met and is unlikely to be met until June 2017 when new recruits start in post.

Early intervention staff are being used flexibly from across the county to address the issues, which are mainly in the south.

Draft Division dashboards have been added to this report. These provide the Board of Directors with further detail on overall performance split by each Division. These will be evolved over the course of the next few months and it is expected that some parts of the current IPR will be removed.

Financial Performance

From a financial perspective the Board is asked to note that in surplus terms, the Trust slightly over achieved the control total by £32k.This is based on the ledger position as at the end of March 2017. However this is subject to change as NHS Improvement have committed to pay additional Sustainability Transformation Fund (STF) income to providers that over achieve their control totals. There will be a further incentive payment for providers such as us where there has been an impact of the Discount rate change on provisions where this impact has been managed internally.

Providers are required to take the additional STF income and flow it directly to their financial bottom line; thereby increasing their reported surplus value by the exact value of the STF income.

Key financial information has been submitted to NHSI on 19 April and based on this NHSI will calculate providers' final additional STF income. Providers will be notified of the amounts by end of business on Monday 24 April which is to be included in the draft accounts required to be submitted on 9am 26 April.

In light of the late notification of additional income and the time taken to process the income through all the relevant templates and documents, a manual update to the final unaudited financial position for 2016/17, which includes the final additional STF allocation, will need to be tabled at the Board meeting.

A briefing for staff will be prepared that explains the year-end adjustments to income created by NHSI STF income allocations.

With regard to other financial performance factors, the Use of Resources (UoR) metrics is unchanged from last month and is as per the forecast: our overall UoR remains a 3. Four of the five metrics are strong at 2, 1, 1 and 1, but the fifth metric, agency spend against ceiling, remains at 4 which triggers an override that restricts the overall rating to a 3.

When considering the impact of agency on the Trust overall Use of Resources rating: to have avoided triggering the override, the Trust would have needed to have spent £458k less agency expenditure during the year (i.e. to have spent less than 50% above ceiling). If that were the case, the overall use of resource rating of the Trust would be 2 not 3. This will be a key metric to scrutinise during the new financial year.

Planning continues for cost improvement action required to reach 2017/18 control total financial plan. Whilst early plans exist for some of the Trust CIP cost reduction of £3.85m (at our risk), the Commissioner-driven QIPP disinvestment schemes that require £3.05m income and cost reduction (at commissioner risk) are not yet agreed.

People Performance

Compulsory training compliance remains high and is above the 85% main contract commissioning for quality and innovation (CQUIN) target. Monthly and annual sickness absence rates remain high.

Budgeted Fte vacancies remain high but are decreasing. Appraisal compliance rates remain low but compliance is increasing.

A Recruitment and Retention project has been established which is focussing on the mid and longer term actions required to alleviate some of the pressures relating to these issues.

Strategic considerations

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

Board Assurances

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

As an integrated performance report the content of 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 papers and aspects of detailed content supporting the overview presented are regularly provided to, Finance and Performance Committee, People and Culture Committee and Quality Committee.

Governance or Legal issues

The integrated nature of this report is in response to the Deloitte Well Led Review and specifically recommendation R 22: *The Board needs to introduce an integrated performance report which encompasses key operational, quality, workforce and finance metrics*

Information supplied in this paper is consistent with returns to the Regulator. This report has replaced the previous operational and financial reports reported to Trust Board.

Equality Delivery System

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.

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

Financial Perspective

Highlights
- Achievement of control total
- Cash better than plan

Challenges
- CIP not delivered full target
- Agency expenditure triggering an override on the new Use of Resources Rating

Operational Perspective

Highlights
- DNA compliance has been achieved this month
- Discharge communications have improved

Challenges
- Achieving Priority Metric compliance by the end of the financial year.
- Incomplete waits for Early Intervention in Psychosis RTT Within 14 Days
- Clustering
- Outpatient cancelation compliance

People Perspective

Highlights
- Compulsory training compliance remains high and is above the 85% main contract commissioning for quality and innovation (CQUIN) target.

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

Quality Perspective

Highlights
- Two new indicators have been added in relation to VTE assessment and HCR20 completion compliance. The indicator relating to fire warden compliance has been removed.
- Quarterly data has been updated to include Q4 16/17 data, allowing emerging quarterly trends to be identified
- No of serious incidents reported to the CCG has remained stable this month, but has decreased compared with the previous quarter
- Episodes of, and incidents during, seclusion have decreased in the last month
- Compliance with Level 3 safeguarding, Think Family and Clinical Safety Planning training has increased
- Recording of capacity for in-patients has increased
- All seclusion forms have been received by the MHA office for March 2017

Challenges
- No of incidents involving physical restraint and prone restraint have increased over the last month and quarter
- No of falls has increased
- No of complaints has increased
- No of outstanding actions for serious incidents has increased

FINANCIAL OVERVIEW – March 2017

Category	Sub-set	Metric	Period		Actual	Rating	Trend	Key Points
Governance	Use of Resources (UoR) Metric	Overall Use of Resources Metric	YTD		3	A	→	As at the end of March the Use of Resources Rating is a 3 as previously forecast. This is due to triggering an override on the agency metric.
		Capital Service Cover	YTD		2	Y	→	
		Liquidity	YTD		1	G	→	
		Income and Expenditure Margin	YTD		1	G	→	
		Income and Expenditure variance to plan	YTD		1	G	→	
		Agency variance to ceiling	YTD		4	R	→	
	Single Oversight Framework	NHS I Segment	YTD		3	n/a	n/a	We have been segmented in segment 3.
				Plan	Actual	Variance	Trend	
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	265	-561	R	↓	The Control Total shows the position including the Sustainability Transformation Fund (STF) and the Underlying Income and Expenditure position excludes the STF. There is a deficit in month, which had previously been forecast. The surplus at the end of the financial year was slightly above plan / control total by £32k. This is based on the actual ledger position at the end of March. However this is subject to change as NHS Improvement will be allocating additional STF income to some providers which will not be known until 24th April. The Normalised Income and Expenditure shows the financial performance adjusting for any non-recurrent costs or benefits that will not continue.
			YTD	2,531	2,562	G	↓	
		Underlying Income and Expenditure position £'000	In-Month	196	-630	R	↓	
			YTD	1,701	1,732	G	↓	
		Normalised Income and Expenditure position £'000	In-Month	196	182	R	→	
			YTD	1,701	2,199	G	→	
	Profitability	Profitability - EBITDA £'000	In-Month	868	10	R	↓	
			YTD	9,806	9,612	R	→	
		Profitability - EBITDA %	In-Month	7.5%	0.1%	R	→	
			YTD	7.1%	7.1%	R	→	
Liquidity	Cash	Cash £m	YTD	13.153	14.106	G	↗	Cash is above plan at the end of the financial year by £1m. It is important to note that there is a proportion of non-cash items in the Income and Expenditure position. Capital ended the year slightly behind plan as forecast.
	Net Current Assets	Net Current Assets £m	YTD	7.570	2.843	R	↓	
	Capex	Capital expenditure £m	YTD	3.450	3.365	R	↑	
Efficiency	CIP	CIP achievement £m	In-Month	0.358	0.195	R	→	CIP is behind plan at the end of the financial year as previously forecast. This is compensated for by other cost avoidance and underspends in the overall position.
			YTD	4.300	2.299	R	↓	
			Recurrent	4.300	1.645	R	→	

Key:

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

Plan In-month or Year end Trust plan

Achieving plan
Not achieving plan

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

OPERATIONAL OVERVIEW – MARCH 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up (M)	Month	95.00%	96.15%	G	↓	All NHSi metrics are all compliant except "Early Intervention in Psychosis RTT Within 14 Days - Incomplete" which is due to staff vacancies and "Priority Metrics" which is a new indicator and does not become a measured target until the next financial year. For each metric we have indicated if it is monitored by NHSi Quarterly (Q) or Monthly (M).
			Quarter	95.00%	96.97%	G	→	
		Data completeness - Identifiers (M)	Month	95.00%	99.36%	G	→	
			Quarter	95.00%	99.36%	G	→	
		Data completeness - Priority Metrics (M)	Month	85.00%	71.46%	R	→	
			Quarter	85.00%	69.68%	R	↓	
		Crisis Gatekeeping (Q)	Month	95.00%	97.30%	G	↓	
			Quarter	95.00%	98.49%	G	→	
		IAPT RTT within 18 weeks (Q)	Month	95.00%	99.75%	G	→	
			Quarter	95.00%	99.76%	G	→	
		IAPT RTT within 6 weeks (Q)	Month	75.00%	91.50%	G	→	
			Quarter	75.00%	91.09%	G	↑	
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Month	50.00%	85.71%	G	↓	
			Quarter	50.00%	89.74%	G	↑	
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Month	50.00%	46.67%	R	↓	
			Quarter	50.00%	69.23%	G	↑	
		Patients Open to Trust In Employment (M)	Month	N/A	8.96%		→	
			Quarter	N/A	8.70%		→	
		Patients Open to Trust In Settled Accommodation (M)	Month	N/A	59.90%		→	
			Quarter	N/A	57.28%		↓	
		Under 16 Admissions To Adult Inpatient Facilities (M)	Month	0	0	G	→	
			Quarter	0	0	G	→	
		IAPT People Completing Treatment Who Move To Recovery (Q)	Month	50.00%	53.11%	G	↓	
			Quarter	50.00%	53.93%	G	→	
		Physical Health - Cardio-Metabolic - Inpatient (Q)	Month	N/A				
			Quarter	N/A				
		Physical Health - Cardio-Metabolic - EI (Q)	Month	N/A				
			Quarter	N/A				
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)	Month	N/A				
			Quarter	N/A				

Key:

Period

Month Current Month

Quarter Current Quarter

Achieving target

Not achieving target

↑ → ↓ Trend compared to previous month/quarter

OPERATIONAL OVERVIEW – MARCH 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	96.51%	G	→	An action plan has been implemented. We should be able to start evaluating the impact of the actions as each is completed over the next few months.
			Quarter	90.00%	96.51%	G	→	
		CPA Employment Status	Month	90.00%	97.11%	G	→	
			Quarter	90.00%	97.11%	G	→	
		Data completeness - Identifiers	Month	99.00%	99.36%	G	→	
			Quarter	99.00%	99.36%	G	→	
		Data completeness - Outcomes	Month	90.00%	94.59%	G	→	
			Quarter	90.00%	94.59%	G	→	
		Patients Clustered not Breaching Today	Month	80.00%	78.84%	R	→	
			Quarter	80.00%	78.41%	R	→	
		Patients Clustered regardless of review dates	Month	96.00%	94.19%	R	→	
			Quarter	96.00%	94.32%	R	→	
		7 Day Follow-up - all inpatients	Month	95.00%	98.35%	G	→	
			Quarter	95.00%	97.69%	G	↑	
		Ethnicity coding	Month	90.00%	92.08%	G	→	
			Quarter	90.00%	92.08%	G	↓	
		NHS Number	Month	99.00%	99.99%	G	→	
			Quarter	99.00%	99.99%	G	→	
		CPA Review in last 12 Months (on CPA > 12 Months)	Month	95.00%	95.81%	G	→	
			Quarter	95.00%	95.81%	G	→	
		Community Care Data - Activity Information Completeness	Month	50.00%	94.48%	G	→	
			Quarter	50.00%	94.30%	G	→	
		Community Care Data - RTT Information Completeness	Month	50.00%	92.31%	G	→	
			Quarter	50.00%	92.31%	G	→	
		Community Care Data - Referral Information Completeness	Month	50.00%	74.13%	G	↓	
			Quarter	50.00%	75.12%	G	↓	
		Early Interventions New Caseloads	Month	95.00%	137.00%	G	↓	
			Quarter	95.00%	137.00%	G	↓	
		Clostridium Difficile Incidents	Month	7	0	G	→	
			Quarter	7	0	G	→	
		18 Week RTT Greater Than 52 weeks	Month	0	0	G	→	
			Quarter	0	0	G	→	

OPERATIONAL OVERVIEW – MARCH 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Schedule 6	Consultant Outpatient Trust Cancellations	Month	5.00%	8.39%	R	→	The vast majority of cancellations were unavoidable. The main reasons given for cancellations were consultant sickness absence, no consultant/staffing issues and appointments being rescheduled to meet 18 week referral to treatment requirements.
			Quarter	5.00%	7.68%	R	↓	
		Consultant Outpatient DNAs	Month	15.00%	14.90%	G	↑	
			Quarter	15.00%	15.79%	R	→	
		Under 18 admissions to Adult inpatients	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Outpatient letters sent in 10 working days	Month	90.00%	93.71%	G	↑	
			Quarter	90.00%	87.84%	R	↑	
		Outpatient letters sent in 15 working days	Month	95.00%	97.58%	G	↑	
			Quarter	95.00%	94.73%	R	↑	
		Inpatient 28 day readmissions	Month	10.00%	6.77%	G	↓	
			Quarter	10.00%	5.82%	G	↑	
		MRSA - Blood stream infection	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Discharge Fax sent in 2 working days	Month	98.00%	98.25%	G	↑	
			Quarter	98.00%	98.18%	G	→	
		Delayed Transfers of Care	Month	0.80%	0.19%	G	→	
			Quarter	0.80%	0.67%	G	↑	
		18 Week RTT Less Than 18 Weeks - Incomplete	Month	92.00%	95.56%	G	→	
			Quarter	92.00%	96.39%	G	→	

OPERATIONAL OVERVIEW – MARCH 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Performance Dashboard	Fixed Submitted Returns	18 weeks RTT greater than 52 weeks	Month	0	0	G	→	Compliant with Fixed Targets
			Quarter	0	0	G	→	
		18 Week RTT incomplete	Month	92.00%	95.21%	G	→	
			Quarter	92.00%	95.16%	G	↑	
		Mixed Sex accommodation breaches	Month	0	0	G	→	
			Quarter	0	0	G	→	
		Completion of IAPT Data Outcomes	Month	90.00%	95.63%	G	→	
			Quarter	90.00%	95.82%	G	→	
		Ethnicity coding	Month	90.00%	93.34%	G	→	
			Quarter	90.00%	92.58%	G	→	
		NHS Number	Month	99.00%	99.99%	G	→	
			Quarter	99.00%	99.99%	G	→	
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	98.37%	G	→	Compliant with Health Visiting Targets
			Quarter	98.00%	98.95%	G	→	
		% 6-8 Week Breastfeeding coverage	Month	98.00%	98.48%	G	↓	
			Quarter	98.00%	99.87%	G	→	
	IAPT	Recovery Rates	Month	50.00%	53.71%	G	→	Compliant with IAPT Targets
			Quarter	50.00%	53.98%	G	→	
		Reliable & Recovery Rates	Month	65.00%	67.45%	G	↓	
			Quarter	65.00%	68.76%	G	↑	
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	90.00%	99.4%	R	↑	Detailed ward level information shows specific variances
			Quarter	90.00%	102.7%	R	↓	

WORKFORCE OVERVIEW – March 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Mar-17**	10%	**10.44%**	↘	G	↓	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.65% (as at June 2016 latest available data). The monthly sickness absence rate is 0.09% higher compared to the previous month however compared to the same period last year (March 2016) it is 0.39% lower. The annual sickness absence rate is running at 5.59% (as at February 2017 latest available data). The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.14% (as at October 2016 latest available data). Anxiety/stress/depression/other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 31.09% of all sickness absence, followed by surgery at 14.74% and other musculoskeletal problems at 9.36%. Funded Fte vacancy rates have decreased by 0.24% compared to the previous month. The number of employees who have received an appraisal within the last 12 months has increased by 0.52% to 75.14%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £1.972m of which £1.379m related to Medical staff. Compulsory training compliance has increased by 0.90% to 88.73% and remains above the 85% main contract non CQUIN.
			Feb-17		10.76%		G		
		Sickness Absence (monthly)	**Mar-17**	5.04%	**5.70%**	↗	R	↓	
			Feb-17		5.61%		R		
		Vacancies (including 10% funded fte flexibility / cover)	**Mar-17**	10%	**13.95%**	↘	A	↓	
			Feb-17		14.19%		A		
		Vacancies (actual against target)	**Mar-17**	0%	**3.95%**	↘	A	↓	
			Feb-17		4.19%		A		
		Appraisals (all staff - number of employees who have received an appraisal in the previous 12 months)	**Mar-17**	90%	**75.14%**	↗	R	↑	
			Feb-17		74.62%		R		
		Appraisals (medical staff only - number of employees who have received an appraisal in the previous 12 months)	**Mar-17**	90%	**86.11%**	↗	A	↑	
			Feb-17		77.36%		A		
		Qualified Nurses (to total nurses, midwives, health visitors and healthcare assistants)	**Mar-17**	65%	**69.08%**	↘	G	↑	
			Feb-17		69.17%		G		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Mar-17**	£0	**£1.972m**	↗	R	↑	
			Feb-17		£1.735m		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Mar-17**	0%	**65.08%**	↗	R	↑	
			Feb-17		62.47%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**Mar-17**	90%	**88.73%**	↗	A	↑	
			Feb-17		87.83%		A		

Key:

Period Current month and previous month

Plan Trust target

↗ Variance to previous month

Achieving target/within target parameters

Approaching target/approaching target parameters

Not achieving target/outside target parameters

Trend based on previous 4 months

Turnover parameters (8% to 12%)

Vacancy parameters (10% to 20%)

QUALITY OVERVIEW – MARCH 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Safe	No of incidents of moderate to catastrophic actual harm	Month	24	29			Plan: average last fin yr (month).
			Quarter	73	102			Plan: average last fin yr (Qtr). Actual: Q4 data
		No of deaths of patients who have died within 12 months of their last contact with DHcFT	Month	170	115			
			Quarter	511	458			Plan: average last fin yr (Qtr). Actual: Q4 data
		No of serious incidents reported to the CCG	Month	6	3			Plan - average last fin yr (month)
			Quarter	18	10			Plan: average last fin yr (Qtr). Actual: Q4 data
		No of episodes of patients held in seclusion	Month	6	5			
			Quarter	35	21			Plan: average last fin yr (Qtr). Actual: Q4 data
		No of incidents involving patients held in seclusion	Month	20	10			
			Quarter	61	39			Plan: average last fin yr (Qtr). Actual: Q4 data
		No of incidents involving physical restraint	Month	55	73			
			Quarter	165	170			Plan: average last fin yr (Qtr). Actual: Q4 data
		No of incidents involving prone restraint	Month	10	23			Month plan based on average from 1/7/16 when prone restraint collected on Datix as defined field
			Quarter	29	46			Qtr plan based on average for Q2/Q3/Q4. Actual Q4 data
		No of incidents of physical assault - patient on patient	Month	15	10			
			Quarter	44	31			Actual: Q4 data.
		No of incidents of physical assault - patient on staff	Month	20	17			
			Quarter	61	42			Actual: Q4 data.
		No of falls on in-patient wards	Month	38	43			
			Quarter	113	94			Actual: Q4 data.
		No of incidents of absconsion	Month	43	34			
			Quarter	130	120			Actual: Q4 data.
		No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	78.09%			
			Quarter	100%	77.77%			
		Of above, no of patients with a Safety Plan	Month	90%	8.17%			Safety Plan to replace FACE from 1/4/2017
			Quarter	90%	7.90%			
		% of staff compliant with Level 3 Safeguarding Children training	Month	85%	80.04%			Target reduced to 85%
			Quarter	85%	NA			Qtr comparison not available
		% of staff compliant with Think Family training	Month	85%	80.31%			Target reduced to 85%
			Quarter	85%	NA			Qtr comparison not available
		% of staff compliant with Clinical Safety Planning eLearning	Month	95%	94.89%			
			Quarter	95%	NA			Qtr comparison not available
		No of people with LD or Autism admitted without a CTR (Care & Treatment Review)	Month	0	NA			Data quality confirmation to be completed for March 2017 data
			Quarter	0	NA			
		% of compliance with inpatients VTE assessment	Month	95%	7.07%		NEW	
			Quarter	95%	NA			
		HCR20 assessment completed, Low Secure	Month	100%	10.00%		NEW	No of patients with in date HCR20 assessment
			Quarter	100%	NA			

QUALITY OVERVIEW – MARCH 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Caring	No of complaints opened for investigation	Month	9	15			
			Quarter	26	43			Actual: Q4 data.
		No of concerns received	Month	18	32			
			Quarter	53	84			
		No of compliments received	Month	72	86			
			Quarter	217	236			
		No of investigations by the Parliamentary Ombudsman	2015/16	5	1			
			2016/17	5	8			1 further investigation from PO instigated this month
		% of complaints upheld (full or in part) by the Parliamentary Ombudsman	2015/16	2	0			
			2016/17	2	2			4 ongoing, 1 NFA
		% of responded to (orange) complaint investigations completed within 40 working days, opened after 01/04/2016	Year	100%	21%			140 (orange) complaints. 59 not responded to within 40 working days. 52 ongoing
			Year	100%	0%			7 (red) complaints. 2 not responded to within 60 working days. 2 ongoing.
		No of incidents requiring Duty of Candour	Month	2	1			These figures will fluctuate based on the outcome of investigations.
			Quarter	8	2			
	Effective	% of in-patients with a recorded capacity assessment	Month	100%	91.62%			
			Quarter	100%	91.00%			
		% of patients who have had their care plan reviewed and have been on CPA > 12months	Month	90%	95.00%			
			Quarter	90%	95.95%			
		No of seclusion forms not received by MHA Office	Month	0	0			
			Quarter	0	2			Actual: Q4 data.
		% of CTO rights forms received by MHA Office	Month	100%	93.00%			
			Quarter	NA	NA	NA	NA	
		% of in patient older adults rights forms received by MHA Office	Month	100%	83.30%			
			Quarter	NA	NA	NA	NA	
	Responsive	% of staff uptake of Flu Jabs	Month	45%	38.40%			Data to end of 30/11/16
			Year	45%	22.70%			Relates to 2015.16 compaign
		% of policies in date	Month	95%	96.90%			
			Quarter	NA	NA	NA	NA	
	Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	90%	45.99%			
			Quarter	90%	NA	NA	NA	
		% of staff who have received Management Supervision, within defined timescales	Month	90%	63.00%			
			Quarter	90%	NA	NA	NA	
		No of outstanding actions following serious Incident investigations	Month	0	52			Total overdue actions as at 03/04/2017
			Quarter	0	NA		NA	
		No of outstanding actions following complaint investigations	Month	0	53			Total overdue actions as at 03/04/2017
			Quarter	0	NA	NA	NA	
		No of outstanding actions following CQC comprehensive review report	Month	0	81			Figure as at 29/03/2017

Financial Section

Governance – Use of Resources (UoR) Rating

The Use of Resources rating at the end of the financial year is a 3 as forecast, which is due to triggering the override rule as the agency metric is a 4.

	YTD @ Quarter 1		YTD @ Quarter 2		YTD @Quarter 3		YTD @ Quarter 4	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Capital Service Capacity rating	3	2	2	2	2	2	2	2
Liquidity rating	2	1	1	1	1	1	1	1
I&E Margin rating	2	1	1	1	1	1	1	1
Distance from Financial Plan	1	1	1	1	1	1	1	1
Agency distance from Cap	1	4	1	4	1	4	1	4
UoR	2	2	1	2	1	2	1	2
4 on any metric	No Trigger	Trigger	No Trigger	Trigger	No Trigger	Trigger	No Trigger	Trigger
UoR	2	3	1	3	1	3	1	3

To note some of the metrics including the overall rating does not have a plan set by NHS Improvement, so the plan figures are based on an internal calculation.

As four of the metrics are in a healthy position and it is the agency metric that is driving the lower rating and the trigger, this is the area of focus from a headroom perspective. If agency expenditure had been £458k less during the financial year we would have not triggered an override and remained at an overall rating of 2.

Income and Expenditure

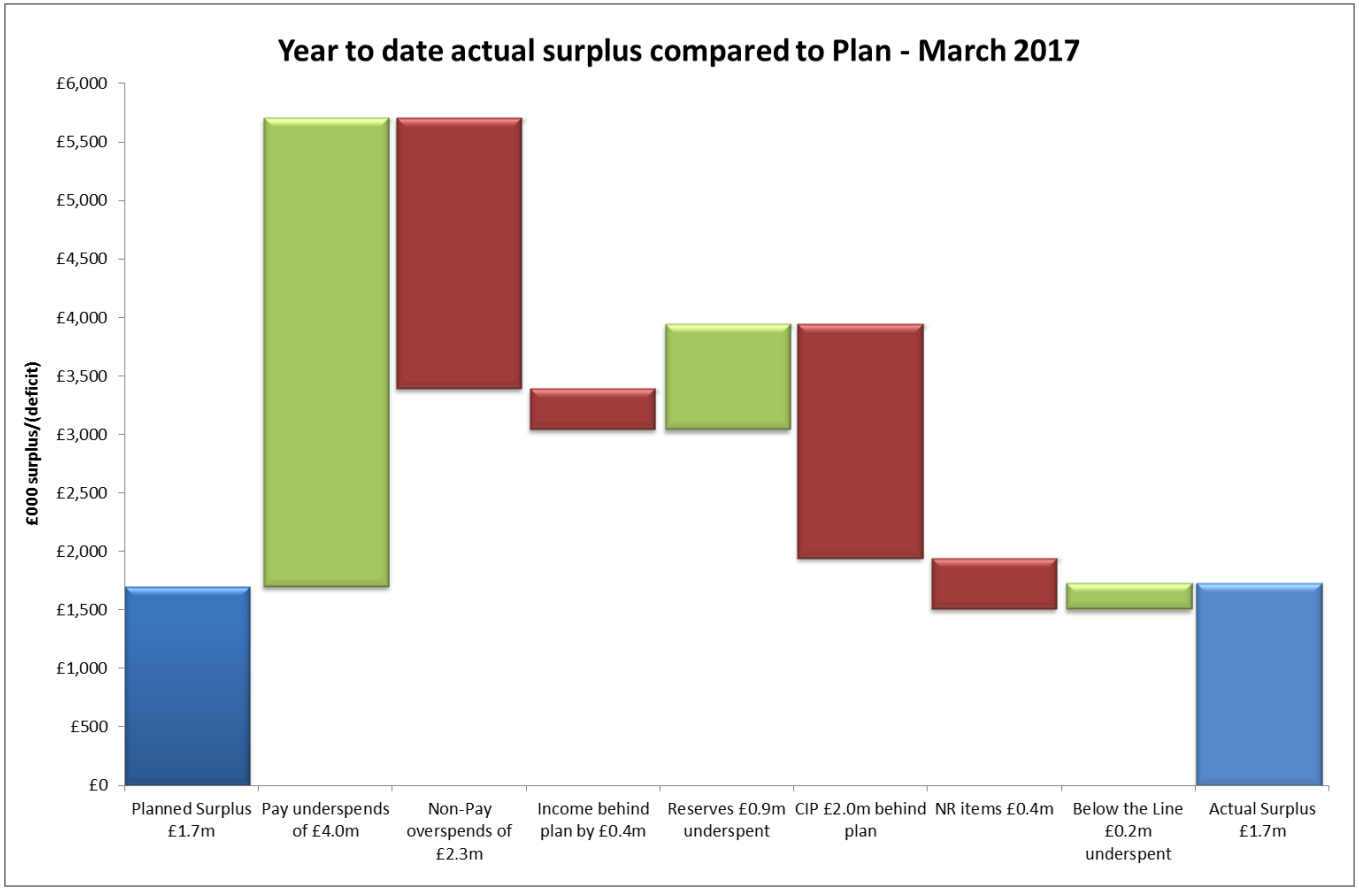
Statement of Comprehensive Income	March 2017					
	Current Month			Year to Date / Outturn		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	£000	£000	£000	£000	£000
Clinical Income	10,580	10,636	57	126,576	124,233	(2,343)
Non Clinical Income	918	1,160	242	11,020	10,782	(238)
Employee Expenses	(8,422)	(8,346)	76	(101,492)	(96,669)	4,823
Non Pay	(2,208)	(3,441)	(1,233)	(26,298)	(28,734)	(2,436)
EBITDA	**868**	**10**	**(858)**	**9,806**	**9,612**	**(194)**
Depreciation	(295)	(294)	0	(3,534)	(3,368)	166
Impairment	(300)	(394)	(94)	(300)	(627)	(327)
Profit (loss) on asset disposals	0	0	0	0	0	0
Interest/Financing	(175)	(175)	0	(2,141)	(2,101)	40
Dividend	(133)	(102)	32	(1,600)	(1,581)	19
Net Surplus / (Deficit)	**(35)**	**(955)**	**(920)**	**2,231**	**1,935**	**(295)**
Technical adjustment - Impairment	(300)	(394)	(94)	(300)	(627)	(327)
Control Total Surplus / (Deficit)	**265**	**(561)**	**(826)**	**2,531**	**2,562**	**32**
Technical adjustment - STF Allocation	69	69	0	830	830	0
Underlying Net Surplus / (Deficit)	**196**	**(630)**	**(826)**	**1,701**	**1,732**	**32**

As reported all year, due to the timing differences between the submission of the annual plan and the conclusion of contract negotiations a set of income and expenditure assumptions were included in the plan that are not in the actual position. Therefore all year there have been variances across Income, pay and non-pay but mostly with nil effect overall.

The Statement of Comprehensive Income shows both the control total of £2.5m which includes the Sustainability Transformation Fund (STF) and the underlying surplus / (deficit) against the underlying plan with the STF excluded £1.7m.

Clinical Income is £57k more than plan in month and at the end of March is £2.3m less than plan, which a significant proportion is due to differences in planning assumptions with offsetting expenditure reductions. There is also underperformances on activity related income.
Non Clinical income is ahead of plan in the month by £0.2m but remains behind plan at the end of the financial year by £0.2m. £0.4m of this relates to a miscellaneous income target with no income against it.

Pay expenditure is slightly under plan in the month by £76k and remains under plan by £4.8m at the end of the year. A significant proportion is due to planning assumptions (with offsetting income reductions) but also vacancies and recruitment.
Non Pay is overspent in the month by £1.2m mainly due to year end provisions, and is £2.4m worse than plan which mainly relates to Provisions, Drugs and PICU expenditure.

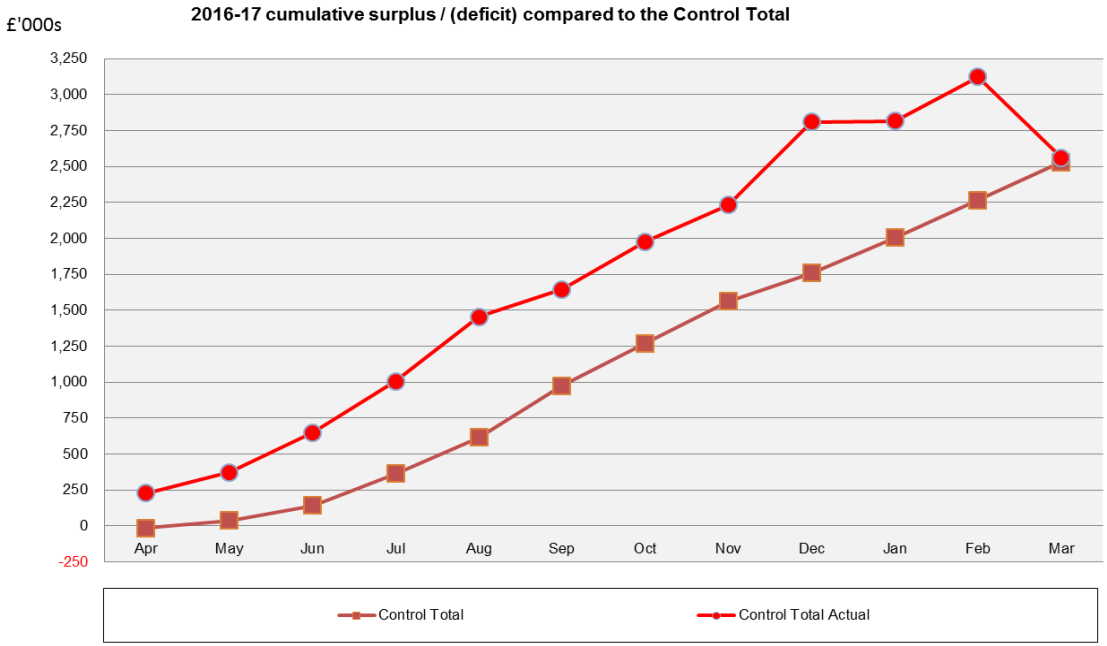


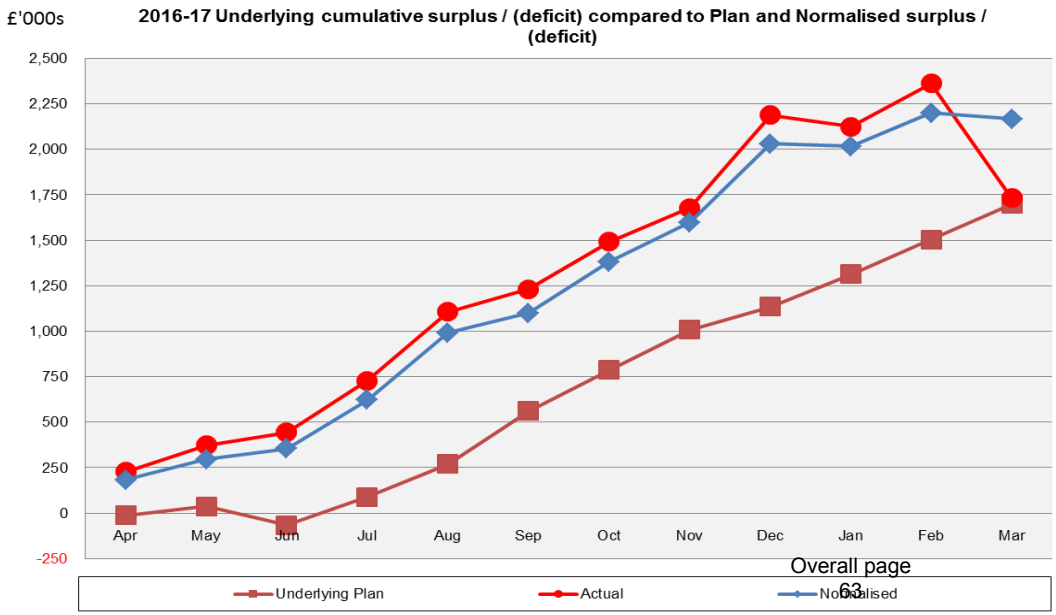
Summary of key points for YTD variances

Overall favourable variance to plan year to date which is driven by the following:

- Underlying Pay expenditure is significantly underspent which is mainly driven by vacancies across the Trust. The variances due to planning assumptions are contained within the reserves underspend and the non-recurrent costs that have been incurred this year are contained within the NR items category.
- Non pay overspends mainly relate to Provisions, Drugs and PICU placements.
- Income is behind plan mainly due to activity related services. Income variances related to planning assumptions are contained within the reserves underspend.
- Reserves are underspent due to actual expenditure phased differently to the original plan, including net differences in planning assumptions as referred to above.
- This is helping to offset the CIP which is behind plan year to date by £2.0m.

Normalised Income and Expenditure position





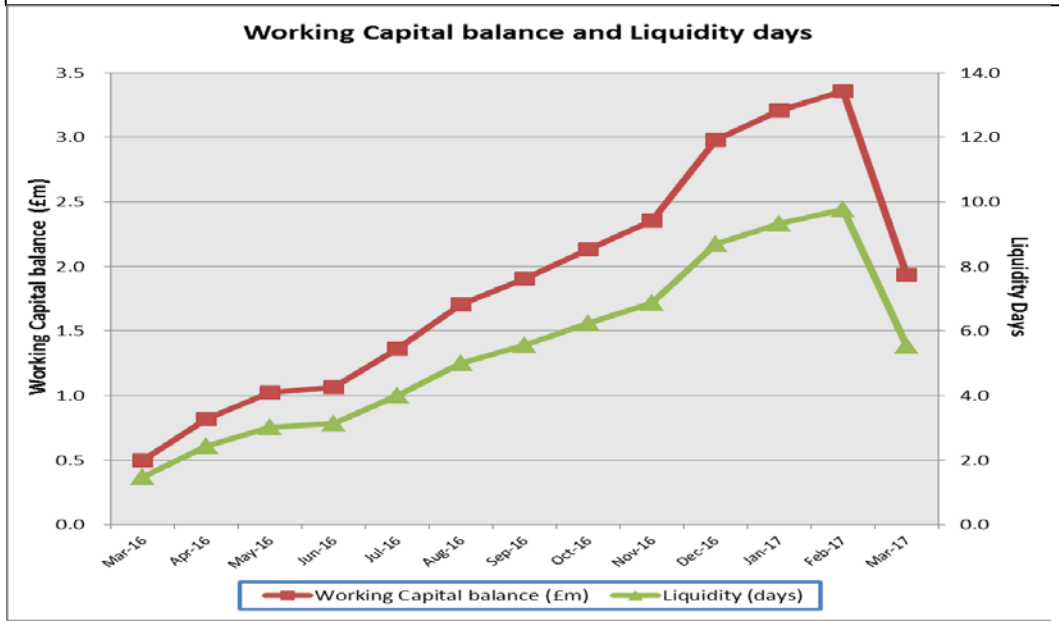
The first graph shows the actual cumulative surplus against the control total (including the Sustainability Transformation Fund (STF). The actual surplus ended the financial year slightly above plan by £32k.

The second graph shows the underlying actual surplus against the underlying plan excluding the STF.

This graph also shows the normalised financial position. This is referring to the position removing any one off non-recurrent items of cost or income that is not part of the business as usual.

There is some additional non-recurrent income in the position along with additional non-recurrent costs related to Governance Improvement Action Plan, CQC action plan for additional resources and an increase in provisions. In the normalised position these have been removed.

Liquidity



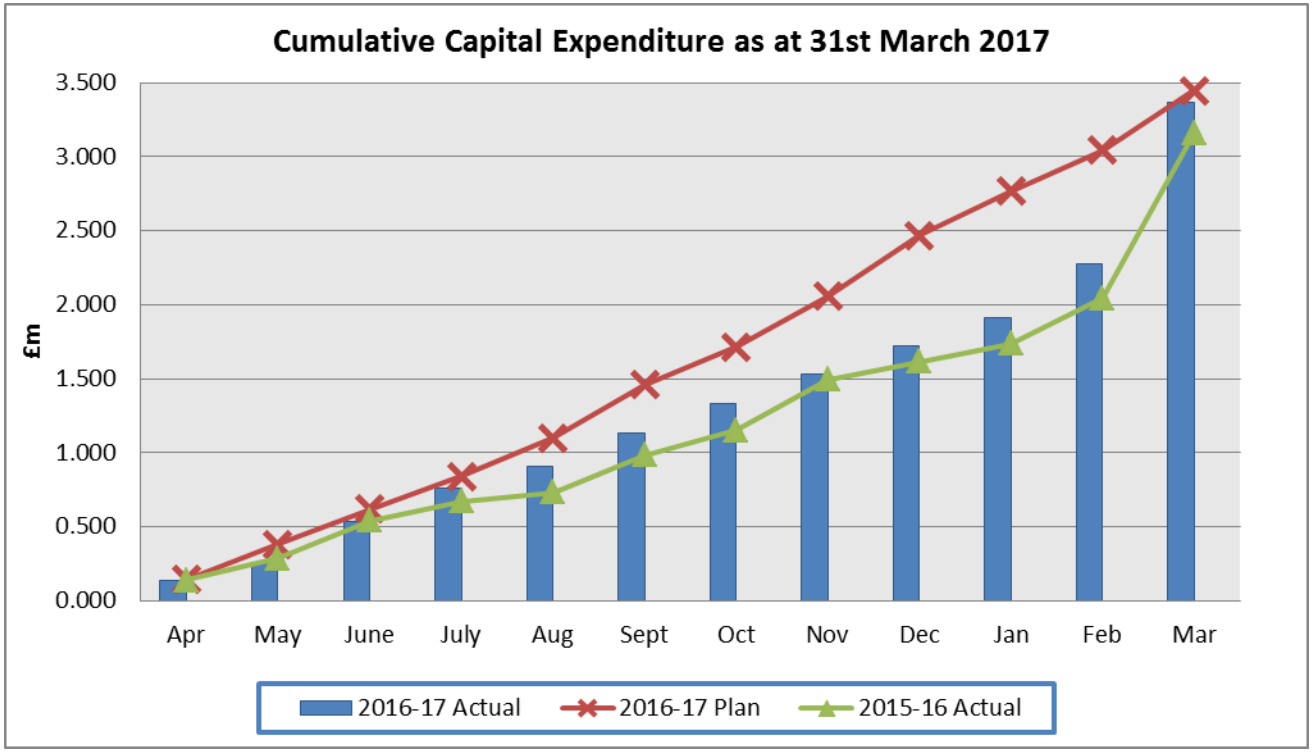
The first graph shows the working capital balance for the last 12 months (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

During this financial year working capital and liquidity continued to improve due to higher cash levels. The downturn at the end of March is reflective of the increase in year end transactions such as provisions, along with an increase in payables mainly related to capital as works have concluded at the end of March.
The liquidity at March is at 5.5 days which still gives a rating of 1 (the best) on that metric (-7days drops to a rating of 2).

The Trust Board is reminded that sector benchmarking information recently provided by external auditors illustrates that the peer average continues to be around +19 days, therefore our liquidity must remain a strategic priority for us to continue to improve and protect.

Cash is currently at £14m which is £1m better than the plan at the end of March. Within the Income and Expenditure position of achieving the plan, there is a proportion of non-cash items.

Capital Expenditure

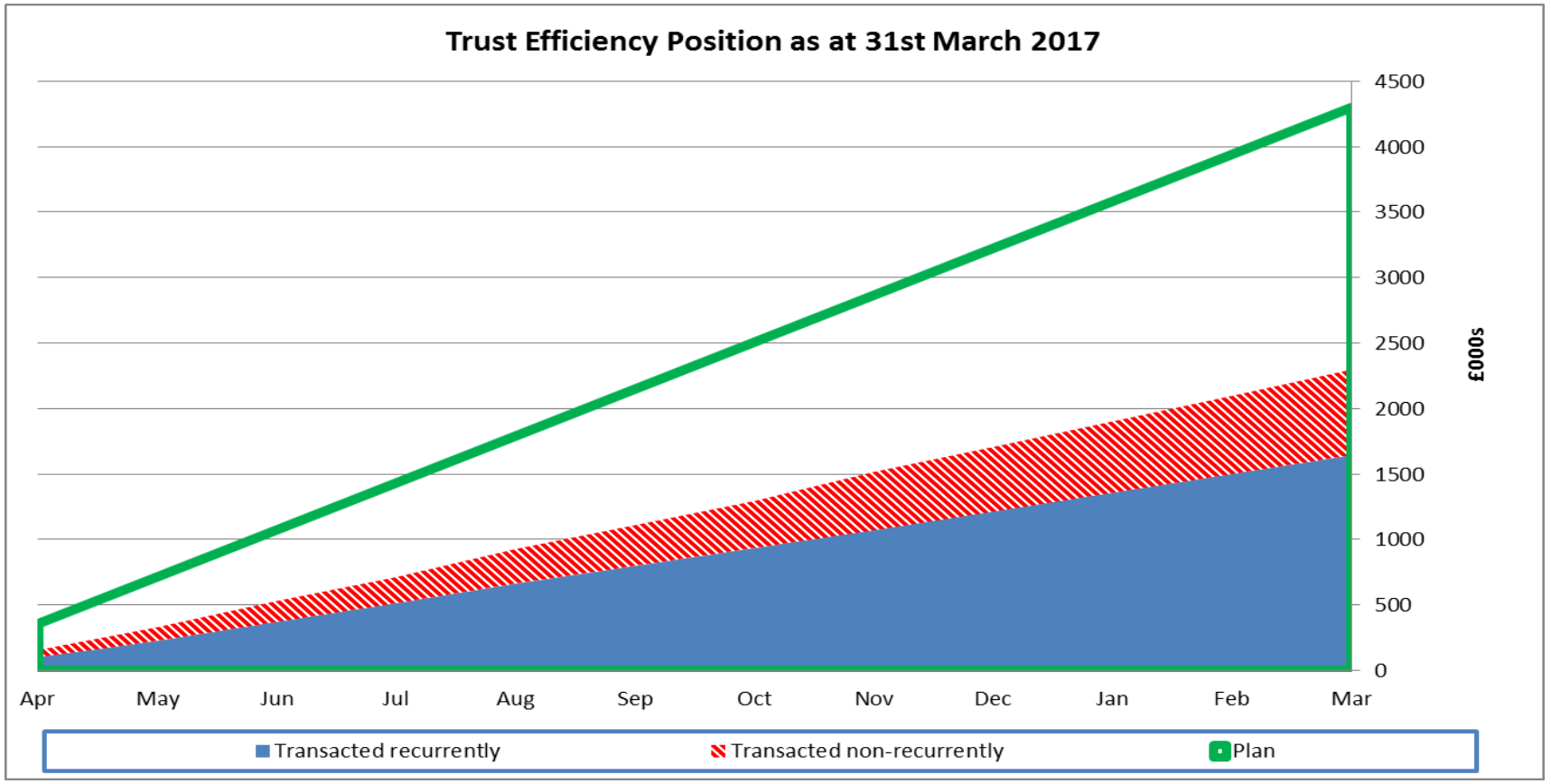


Capital Expenditure is slightly behind plan by £85k. The small underspend relates to the re-prioritisation of capital monies during the year in order to fund more urgent schemes such as the actions arising from the CQC inspection.

Works have been completed on several large projects at the end of March and not all capital expenditure has resulted in cash out due to the timing of payments.

Efficiency

Cost Improvement Programme (CIP)



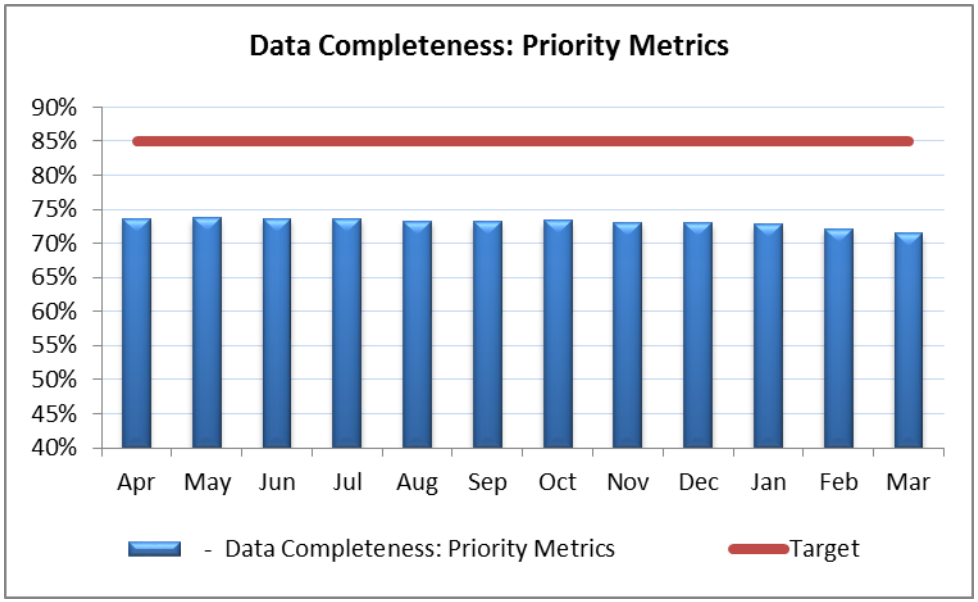
At the end of the financial year there was £2.3m of assured CIP against a plan of £4.3m, which left a gap of £2.0m. Of this £2.3m assured CIP £0.65m was assured non-recurrently.

Even though CIP has not been fully assured the control total has been achieved through expenditure underspends and income measures.

Trust Management Team and Executive Leadership Team continues to performance-monitor CIP delivery which is reported to Finance and Performance Committee who have delegated authority from Trust Board for oversight of CIP delivery.

Operational Section

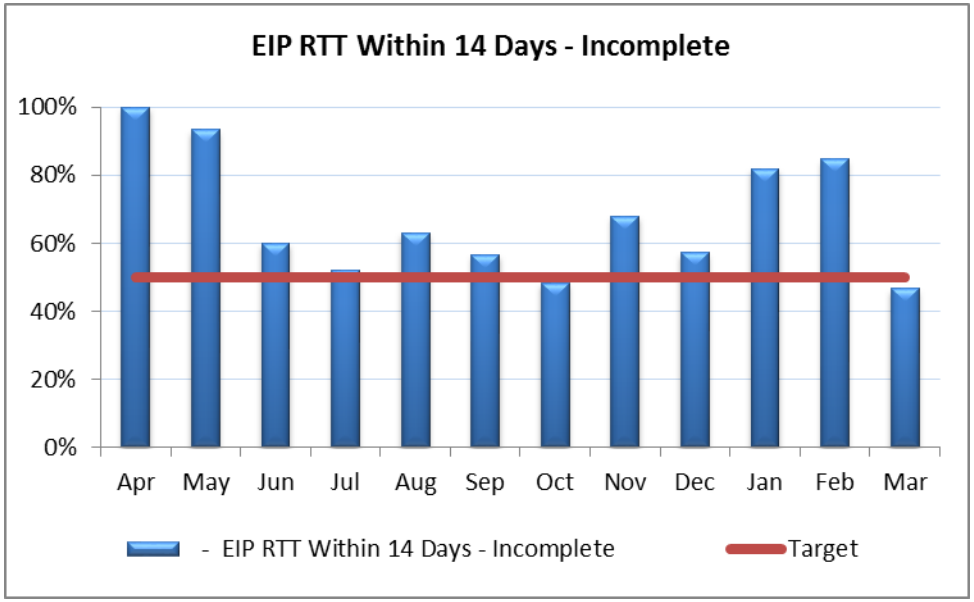
Data Completeness: Priority Metrics



As previously reported, the performance dashboard was amended on 1st December 2016 to reflect the NHS Improvement Single Oversight Framework targets which came into force from 1st October 2016. The national requirement is to achieve the priority metrics target of 85% by financial year end. Achieving this target in the timescale will be extremely challenging.

Trust Management Team to receive and consider options for resolving how performance can be improved against this standard.

Early Intervention in Psychosis RTT Within 14 Days - Incomplete



We currently have 4 Band 6 clinician vacancies in the Service. This gap means that we are at risk of breaching the 50% referral to treatment target.

We have been taking urgent action to accelerate the recruitment process and have 3 candidates to interview for the vacancies on 13th April. We are hoping to be able to offer all candidates posts and will then get them into post, aiming to further accelerate process to avoid delay. However this still means a likely soonest start date of end of May, and more realistically some time in June.

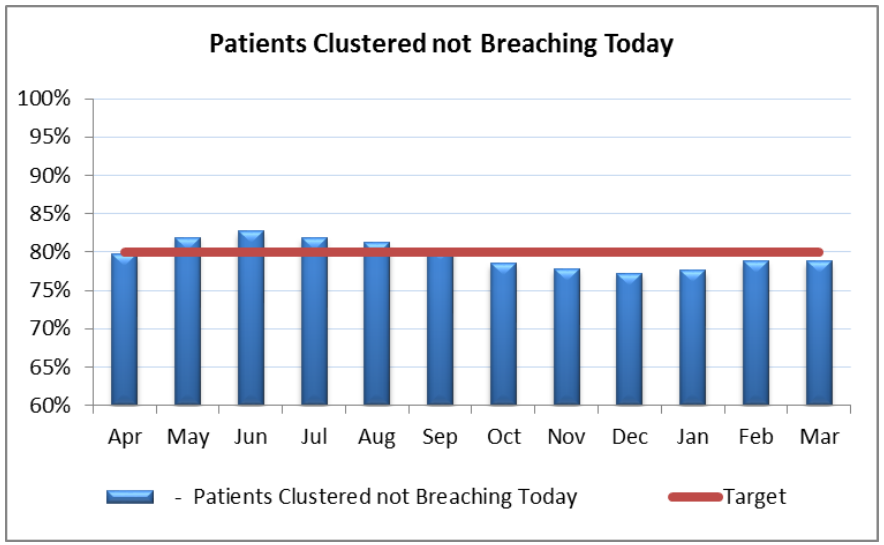
We have had an open request for agency staff over the past month, but have only recently been supplied with a clinician to start 10th April.

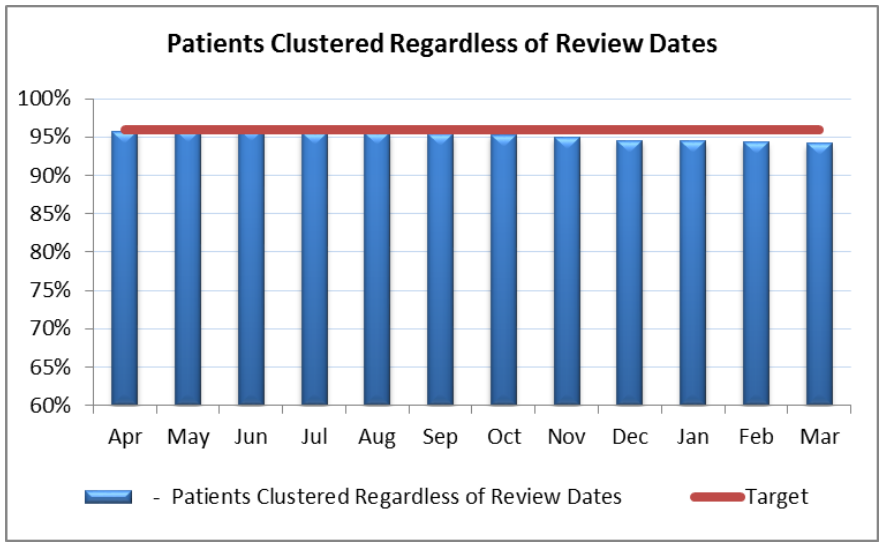
Resource is being used flexibly from North EIS to pick up cases around border areas and to undertake some assessments. This has to be balanced in order that those services are not compromised. This might mean that we breach but that we have been able to prioritise cases that do need to be picked up.

We have communicated with Neighbourhood team managers to ask that they prioritise cases transitioning from EIS in order that we can improve flow from EIS and generate some capacity, however you will be aware of the challenges in Neighbourhood services already.

We are asking all staff who work part time hours to consider temporarily increasing hours to help capacity and we are working very hard to ensure that inappropriate information does not remain on the live report and skew the reporting figures.

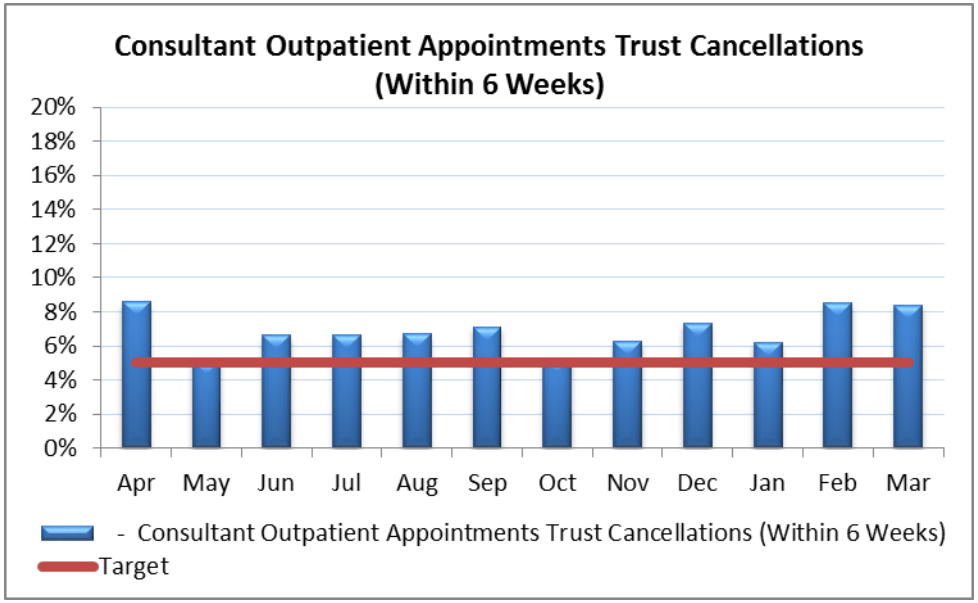
Clustering





Action continues to be taken to sustain performance in this area. Finance and Performance Committee will receive a deep dive on this at its May meeting

Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)



The vast majority of cancellations were unavoidable. The main reasons given for cancellations were consultant sickness absence, no consultant/staffing issues and appointments being rescheduled to meet 18 week referral to treatment requirements.

Associate Clinical Directors to review cancellations with a reason of annual leave to establish whether enough notice was given and if not, to reiterate that at least 6 weeks' notice is required for annual leave, to ensure patients are not inconvenienced.

Campus Division Performance Dashboard 2016/17 Month 12

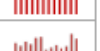
Quality, Safety and Experience

Indicator	Period	Target	Actual	RAG	Last 12 months
CPA 7 day follow-up	Monthly	95%	97%	G	
Crisis home treatment episodes	Monthly	N/A	81	N/A	
Delayed transfers of care	Monthly	0.8%	0.2%	G	
Never events	Monthly	0	0	G	
Incidents	Monthly	N/A	381	N/A	
Serious incidents	Monthly	N/A	7	N/A	
Falls resulting in severe injury/ death	Monthly	0	0	G	
Grade 3 or 4 pressure ulcers	Monthly	0	0	G	
MRSA Bacteraemia	Monthly	0	0	G	
Crisis gatekeeping	Monthly	95%	97%	G	
Mixed sex accommodation breaches	Monthly	0	0	G	
Under 16 admissions to adult facilities	Monthly	0	0	G	
New complaints	Monthly	N/A	4	N/A	
New concerns	Monthly	N/A	5	N/A	
Complaints upheld/partially upheld	Monthly	N/A		N/A	
Compliments	Monthly	N/A	37	N/A	
Friends and Family Test % positive	Monthly	N/A	96%	N/A	
Complaint response breaches	Monthly	N/A		N/A	

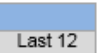
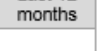
Pulse Check

Indicator	Period	Target	Actual	RAG	Last 12 months

Performance

Indicator	Period	Target	Actual	RAG	Last 12 months
Hartington Unit bed occupancy – including leave	Monthly	85%	102%	R	
Hartington Unit bed occupancy – excluding leave	Monthly	85%	87%	R	
Hartington Unit length of stay	Monthly	36	64	R	
Radbourne Unit bed occupancy – including leave	Monthly	85%	100%	R	
Radbourne Unit bed occupancy – excluding leave	Monthly	85%	93%	R	
Radbourne Unit length of stay	Monthly	36	47	R	
Kingsway bed occupancy – including leave	Monthly	85%	78%	G	
Kingsway bed occupancy – excluding leave	Monthly	85%	72%	G	
Kingsway length of stay	Monthly	N/A	190	N/A	
Activity against contract – inpatient rehab.	Monthly	95%	89%	R	

People

Indicator	Period	Target	Actual	RAG	Last 12 months
Vacancy rate	Monthly	N/A	0.6%	N/A	
Turnover – rolling 12 months	Yearly	10%	11.7%	G	
Sickness – in month	Monthly	5%	6%	R	
Annual appraisals	Monthly	90%	84%	R	
Mandatory training	Monthly	85%	90%	G	
Agency staff use	Monthly	1.9%	1%	G	
Bank staff use	Monthly	5%	14%	R	
Clinical supervision	Yearly	100%	29%	R	
Managerial supervision	Yearly	100%	46%	R	

Campus Division Performance Dashboard 2016/17 Month 12

Finance					
Indicator	Period	Target	Actual	RAG	Last 12 months
Performance against budget £'000s	In month	2447	2473	R	
Performance against budget £'000s	Year to date	29930	30065	R	
Out of area placement expenditure (PICU) £'000s	Monthly	1065	1471	R	

General Manager Summary

- Length of stay/ out of area placements project has commenced which is focusing on length of stay issues and will involve implementing a structured programme of improvement.
  This will include a review of utilisation of leave beds across the different units to facilitate an enhanced universal approach
- Recruitment and Retention group has been launched to focus on these issues
- The levels of DTOC have decreased this is in part due to a review of the application of the DTOC criteria which is a very restricted criteria.

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Central Services Division Performance Dashboard 2016/17 Month 12

Quality, Safety and Experience

Indicator	Period	Target	Actual	RAG	Last 12 months
Never events	Monthly	0	0	G	
Incidents	Monthly	N/A	44	N/A	
Serious incidents	Monthly	N/A	6	N/A	
MRSA Bacteraemia (perinatal)	Monthly	0	0	G	
New complaints	Monthly	N/A	3	N/A	
New concerns	Monthly	N/A	3	N/A	
Complaints upheld/partially upheld	Monthly	N/A		N/A	
Compliments	Monthly	N/A	144	N/A	
Friends and Family Test % positive	Monthly	N/A	100%	N/A	
Complaint response breaches	Monthly	N/A		N/A	

Pulse Check

Indicator	Period	Target	Actual	RAG	Last 12 months

Performance

Indicator	Period	Target	Actual	RAG	Last 12 months
Activity against contract – ASD assessments (cumulative)	Monthly	100%	162%	G	
Activity against contract – perinatal inpatient bed days	Monthly	100%	87.5%	R	
Activity against contract – perinatal south community contacts	Monthly	100%	113%	G	
Activity against contract – eating disorder service contacts	Monthly	100%	143%	G	
Waiting list - ASD assessment	Monthly	N/A	379	N/A	
Waiting list - dietetics	Monthly	N/A	5	N/A	

Performance

Indicator	Period	Target	Actual	RAG	Last 12 months
Waiting list – eating disorders	Monthly	N/A	16	N/A	
Waiting list – LD speech and language therapy	Monthly	N/A	169	N/A	
Waiting list - physiotherapy	Monthly	N/A	78	N/A	
Waiting list – psychological therapies	Monthly	N/A	105	N/A	
Waiting list - psychology	Monthly	N/A	598	N/A	
IAPT step 2 discharges	Monthly	N/A	84	N/A	
IAPT step 3 discharges	Monthly	N/A	712	N/A	
IAPT recovery rate	Monthly	50%	53.4%	G	
IAPT reliable improvement & recovery rate	Monthly	65%	70.6%	G	
Substance Misuse City:					
TOPS compliance - start	Quarterly	80%	98%	G	
TOPS compliance - review	Quarterly	80%	91%	G	
TOPS compliance - exit	Quarterly	80%	94%	G	
Waiting time into treatment over 21 days	Quarterly	0%	0%	G	
Substance Misuse County:					
TOPS compliance - start	Quarterly	80%	99%	G	
TOPS compliance - review	Quarterly	80%	93%	G	
TOPS compliance - exit	Quarterly	80%	96%	G	
Waiting time into treatment over 21 days	Quarterly	0%	1%	A	

People

Indicator	Period	Target	Actual	RAG	Last 12 months
Vacancy rate	Monthly	N/A	9.5%	N/A	
Turnover – rolling 12 months	Yearly	10%	10%	G	

Central Services Division Performance Dashboard 2016/17 Month 12

People					
Indicator	Period	Target	Actual	RAG	Last 12 months
Sickness – in month	Monthly	5%	5.2%	R	
Annual appraisals	Monthly	90%	79%	R	
Mandatory training	Monthly	85%	88%	G	
Agency staff use	Monthly	1.9%	1.3%	G	
Bank staff use	Monthly	5%	3.6%	G	
Clinical supervision	Yearly	100%	47%	R	
Managerial supervision	Yearly	100%	64%	R	

Finance					
Indicator	Period	Target	Actual	RAG	Last 12 months
Performance against budget £'000s	In month	1660	1644	G	
Performance against budget £'000s	Year to date	19803	19445	G	

General Manager Summary

- Recruitment and Retention group has been launched to focus on these issues
- Pressures around LD medical agency and Perinatal medical agency. LD in recruitment and perinatal awaiting return of consultant.
- Supervision improving (49% and 67% at 19/4) as several months into action plans for substance misuse, perinatal and medical secretaries but still in lag / catch up phase.
- Monitoring perinatal bed occupancy. Increasing after dip and collating information on accepted and non-accepted referrals to inform demand position.

Children's Services Division Performance Dashboard 2016/17 Month 12

Quality, Safety and Experience

Indicator	Period	Target	Actual	RAG	Last 12 months
Never events	Monthly	0	0	G	
Incidents	Monthly	N/A	13	N/A	
Serious incidents	Monthly	N/A	0	N/A	
New complaints	Monthly	N/A	2	N/A	
New concerns	Monthly	N/A	6	N/A	
Complaints upheld/partially upheld	Monthly	N/A		N/A	
Compliments	Monthly	N/A	5	N/A	
Friends and Family Test % positive	Monthly	N/A	100%	N/A	
Complaint response breaches	Monthly	N/A		N/A	

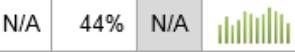
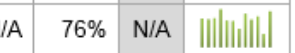
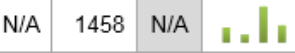
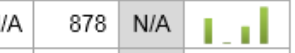
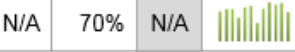
Pulse Check

Indicator	Period	Target	Actual	RAG	Last 12 months

Performance

Indicator	Period	Target	Actual	RAG	Last 12 months
Paediatric current waits < 18 weeks	Monthly	90%	50%	R	
Paediatric waiting list	Monthly	N/A	999	N/A	
Paediatric new referrals	Monthly	N/A	263	N/A	
Paediatric attended 1st appointments	Monthly	N/A	193	N/A	
CAMHS current waits < 18 weeks	Monthly	90%	98%	G	
CAMHS waiting list	Monthly	N/A	283	N/A	
CAMHS activity – attended contacts	Monthly	N/A	1988	N/A	
CAMHS caseload	Monthly	N/A	1886	N/A	

Performance

Indicator	Period	Target	Actual	RAG	Last 12 months
CAMHS RISE – referrals from A&E seen same day	Monthly	N/A	44%	N/A	
CAMHS RISE – discharges with completed ESQ	Monthly	N/A	37%	N/A	
CAMHS RISE – discharges with completed SFQ	Monthly	N/A	52%	N/A	
CAMHS RISE – A&E referral rate (as a percentage of total referrals)	Monthly	N/A	78%	N/A	
Children in care health assessments – children aged under 5	Monthly	N/A	71%	N/A	
Children in care health assessments – children aged 5 and over	Monthly	N/A	76%	N/A	
10-14 day breastfeeding coverage	Monthly	98%	96%	R	
6-8 week breastfeeding coverage	Monthly	98%	94%	R	
National child measurement programme (NCMP)	Quarterly	N/A	1458	N/A	
Audiology contacts	Quarterly	N/A	878	N/A	
SEND process – letter 1 responses within 15 days	Monthly	N/A	70%	N/A	
SEND process – letter 2 responses within 42 days	Monthly	N/A	51%	N/A	

People

Indicator	Period	Target	Actual	RAG	Last 12 months
Vacancy rate	Monthly	N/A	8.7%	N/A	
Turnover – rolling 12 months	Yearly	10%	13.8%	R	
Sickness – in month	Monthly	5%	4.8%	G	
Annual appraisals	Monthly	90%	73%	R	
Mandatory training	Monthly	85%	89%	G	
Agency staff use	Monthly	1.9%	3.3%	R	
Bank staff use	Monthly	5%	2.9%	G	

Children's Services Division Performance Dashboard 2016/17 Month 12

People					
Indicator	Period	Target	Actual	RAG	Last 12 months
Clinical supervision	Yearly	100%	69%	R	
Managerial supervision	Yearly	100%	64%	R	

Finance					
Indicator	Period	Target	Actual	RAG	Last 12 months
Performance against budget £'000s	In month	1273	1244	G	
Performance against budget £'000s	Year to date	15173	13921	G	

General Manager Summary

- **Paediatric current waits < 18 weeks**
  This report was submitted to TMT and approved at meeting held on 10/04/17

  CMDG mar 17 (3) (3).docx (3).doc
- **Clinical supervision**
  Although significant progress has been made regarding recording, services are struggling to achieve required level. Further emphasis will be placed upon this over the next month and raised within COAT.
- **Managerial Supervision**
  Services are struggling to achieve required level. Further emphasis will be placed upon this over the next month and raised within COAT.
- **10-14 day breastfeeding coverage**
  Although coverage target has not been reached, the prevalence target has been achieved for this month.
- **6-8 week breastfeeding coverage**
  Although coverage target has not been reached, the prevalence target has been achieved for this month.
- **Turnover – rolling 12 months**
  All services have been impacted by difficulty to recruit new staff. Recruitment Fair took place on 11th March 2017. Although awaiting final confirmation, all indications are that a large number of staff have been appointed and the vast majority of vacancies have been filled as a result of recruitment fair. Recruitment and Retention group has been launched to focus on these issues
- **Annual appraisals**
  Services are struggling to achieve required level. This is specifically the case within Universal services which has been significantly impacted by large number of vacancies. Further emphasis will be placed upon this over the next month and raised within COAT.
- **Agency staff use**
  Specifically in CAMHs and Community Paediatricians. Recruitment plans are in place to reduce this over the next 3 months.

Neighbourhood Services Division Performance Dashboard 2016/17 Month 12

Quality, Safety and Experience					
Indicator	Period	Target	Actual	RAG	Last 12 months
Never events	Monthly	0	0	G	
Incidents	Monthly	N/A	44	N/A	
Serious incidents	Monthly	N/A	5	N/A	
New complaints	Monthly	N/A	5	N/A	
New concerns	Monthly	N/A	26	N/A	
Complaints upheld/partially upheld	Monthly	N/A		N/A	
Compliments	Monthly	N/A	20	N/A	
Friends and Family Test % positive	Monthly	N/A	79%	N/A	
Complaint response breaches	Monthly	N/A		N/A	

Pulse Check					
Indicator	Period	Target	Actual	RAG	Last 12 months

Performance					
Indicator	Period	Target	Actual	RAG	Last 12 months
North Derbyshire					
Community caseload	Monthly	N/A	2821	N/A	
Community waiting list	Monthly	N/A	359	N/A	
Community referrals	Monthly	N/A	322	N/A	
Community activity	Monthly	N/A	4731	N/A	
Community discharges	Monthly	N/A	318	N/A	
Outpatient memory assessment service caseload	Monthly	N/A	1092	N/A	
Outpatient caseload (exc. MAS)	Monthly	N/A	5117	N/A	
Outpatient waiting list < 18 weeks	Monthly	92%	98%	G	

Performance					
Indicator	Period	Target	Actual	RAG	Last 12 months
South Derbyshire					
Community caseload	Monthly	N/A	2508	N/A	
Community waiting list	Monthly	N/A	658	N/A	
Community referrals	Monthly	N/A	293	N/A	
Community activity	Monthly	N/A	3786	N/A	
Community discharges	Monthly	N/A	306	N/A	
Outpatient memory assessment service caseload	Monthly	N/A	519	N/A	
Outpatient caseload (exc. MAS)	Monthly	N/A	3419	N/A	
Outpatient waiting list < 18 weeks	Monthly	92%	92%	G	
Derby City					
Community caseload	Monthly	N/A	1834	N/A	
Community waiting list	Monthly	N/A	309	N/A	
Community referrals	Monthly	N/A	145	N/A	
Community activity	Monthly	N/A	4049	N/A	
Community discharges	Monthly	N/A	137	N/A	
Outpatient caseload	Monthly	N/A	3193	N/A	
Outpatient waiting list < 18 weeks	Monthly	92%	95%	G	

People					
Indicator	Period	Target	Actual	RAG	Last 12 months
Vacancy rate	Monthly	N/A	4.4%	N/A	
Turnover – rolling 12 months	Yearly	10%	9.8%	G	
Sickness – in month	Monthly	5%	6%	R	
Annual appraisals	Monthly	90%	73%	R	
Mandatory training	Monthly	85%	89%	G	
Agency staff use	Monthly	1.9%	13.6%	R	

Neighbourhood Services Division Performance Dashboard 2016/17 Month 12

People					
Indicator	Period	Target	Actual	RAG	Last 12 months
Bank staff use	Monthly	5%	1.5%	G	
Clinical supervision	Yearly	100%	56%	R	
Managerial supervision	Yearly	100%	69%	R	

Finance					
Indicator	Period	Target	Actual	RAG	Last 12 months
Performance against budget £'000s	In month	1886	1932	R	
Performance against budget £'000s	Year to date	22557	21641	G	

General Manager Summary

- Work on recruitment and retention has kept turnover within the required target for the rolling 12 months. Sickness absence has slightly exceeded target but has improved throughout the year
- We have been working on improving appraisal rates but a lot of new starters and pressure within the neighbourhood teams means we have not achieved the target.
- We have exceeded target for use of agency staff and this has varied over the year, there have been issues with recruiting in some areas where other Trusts' border on our areas and there is a lot of competition for prospective candidates. Sickness absence, secondments (which we try to avoid) and age of the staff group set particular issues with recruitment and retention that have contributed to the overall use of agency staff and is very difficult to counteract, however it is a challenge we constantly try to overcome.
- Recruiting to medical posts has been extremely challenging throughout the year, this is a national issue and we have worked with other Trust departments to try and resolve this
- Work has been done in all neighbourhoods to achieve the 18 week waiting for outpatients and this is reflected in our meeting the target.
- Rates of supervision are not to target and are a concern. We have looked at the reporting framework and the way we manage supervision across all the teams to enable improvement. However we expect this to require ongoing and sustained attention going forward.
- Overall these teams are managing with an acknowledged gap in resource against an increase in rate of referral and caseload. We have recruited well over the past twelve months but these factors combine to make it very difficult to sustain performance across the range of indicators.

WARD STAFFING

Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
AUDREY HOUSE RESIDENTIAL REHABILITATION	74.52%	155.7%	69.2%	171.0%	35.5%	Yes	We now have a changed skill mix in terms of working with 2 qualified at night. Our ratio of qualified nurses is greater than that of Nursing assistants as we are aiming for 2 qualified per shift.
CHILD BEARING INPATIENT	88.71%	81.7%	81.2%	100.0%	135.5%	Yes	Current fill rate tolerances for day registered nurses were broken due to supernumerary/induction status of two new starters and cover for maternity leave. Broken on nights due to observation levels and long term sickness absence cover.
CTC RESIDENTIAL REHABILITATION	88.36%	103.4%	85.7%	138.7%	83.9%	Yes	No comment received
ENHANCED CARE WARD	96.13%	76.1%	135.2%	66.1%	206.5%	Yes	We still have vacancies in RN cover and are using unqualified staff cover. We have 3 new starters on horizon. One to start in April and a further 2 at the beginning of August. We are attempting to cover all vacant shifts with bank staff that are familiar with ward. The high rate for Unqualified staff at night reflects both backfill for qualified staff 34% short, plus exceptionally high clinical activity in relation to observation levels both on and off ward. Though out the month in question have constantly had at least 2 patients on high levels either 1 or 2.
HARTINGTON UNIT - MORTON WARD ADULT	101.34%	105.5%	123.8%	53.2%	293.5%	Yes	We have 5 registered nurse vacancies of which we are awaiting start dates for the staff already recruited into post. We have band 3 vacancies also of which we are awaiting start dates also.
HARTINGTON UNIT - PLEASLEY WARD ADULT	106.13%	115.5%	77.6%	55.9%	161.3%	Yes	Some of the Care Staff shifts on days have been covered by Registered Nurses due to the need to cover short-term sickness and redeployment of Care Staff. The under safer staffing figures of Registered Nurses on nights is because we haven't always been able to cover the shifts with 2 Registered Nurses due to re-deployment to support other wards and to cover the Hartington Unit bleep holder role, these shifts have been back filled with Care Staff.

WARD STAFFING

Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
HARTINGTON UNIT - TANSLEY WARD ADULT	97.98%	74.4%	137.0%	50.0%	212.9%	Yes	Deficits in Registered Nurse duties have been filled by predominantly Bank HCA duties to enable overall staffing figures of 5/5/3. Absenses and vacancies mean that only around 60% of the budgeted wte at Band 5 is available for duty before taking into account short term sickness, training or annual leave in addition only 50% of wte Band 6 is available for duty on day duty to cover Lead Nurse and Bleep duties or clinical shifts. All registered staff are doing extra shifts where they can to keep a safe skill mix and staffing ratio we expect as sickness reduces and staff return from maternity leave the skill mix will once again improve.
KEDLESTON LOW SECURE UNIT	68.23%	99.3%	84.2%	101.6%	100.0%	Yes	we currently have 2 vacancies for nursing assistants and 3RN's. We are currently working at lower staffing levels due to reduction in number of patients in preparation for the refurbishment works so this will contribute to some shifts looking like they are unfilled.
KINGSWAY CUBLEY COURT - FEMALE	67.92%	112.8%	107.2%	61.3%	130.1%	Yes	The reasons for breaking tolerance rate are: sickness, Annual leave, Maternity leave and Training.
KINGSWAY CUBLEY COURT - MALE	63.80%	77.9%	112.0%	72.6%	162.4%	Yes	Regarding the 'red' areas on the report: We currently have RN vacancies on the ward but have maintained 2 registered on each shift. On night shifts we have been unable to cover all the nights with 2 RNs however there were nights during the month when the 2nd RN was moved to cover another ward. The reason for over booking of Nursing assistants for nights was due to supportive observations on the ward

WARD STAFFING

Ward name		Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
	Occupancy % Rate	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	103.76%	92.4%	107.0%	100.0%	153.3%	Yes	This has been increased due to the clinical activity on the ward and the increased levels of 2 patients and also considering the increased bed numbers on the ward recently.
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	95.32%	84.2%	152.5%	59.7%	283.9%	Yes	Ward 33 are unable to meet the required fill rates due to significant Band 5 Registered Nurse vacancies, on nights currently only able to roster 1 Registered Nurse on shift, unqualified on nights and days have been rostered with regular staff to support.
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	104.19%	85.9%	135.8%	77.4%	238.7%	Yes	Ward 34 have had a continued high clinical activity, we continue to carry band 5 vacancies which is being addressed through recruitment.
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	104.35%	76.1%	135.3%	66.1%	117.7%	Yes	We have broken current fill rates as we are currently unable to fill our qualified nursing vacancies. We have increased our number of regular nursing assistants to back fill into these vacancies.
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	99.52%	101.4%	126.7%	58.1%	300.0%	Yes	There is an increase of day care staff due to the high clinical activity on the ward. Registered Nurses on nights are low due to staff vacancies and care staff (at Night) higher to compensate for this.

Workforce Section

WORKFORCE DASHBOARD

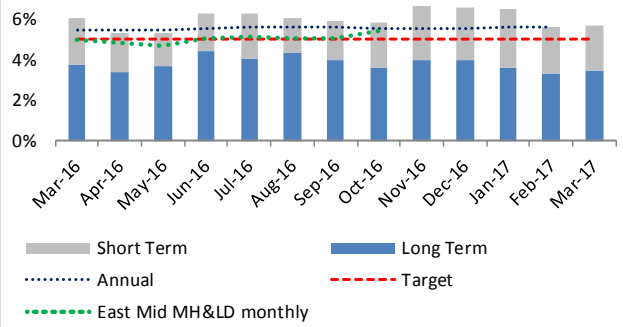
Wellbeing

Sickness Absence

(Monthly)

Jan-17	Feb-17	Mar-17
6.47%	5.61%	**5.70%**

Target 5.04%



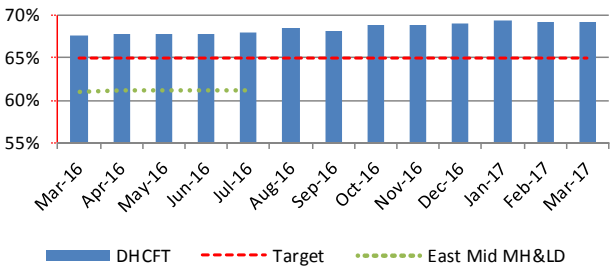
The monthly sickness absence rate is 0.09% higher compared to the previous month however it is 0.39% lower than in the same period last year. The Trust annual sickness absence rate is running at 5.59% (as at Feb 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 31.09% of all sickness absence, followed by surgery at 14.74% and other musculoskeletal problems at 9.36%. Compared to the previous month short term sickness absence has decreased by 0.03% and long term sickness absence has increased by 0.12%.

Qualified Nurses

(To total nurses, midwives, health visitors and healthcare assistants)

Jan-17	Feb-17	Mar-17
69.24%	69.17%	**69.08%**

Target 65%



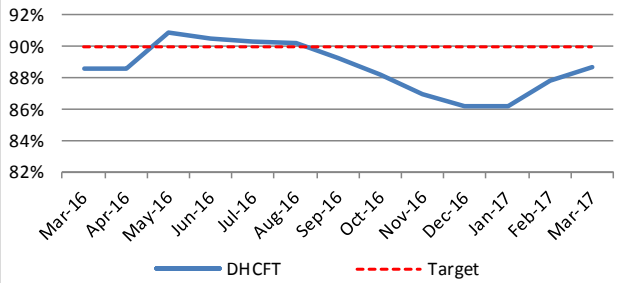
Contracted staff in post qualified nurses to total nurses, midwives, health visitors and healthcare assistants is running at 69.08%. Vacancy rates can impact on this measure. The average for East Midlands Mental Health & Learning Disability Trusts is 61.19%. Health Visitors represent 5.04% of the Trust total and are not included in the Qualified Nurses calculation. Healthcare Assistants and Nursing Support staff represent 25.88% of the total.

Compulsory Training

(Staff in-date)

Jan-17	Feb-17	Mar-17
86.21%	87.83%	**88.73%**

Target 90%



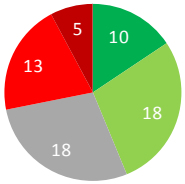
Compulsory training compliance continues to remain high running at 88.73%, an increase of 0.90% compared to the previous month. Compared to the same period last year compliance rates are 0.14% higher. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target.

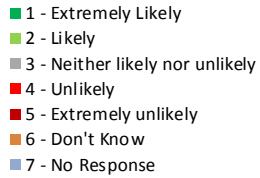
WORKFORCE DASHBOARD

Motivation

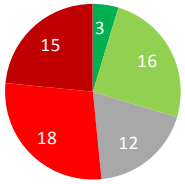
Staff FFT Q2 2016/17 (In-Patient campus focus; 64 responses, 10.08% response rate) **& Staff Survey** 2016

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





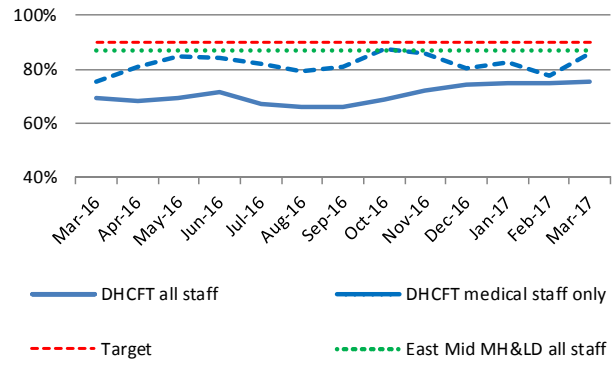
How likely are you to recommend this organisation to friends and family as a place to work.



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

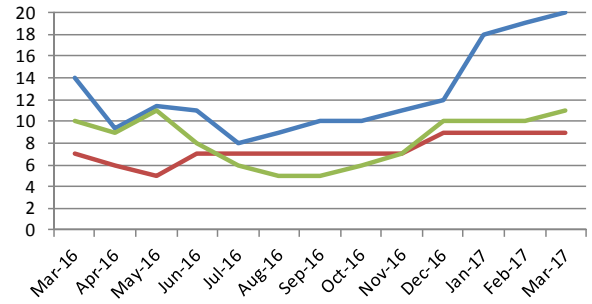
Appraisals	Jan-17	Feb-17	**Mar-17**
(All staff)	74.60%	74.62%	**75.14%**

Target 90%

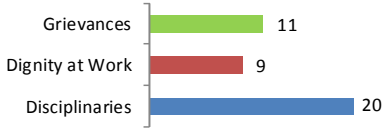


The number of employees who have received an appraisal within the last 12 months has increased by 0.52% during March 2017 to 75.14%. Compared to the same period last year, compliance rates are 5.02% higher. Medical staff appraisal compliance rates are running at 86.11%. According to the 2016 staff survey results, the national average for Mental Health & Learning Disability Trusts is 88.79%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 82.86%.

Grievances/Dignity at Work/Disciplinaries as at 31/03/2017



There are 11 grievance cases lodged at the formal stage. 1 new grievance has been lodged in the period. No new Dignity at Work cases have been identified. 1 new Disciplinary case has occurred in the period with the possibility of 2 being resolved during the next period. Efforts are on-going to manage the cases with robust requests being escalated to Deputy Director level should managers not be progressing cases in a timely way.



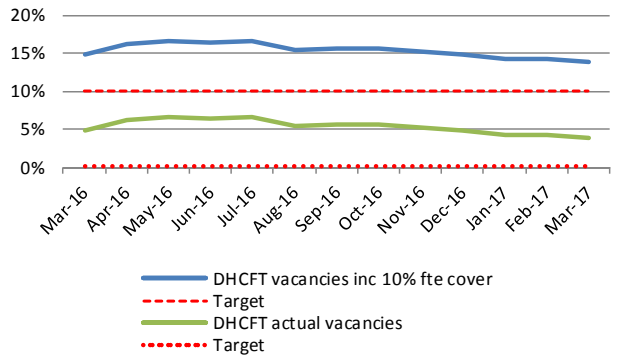
WORKFORCE DASHBOARD

Attendance

Vacancy

	Jan-17	Feb-17	Mar-17
(Funded full time equivalent) Including 10% funded fte flexibility/cover	14.35%	14.19%	**13.95%**
Actual against target	4.35%	4.19%	**3.95%**

Target 10%/0%

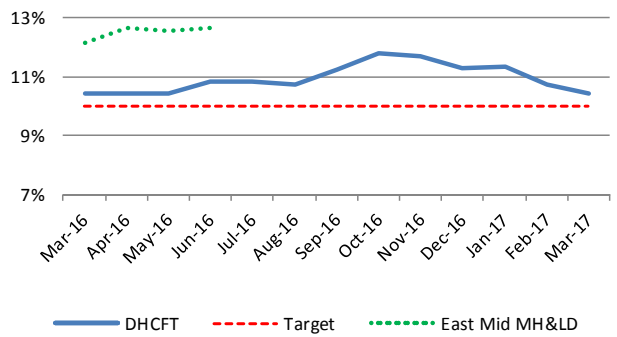


The Trust target for contracted staff in post is 90% which allows 10% funded full time equivalent surplus for flexibility including sickness and annual leave cover in In-Patient areas. The funded fte vacancy rate has decreased by 0.24%. April 2016 included additional full time equivalent investment for 2016/17. During the previous three months, 54 employees have left the Trust and 83 employees have joined the Trust.

Turnover

	Jan-17	Feb-17	Mar-17
(Annual)	11.37%	10.76%	**10.44%**

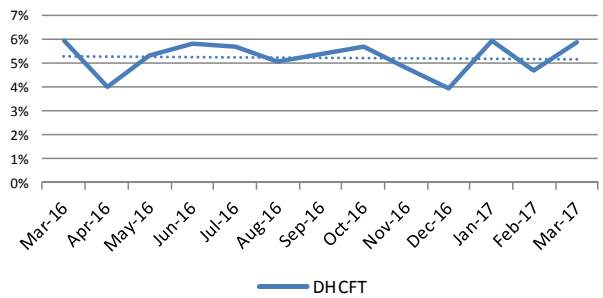
Target 10%



Annual turnover remains within Trust target parameters at 10.44% and remains below the average for East Midlands Mental Health & Learning Disability Trusts. The average number of employees leaving over the last 12 months has decreased by 0.50 to 20.83. During March 2017 22 employees left the Trust which included 8 retirements.

Agency Usage

	Jan-17	Feb-17	Mar-17
(Spend)	5.91%	4.70%	**5.86%**



Total agency spend in March was 5.86% (6.54% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.4%, Medical 4.6% and other agency usage -0.1%. Agency Qualified Nursing spend against total Qualified Nursing spend in March was 3.9%. Agency Medical spend against total Medical spend in March was 22.5%. Overall page the level of Agency expenditure exceeded the ceiling set by NHSI by £1.972m of which £1.379m related to Medical staff.

Quality Section

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 26 April 2017

Quality Position Statement

Purpose of report

This report provided the Trust's Board of Directors with an update on our continuing work to improve the quality of services we provide in line with our Trust Strategy, Quality Strategy and Framework and our strategic objectives.

Executive Summary

This position statement sets out:

1. Safety planning
2. Safe transitions from prison service to the Trust
3. National Guidance on Learning from Deaths published by the National Quality Board March 2017
4. Quality Leadership of developing new roles- the pilot of Associate practitioners in the region and Trust
5. Quality visits
6. Care Quality Commission Comprehensive Inspection – re-visits
7. Warning notice- medium risk concerns removal in March 2017
8.

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

Strategic Considerations

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

(Board) Assurances

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

Consultation

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

Governance or Legal issues

Evidence of our compliance with the Health and Social Care Act 2008 (Regulation activities) Regulations 2014 Part 3 and Care Quality Commission (Registration) Regulations 2009 (Part 4).

Children and Families Act 2014.

Equality Delivery System

Any impact or potential impact on equality is considered as a key part of all our quality work.

Recommendations

The Board of Directors is requested to:

1) Receive this quality position statement
2) Gain assurance, be advised on quality leadership strategy and engagement and information on its content and seek clarity or challenge on any aspect of the report

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

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

QUALITY POSITION STATEMENT

1. SAFE SERVICES

1.1 Safety Planning

The FACE risk assessment tool is being de-commissioned at the end of March, so the Safety Planning tool will be the place for staff to record risk assessment and risk management. This is being used already in some areas, but there continues to be concerns from other key service areas about the appropriateness of the tool to their relevant areas. We are keen to capture these concerns, together with ideas from staff for improvement and to change our culture and practice in personalised safety planning. In partnership with communications, staff continue to feed into our smart survey and ideas generation to improve the tool and how it works and this approach will stay open to consultation until all staff groups have contributed and this quality improvement can be refined and adapted to be fit for purpose.

Action: Continued re-design and improvement led by John Sykes as chair of the Patient Safety improvement work.

1.2 Safe Transitions From Prison Service to the Trust - Concerns

1.3 The Trust have raised concerns with Nottinghamshire Healthcare Trust Board regarding releases from prison at short notice of service uses with severe mental illness, often psychotic conditions and dual diagnosis. Referrals have been made for service users requiring urgent Psychiatric Intensive Care PICU admissions under the Mental Health Act where, due to a combination of communication difficulties and lack of PICU availability, serious clinical risks have developed that have not been possible to fully mitigate. NHS England are to conduct a “near miss” homicide review on one of these cases.

In the meantime, both trusts have been doing what they can to reduce the risk in the future. The Medical Director of Derbyshire Healthcare has met with the Clinical Director of Forensic Services in Nottingham. Measures have been put in place to improve communication. A single point of contact and pathway has been established in Derbyshire. Significant resource gaps have been identified, however, by the chief executive in Nottingham and our Trust Board. There is no outreach prison service in Nottingham and in Derbyshire there is no community forensic team although we do have a part time forensic community consultant. There is no PICU available within Derbyshire and although we have a PICU liaison nurse it is difficult to establish a proper working relationship and flow thorough of patients remotely. These issues are already known to commissioners and noted on the Quality assurance risk log and correspondence and good practice guides on expected standards for forensic community mental health teams have been shared with our Lead Clinical Commissioners.

The on-going concern has been noted by Nottingham Safeguarding Board and they have shared information with the safeguarding boards in Derbyshire and Derby City.”

Action

1. This is a known and longstanding risk on the Trust and Commissioner's quality assurance issues log. In last year's contracting round, the proposal was to address the potential issue as part of the 17/18 contracting round and proposal to invest in neighbourhood community services including the need to meet the needs of community forensic services. This was not a known commissioning gap and was not invested in this year, due to the known and significant financial gap for Commissioners.
2. The Trust has been completing benchmarking and service needs for Psychiatric intensive care and this service risk is now directly Commissioner and led by Commissioners in sourcing and securing this service from April 2017.
3. The Trust will be completing a benchmarking exercise with all Mental Health Trust providers to establish whether the community forensic team commissioning gap in service whether this is a common issue or an isolated risk to Derbyshire.
4. The integrated Quality Leadership Teams will be reviewing the NICE guidelines for Mental Health of Adults in Contact with the Criminal Justice System (2017). Early indications are that the Trust may not be fully compliant with this NICE guideline and additional liaison with Commissioners on their recommendations and Commissioning requirements will be required. To explore the risks of an extensive waiting list for care co-ordination, the inability to allocate a Care Co-ordinator following an unplanned release from a remand prison, the current cluster of failures in timely and effective communication on prison release namely safe transitions. Further work to mitigate this risk is required and a collaborative systems approach is being explored with Commissioners and partners.

   Commissioners and providers of criminal justice services and healthcare services should ensure effective identification, assessment, co-ordination and delivery of care for all people with a mental health problem in contact with the criminal justice system. This should include people who are transferring from young offender services and those on probation. In particular, ensure that:

   - *all people with a severe or complex mental health problem have a designated Care Co-ordinator.*
   - *during transitions between services care plans are shared and agreed between all services.*
   - *effective protocols are in place to support routine data sharing and, when necessary, joint plans of care between health services (including primary and secondary care services) and criminal justice agencies to reduce unnecessary assessments and promote effective interventions.*

5. The Derby City Safeguarding Board were briefed on the incident and issue on 11 April 2017, following an escalation by the Nottingham Safeguarding Board. This has been released to the Safeguarding Board to confirm the current position.

2. NATIONAL GUIDANCE ON LEARNING FROM DEATHS PUBLISHED BY THE NATIONAL QUALITY BOARD MARCH 2017

This recently published guidance is complementary to the CQC's report Learning, Candour and accountability; a review of the way NHS Trusts review and investigate the deaths of patients in England.

This work follows on from the events in mid Staffordshire and a review of 14 hospitals with the highest mortality rates. There is a concern that trust boards are gaining false assurance from aggregate mortality rates and that Trusts need to identify practical steps that can be taken to reduce genuinely avoidable deaths. The CQC report concluded that not enough priority is given to learning the lessons from deaths and not enough is being done to engage bereaved families in a meaningful and compassionate way.

Trust boards are required to have:

- A Patient Safety Director - John Sykes
- A Non-Executive Director with oversight - Anne Wright
- An updated policy by September 2017 explaining how it responds and learns from deaths of patients who die under its care.

Quarterly reports should be received by the Board from April 2017 with the proposed policy framework set out by quarter 2 and data and learning points published by quarter 3. These should identify how many patients died due to problems in our care. It is recognised that this will be subjective and should not be used for benchmarking against other organisations or by external bodies to make judgements about the quality of care. The CQC however, will review the processes used and the level of family involvement. Guidance on the latter will be published by the National Chief Nurse.

The Trust already has a Family Liaison service in operation for over two years.

The Trust already has a mortality surveillance group which his multi-disciplinary. Members of this group and those undertaking investigations should have specialist training. The group should work with commissioners and share learning with other organisations. Lessons learnt should be seen alongside complaints and other relevant information.

One key change of approach is that there should be retrospective case record reviews following the deaths of those with severe mental illness and learning disability. This should focus on the management of physical health long term conditions as well as looking at mental health care. There is already a learning disability mortality review (LeDeR) process established. There is no consensus as to what approach should be taken to a review of those with serious mental illnesses. A structured judgement review (SJR) is available from the Royal College of Physicians' for acute hospitals and its application in the mental health setting is being investigated by Professor Allen Hutchinson in Yorkshire and Humberside AHSN improvement academy. These case record reviews will be in addition to investigation of

suicide and homicides and review of Regulation 28 notices from the Coroner. They are likely to lead to additional reporting to the National Reporting and Learning System (NRLS).

It is emphasised that patients detained by the Mental Health Act who die should be reported immediately to the CQC and require notification to the Coroner. The Trust's Mortality Surveillance Group has developed processes to identify and report each death of patients open to the trust and now must determine which patients are considered to be included or a case review and state which patients are specifically excluded.

Currently there are large numbers of deaths in older age patients which are not reviewed or investigated to the future standard and it would not be possible with current resources to do so for all of them. The methodology for selection to review and promote the most effective monitoring and learning. This will need to be determined and resource implications quantified by the Mortality group and recommendations for an effective system will be escalated to the Trust management team, if required

Dr John Sykes

4 WELL LED

4.1 Quality Leadership of developing new roles- the pilot of Associate Practitioners in the region and Trust progress

DHCFT Nurse Associate Progress – March 2017.

The organisation has 5 Trainee nursing associates on the national pilot. The trainees are all on band 3 posts and commenced their training on 31 January 2017 with Derby University.

The candidates are expected to achieve 3375 practice hours in total in the two years. This means they need an average of 37.5 hours per week, with no more than 7 weeks of absence each year.

Placements are being looked at across our STP footprint. There is a requirement to undertake 8 weeks of placement a year. We are looking at negotiating our placements with Royal Derby so our trainees can go to areas which are relevant to our organisation. The Physical Care Committee have been consulted re: where our trainees should go, to ensure safe and effective practice.

The following shows our trainees and where they are based:

Area of work

- City Crisis Team
- Cherry Tree close
- Neighbourhood Team (City)
- Cherry Tree close

- Neighbourhood Team (City)

The group has given positive feedback. They are currently undertaking the anatomy and physiology modules. One Associate Nurse trainee is already working with the Medic to set up the Physical Health Clinic for the neighbourhoods and both trainees from the neighbourhoods will be running these clinics, undertaking physical checks, ECGs, venepuncture. These are known improvement areas for these teams and coupled with the clinical pressures in these teams to ensure effective deployment of pilot posts have been coupled with service support. Early indicators are these pilots are progressing well.

The Nursing and Education team are working with Cherry Tree Close to map out how they can utilise the Trainee Nursing Associates in their service. This service has identified basic physical skills training as an urgent need for their support staff. The education team will support the trainee nursing associates in this service to lead on this work, with support, in addition to ensuring these new trainees have an effective training programme.

It was an active Trust decision not to pilot the Associate Nurse role in higher risk in-patient service areas, as these roles progress and supervision and oversight models have been modelled, further pilots will be reviewed for the potential to expand the pilots into other service areas.

DHCFT and DCHS are working on recruiting a band 6 to support trainees across both organisations; this post is funded via HEE funds.

Action: There is clear commitment from the Executive Director of Nursing and Patient Experience and the pilot areas team to support the Associate Nurse pilot in the Trust. The next stage of formal NMC regulation is in a design phase with expected regulatory guidance on registration in. This will require adaptation the registration and revalidation Trust policy on receipt. Further development work on a core Nursing Associate job description and competency framework, will be developed by Education and Nursing working collaboratively and confirmed to through the Nurse Leadership group by October 2017.

5 EFFECTIVE

5.1 Quality Visits

The reviewed technical guidance and briefing on Quality Visits is now complete and has been distributed to those who are conducting Quality Visits. There are 76 areas to visit. Twenty one of these are booked. We are awaiting confirmation from three more teams, and the rest are to be arranged over the coming months. Each visit is led by an Executive Director. The key theme for this year is the continuation of the key lines of enquiry. In addition, staff to showcase family inclusive practice or the Triangle of Care for clinical services and inclusivity for non-clinical areas.

5.2 Care Quality Commission Comprehensive Inspection – Re-visits results

The CQC full inspection report was published on 29 September 2016. We have received visits to services

- Forensic inpatient service re-graded positively to "requires improvement."
- Older Adults Wards – re-graded positively "requires improvement."
- Children and Young People's Health service - safety domain inspection only – re-graded to "good". Overall service rating not changed as whole service was not reviewed.
- Learning Disability services - clinical audit of key practices. No change in rating, remains "at requires improvement."

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community health services for children, young people and families	Good	Good	Outstanding ☆	Requires improvement	Requires improvement	Requires improvement
Community mental health services for people with learning disabilities or autism	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Community-based mental health services for adults of working age	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community-based mental health services for older people	Good	Good	Good	Requires improvement	Good	Good
Forensic inpatient/secure wards	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Long stay/rehabilitation mental health wards for working age adults	Good	Requires improvement	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Specialist community mental health services for children and young people	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆
Wards for older people with mental health problems	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Colleagues in Substance Misuse services continue to prepare for their expected visit, which would be expected in 2017.

Each lead for CQC outstanding actions has been offered 1-1 support and many have accepted this. Progress is reviewed monthly and reported to the Quality Committee.

In addition the warning notice, which was applied to the Trust Section 29a, has now been lifted in March and the CQC improvement plan is subject to standard management by the areas CQWC team. One outstanding issue is continued work to address the Equalities aspects and networks for staff support and deliver upon the Equalities Action Plan.

Report prepared by:	**Carolyn Green** **Executive Director of Nursing and Patient Experience and** **John Sykes** **Medical Director**
Report presented by:	**Carolyn Green** **Executive Director of Nursing and Patient Experience**

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors - 26 April 2017

DHCFT Equality Delivery System (EDS2) Update

Purpose of Report:

The purpose of this paper is to present to the Board an update against the goals of the EDS2, including actions to date, equality objectives and associated work streams. The document also sets out the next steps in terms of governance and assurance to deliver on its EDS2 performance grading for 2017/18, including Board Assurance Framework 3d. Appendix 1 is an update against the equality objectives, including EDS2 actions embedded in the People Plan.

Executive Summary

What is the Equality Delivery System2 (EDS2)?

The EDS2 is an evidence-based tool to help drive up a strategic approach to equality performance and enable organisations to embed equality into mainstream NHS business. The EDS2 is a public commitment of how NHS organisations plan to meet the needs of local people and staff, and if implemented well, helps to meet the duties placed on them by the Equality Act 2010. It also sets out how, they recognise the differences between people, and how they aim to make sure that any gaps and inequalities are identified and addressed (so no one is left behind). Wherever you go for NHS services you will find organisations now working to the same set of goals around equality, diversity and human rights.

The Trust Board received an EDS2 update and provisional internal self-assessment report on the 7 September, 2016. Deep Dive of BAF Risk 1b Equality was presented at People & Culture Committee on 21 February, 2017 by Amanda Rawlings, Director People & Organisational Effectiveness (closed Datix 3 April, 2017). Also an interim progress report, identifying Director leads for each of the 4 EDS Goals and accompanying implementation plan to carry out EDS2 2016/17 validation was shared at the Quality Committee on the 9 March, 2017 by Carolyn Green, Director of Nursing and Patient Experience.

How are we doing?

A steadfast approach continues to be maintained through the Equalities Forum across both service delivery and workforce to ensure equality compliance and actions are achieved and proactively performance managed. Updates are provided to the People & Culture Committee (PCC) as part of the People Plan. Appendix 1 is the latest update provided to PCC on the 20 April, 2017, which includes EDS2 grading tracker, demonstrating upward RAG rating score following external validation, resulting in no reds/undeveloped for service delivery and experience goals 1 & 2.

The Trust Board received an EDS2 update and provisional internal self-assessment report and EDS2 dashboard on the 7 September, 2016, which is published on our website (Appendix 2). The EDS2 methodology involves a nine step approach, which includes external validation by stakeholders, who review our performance for each of the 18 outcomes based on the evidence we have shared. If there is disagreement about any

grade, the views of the local stakeholders should be given weight.
The validated EDS2 grading result table and specific service actions for Goals 1 & 2 can be found at Appendix 3.

Goals 1 & 2 for Improved patient access, experience and outcomes (*(REGARDS Groups - getting, using, experiencing and benefiting from our services)* took place on the 22 March, 2017 with stakeholders, service users and carers. The Trust Chair, CEOs and senior leaders were actively involved in the event and demonstrated a strong commitment to equality and making a difference. The validated EDS2 dashboard shows a positive upward trend in RAG rating and is presented at Appendix 3. This includes grading and a summary of service specific actions/objectives recommended on the day for Neighbourhoods (City, Clay cross and Bolsover) and Perinatal Services. Kath Lane, Deputy Director of Operations and General Managers Claire Biernacki and Joe Wileman, will share progress with stakeholders via a 'You said, we did' report against each of the 9 outcomes in September, 2017.

Goal 4: Inclusive leadership *(leaders, showing strong and sustained commitment to promoting equality within and beyond. Engaging and responding to the needs of the diverse REGARDS groups). Current RAG ratings:*

- 4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations (Developing/Amber)
- 4.2 Papers that come before the Board and other major committees identify equality –related impacts including risks, and say how these risks are to be managed (Undeveloped/red)
- 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination. (Undeveloped/red)

Work is progressing to start to address the 'undeveloped/red' grading through a focused equality Board development session, facilitated by Director of People and Organisational Effectiveness and Trust equality lead, on the 12 April, 2017. This provided protected time to take stock of our corporate Equality Objectives and identify specific board actions to drive a strategic approach to improve our equality performance and proactively leverage the benefits of inclusion and engagement. Members have drafted a set of top six focused actions that can make a major impact, drive inclusive behaviours, and ensure compliance, integration and continuous improvement and delivery of our corporate equality objectives. The draft actions will be refined and a SMART action plan will be developed and included in the coming business planning period. It is proposed that this is presented in more detail at the May 2017 Board meeting.

Board equality action plan -provisional draft top six actions for further discussion and refinement :

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

Goal 3: Empowered, engaged and well supported staff *(The Trust a good and fair employer for all REGARDS groups).* Work is in progress to improve the lived experience and proactive engagement of REGARDS staff, including investment in Black and Minority Ethnic (BME) staff network. This network is championed by Ifti Majid Trust CEO and staff have feedback to Director of People & Organisational Effectiveness that they are feeling more valued and confidence and belief in leadership commitment to equality and inclusion (during network meetings and Equality Forum 10 April, 2017). We are also working in partnership with DCHS to enable our staff to access the Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) Staff Support Network and Long Term Conditions & Disability Staff Support Network. A draft BME Staff Network Conference Report, 17 March, 2017 can be found at Appendix 4 and will be launched during Equality & Diversity week commencing 15 May, 2017.

EDS2 17/18 forward planning and risk management - ensuring Trust operates inclusively and demonstrating compliance with Equality Act

- Equality Board Assurance Framework (BAF) 3d completed to manage risk over the year and put in place control measures, for example to improve recording of service user protected characteristics on clinical systems (discussion during Board development session on the 12th April 2017 to agree a 85% completion rate across each REGARDS group). Targeted liaison/outreach work with key community stakeholders to maintain robust relationships and continued two-way dialogue (Appendix 5)

- In recognition of our support and partnership working with Action for Blind - Trust invited to mark the charities 150 years and merger with Royal Institute for the Blind at House of Lords 11th May, 2017.

- DHCFT hosted the British Sign Language Charter Partnership on the 3 April with Robin Ash from the British Deaf Association. Director of People & Organisation Effectiveness has made a firm commitment to partnership working with British Deaf Association. Deputy Director of Operations leading the implementation of the British Sign Language Charter Standards and Ifti Majid, CEO is opening the health information event on the 17tMay, 2017 at Derby Deaf Club.

Forward planning - legislation milestones and implementation plans as discussed at Equality Forum 10 April, 2017

- Publication of latest workforce data across all 9 protected characteristics and Service delivery understanding our service users EDS2 report – request made to be uploaded by communication team on E & D webpages. Publishing information - 31st January is the next publication date in line with the Public Sector Equality Duty.
- Equality & Diversity report included in corporate Annual Report – completed.
- EDS2 Implementation Plan 17/18 for the year – draft has been developed and in process of agreeing EDS2 works streams, dates for self-assessment and external validation with appropriate leads in preparation for discussion at Equality Forum 10th July, 2017 and tabled for Board approval 27th September, 2017.
- REGARDS wheels sponsored by the Director of Nursing and Patient Experience to support Equality Impact Risk Analysis.
- Workforce Race Equality Standard (WRES) and Action Plan – to be submitted centrally through Unify 2 system (via IM & T) August 2017 and published on

website annually along with Board statement. WRES action plan to be developed and tabled at key committees as part of reporting schedule, including Board 27th September, 2017.

- New draft regulations and equality duties - Gender Pay reporting and Disability Standard preparatory year (publish 30th March 2018). Work is underway nationally via Electronic Staff Solution to enable Trust to run and publish this data across all protected characteristics.

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

(Board) Assurances

The Equality Forum together with Quality Assurance and People and Culture Committees will ensure the Trust meets its statutory duties under the Human Rights Act (1998). Equality Act (2010) and Public Sector Equality Duty

- EDS2 16/17 – completed and You said, we did feedback by General Manager in September 2017.
- EDS2 17/18 implementation and work plan tabled at Equality Forum 10th July, 2017 and Board 27th September, 2017.
- BAF risk 3d is presented to Equality Forum and PPC to discuss controls attached at Appendix 5. Controls to ensure data completion (85% target) and stakeholder capacity – discussed at Equality Forum 10th April, Board Development 12th April, and PCC 20 April, 2017.

Consultation

- The EDS2 methodology involves a nine step approach, which includes external validation by external stakeholders, who review our performance for each outcome based on the evidence we have shared. If there is disagreement about any grade, the views of the local stakeholders should be given weight. This process has taken place 22/3/2017. The report includes feedback from external stakeholders below and in the EDS2 dashboard (Appendix 3).
- Members of our 4Es Strategic Alliance were invited and North Derbyshire Mental Health Carers Forum, Peaks & Dales Advocacy, North Derbyshire Voluntary Action and Health watch Derby participated in the grading process. External feedback has been very positive "*I would like to send some feedback following the EDS event. I thought it a quite a good event. Venue and facilities (parking) was very good. Can I say that I was pleased to see Health watch input was not ignored –*

and helped provide a more honest and accurate grading on access. Lastly and most importantly may I add that the Trust is one of a kind – no other Trust is currently hosting EDS grading events attended by external stakeholders? No other Trust has a valuable patient forum like 4Es. Stakeholder engagement standard is really commendable. I am reassured the complaints and feedback outcome has externally been graded as developing. It is a fairer summation and as I told Carolyn Green, Director of Nursing, I have no doubt the Trust will convert it into achieving". (SM, Health watch Derby email 23/3/2017)

- BAF 17/18 3d (Appendix 5) includes controls to ensure we maximise stakeholder engagement and transparency in line with nine step EDS process and methodology.

Equality Delivery System

Please see Appendix 3 for grading and priority actions identified by stakeholders.
The EDS2 is basically a robust Equality Impact Risk Analysis of our core functions and demonstrating equity of access, experience and outcomes and shared at EDS2 event 22/3/2017 and equality forum 10/4/2017. The EDS2 has 18 Outcomes, nine examine service delivery and nine examine workforce development and leadership. For each EDS2 Outcome, NHS trusts produce evidence demonstrating analysis of service delivery or workforce data by protected group; evidence of access, experience, outcomes, engagement with protected groups; evidence of equality being included in governance and business processes, and finally, evidence of progression plans to support the inclusion of equality throughout the organisation. Equality Analysis, case studies and presentations were shared with stakeholders to aid grading based on this data at the EDS2 event. This data will be made available on our website via E & D pages.

It works by ensuring that all of the work of the Trust is benefiting protected groups in different ways. It is also about creating a system where our stakeholders are the ones that are assessing our performance rather than the Trust doing a simple self -assessment. This includes us providing detailed evidence against the specified criteria in the EDS2 and actively engages their stakeholders from all REGARDS protected groups (protected characteristics) in this process, EDS2 evidence is independently graded by stakeholders, Health watch, governors, BME Staff Network and staff-side representatives, who determine the Trust's equality performance.

Corporate equality objectives are implemented via our action plan and embedded in our People Plan and performance managed via Equalities Forum and People & Culture Committee.

Recommendations

The Board of Directors is requested to:

1) Note progress on equality and more specifically the undertaking of our annual EDS2 16/17 goals 1 & 2 including upward RAG improvement.
2) Note and approve EDS2 16/17 external validation for goals 1 & 2 and actions against the 9 outcomes (Appendix 3) and follow-up action to produce a 'You said, we did' report for publishing on website.
3) EDS2 Goal 4 Inclusive leadership – note steps to progress outcomes and proposal to present (Draft) Board top six priority actions and SMART implementation plan at the May 2017 Board meeting.
4) Note BAF 3d and controls (Equality Impact, data completion rates and engagement) to deliver EDS2 17/18 implementation plan, including formal Board approval of EDS2 17/18 plan on the 27th September, 2017 (as per nine step EDS2 process/ methodology).

Report presented by: Harinder Dhaliwal, Assistant Director for Engagement & Inclusion (equality lead)

Report prepared by: Harinder Dhaliwal, Assistant Director for Engagement & Inclusion (equality lead)

Appendices:

- Appendix 1 : Equality & EDS2 update as shared at P&CC on the 20th April, 2017
- Appendix 2: Provisional internal self-assessment EDS2 dashboard on the 7th September, 2016, published on our website.

- Appendix 3: Validated EDS2 external grading result table and specific service actions for Goals 1 & 2 (22nd March, 2017).
- Appendix 4: Draft BME Staff Network Conference Report, 17th March, 2017
- Appendix 5: Equality & Inclusion BAF 17/18 3d.

People Plan - Equalities Update

Action	Update	On track
1) Ensure the trust meets and exceeds legal compliance with the Equalities agenda 2) Embed the Equalities Forum	• Co-ordinated and facilitated the achievement of all actions in the Corporate Equalities Action Plan. Forward plan produced to ensure key areas and progress is reported at Equalities Forum and performance managed. Equalities Forum has met 20th February, 2017 and 10th April 2017. Equalities Forum has included the following equality areas: • Equality data monitoring year end reports 16/17 for workforce and service delivery to be scrutinised. • Workforce Race Equality Standard to be submitted in line with NHS England time frames and preparing our ESR system for new legislation as preparatory year in readiness for Gender Pay reporting and Disability Standard (April 2018) • Equality Board Assurance Framework 3d completed to managed risk and put in place controls measures. Agenda item at Equalities Forum 10th March, 2017 for discussion regarding equality monitoring/data completion and capacity of external stakeholders to support EDS2 grading. Please refer to Appendix 2. • Improving services for Deaf people – Robin Ash, from British Deaf Association and Paul Barker, Chair of North Derbyshire Deaf Forum attended the 20th February, 2017 meeting. Trust hosted the Derbyshire BSL Charter Partnership at Kingsway on the 3rd April, 2017. Positive feedback regarding our Car Parking and barrier texting system. Commitment by senior leaders to support information day for Deaf community and refresh our BSL pledge 17th May 2017. • Equality and Diversity annual report for 2016/17 (in line with the specific duties) has been included in Trust annual report which includes developments and workforce and service equality analysis position as at the end of the financial year. • Equality and Diversity training for all staff – compliance 82.71% (1942 trained out of 2348). Email reminder will be sent out to encourage staff to complete.	

People Plan - Equalities Update

3)To develop an action plan to progress the trust from under developed to achieving in EDS 2	EDS2 validation event for Goals 1 & 2 for service experience and outcomes took place on the 22nd March, 2017 with external stakeholders. Healthwatch Derby, North Derbyshire Mental Health Carers Forum, Peaks & Advocacy and North Derbyshire Voluntary Action, Public Governor and service users. Our stakeholders have graded us based on the evidence we shared and there is a positive trajectory with regards to progressing to achieving. **Goals 1 & 2 for Service experience and outcomes (9)** Internal Self-assessment 7.9.2016 across the 9 outcomes: Nil; Achieving Green (1); Developing Amber (6); Undeveloped Red (2) External Stakeholder validation 22.3.2017: Excelling Purple (1); Achieving Green (6); Developing Amber (2); Nil EDS2 Goal 4 : Workforce outcomes -actions to improve EDS2 RAG rating are as follows: • Staff engagement and building networks event was held on the 30th March, 2017 to explore how we can improve the lived experience and build staff networks for LGBT and Long term Conditions & Disability. Equality lead had connected with DCHS staff networks to explore how we can work together for the benefit of our workforce communities • BME Staff Network Annual Conference and action planning session sponsored and supported by Acting Chief Executive and Director of People and Organisational Effectiveness. The forum will now develop a comprehensive action plan, including BME Reverse mentoring scheme. • Learning organisation and generating knowledge through research and innovation -initial scoping discussions with Professor Johnson, Nottingham University to be part of small scale BME reverse mentoring study (Participation action research project). • Draft BME Staff Network Annual Conference 17th march 2017 can be found at Appendix 2. • EDS Goal 4 : Inclusive Leadership Goal 4 – Board development session 12th April, 2017 to identify top action for the Board and mapping our progress	

		using The governance for equality matrix developed by Institute of Governance and field tested by NHS Coventry.	

EDS2 Dashboard and Assessment 2016/17

DHCFT Equality Delivery System2 Rating 2016/17 (Updated 31/8/2016), Approved 7/9/2016 - Board (this is an internal assessment).

Delivering our vision through EDS2: Are services and employment equally good, working well for everyone?

Goal 1: Better Health Outcomes Healthy living & results for all REGARDS groups.			**Goal 2 : Imporoved patient access and experience** REGARDS Group - getting, using and experiencing our services.		
1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local comunities.	U	2.1	People, carers and communities can rapidly access hospital, community health or primary care services and should not be denied on unreasonable grounds.	G↑
1.2	Individuals' people's health needs are assessed and met in appropriate and effective ways.	A ↔	2.2	People report positive experiences of the NHS.	A ↔
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone informed.	A ↔	2.3	People's complaints about services are handled respectfully and efficiently.	A ↔
1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.	A ↔			
1.5	Screening, vaccination and other health promotion services reach and benefit all communities.	U			
Goal 3: A representative and supported workforce * Is the Trust a good and fair employer for all REGARDS groups?			**Goal 4: Inclusive leadership** Leaders engaging and responsing to the needs of the diverse REGARDS Communities.		
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.	A ↔	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.	A ↔
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their obligations.	A ↔	4.2	Papers that come to the Board and other major committees identify equality related impacts including risks and say how these risks are to be managed.	U
3.3	Training and development opportunities are taken up and positively evaluated by all staff.	A ↔			
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source.	U	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.	U
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives.	A ↔			
3.6	Staff report positive experiences of their membership workforce.*	U			

EDS2 GRADING Grading Key: **RED** = Undeveloped **Amber** = Developing **Green** = Achieveing **Purple = Excelling**

Previous year score - All Amber

Appendix 3: Equality Delivery System2 Dashboard Service Experience & Outcomes Goals 1 & 2 External Grading Results 22/3/2017

		Perinatal & Neighbourhoods (Bolsover/Claycross & City)	Overall Trust wide Grade	Top actions identified by external stakeholders. Accountable Officers : Kath Lane, Claire Biernacki & Joe Wileman 'You said, we did' report due September 2017
Goal 1: Better health outcomes for all (Healthy living & results for all REGARDS groups).	1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities. (promote well-being and reduce health inequalities)	Excelling (Purple)	Achieving (Green)	Comparison of census data would be useful. Show accreditation as evidence.
		Developing (Amber)		CQUIN about Autism. Continue to develop recovery agenda. Links nurses from neighbourhood and Perinatal
	1.2 Individuals' people's health needs are assessed and met in appropriate and effective ways	Excelling (Purple)	Excelling (Purple)	Further develop community services and group offer in North of county.
		Achieving (Green)		Maintain physical healthcare assessments and update on Derby City Pilot.
	1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.	Achieving (Green)	Achieving (Green)	Feedback to commissioners that quality of services is being delivered, the difficult challenges are where services do not or are not resourced sufficiently to deliver. (Re: Critical partner expressed that he felt assured that quality of values in Trust have significantly improved over the past few years and that the challenge is around lack of resources).
		(Green)		CQUIN – transitions from CAMHS to Adult review progress. Review waiting times across neighbourhoods.
	1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.	Excelling (Purple)	Achieving (Green)	
		Developing (Amber)		Need more evidence to show further information around safety and complaints –accessible communication standards. Information and data on use of interpreters. Share our learning with neighbouring hospital (?) – DHCFT Equality lead to link in Daniel (?) in with the Diversity lead.
	1:5 Screening, vaccination and other health promotion services reach and benefit all communities	Achieving (Green)	Achieving (Green)	
		Developing (Amber)		Explore ways of working more closely with DCHS around delirium and frailty. Promote bowel screening with older adults. Make this a primary action in Physical care committee.

Goal 2: Improved patient access and experience (REGARDS Group - getting, using and experiencing our services).	2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied on unreasonable grounds.	Achieving (Green)	Developing (Amber)	Review compliance with new standards re: waiting times. Section in Transgender policy about how people access Perinatal Services.
		Undeveloped (Red)		Rapid access scored green, but routine access undeveloped. Lack of access for older adults. Length of waiting times - clear communication to patients on expectations. Referral pathway for seldom heard communities to proactively deal with referral.
	2.2 People are informed and supported to be as involved as the wish to be in decisions about their care.	Achieving (Green)	Achieving (Green)	Review how we meet needs of Transgender Service Receivers
		Developing (Amber)		Continue having patient forums reaching out to all REGARDS groups –engagement at the local county neighbourhood levels. Raising confidence for individuals to be involved in their own care.
	2.3 People report positive experiences of the NHS (including carers)	Excelling (Purple)	Achieving (Green)	Look into reasons why there are no complaints. Look at whether people with LD and ESOL can complain easily. Look at data against REGARDS groups for next year.
		Developing (Amber)		Need to consider how we better involve carers both locally and trust wide.
	2.4 People's complaints about services are handled respectfully and efficiently.	Developing (Amber)	Developing (Amber)	Look into reasons why there are no complaints for these areas
		Developing (Amber)		

Validated 22/3/2017 in partnership with Healthwatch Derby, North Derbyshire Mental Health Carers Forums, Peaks & Advocacy and North Derbyshire Voluntary Action, service users and Public Governor.

Derbyshire Healthcare
NHS Foundation Trust

Black & Minority Ethnic (BME) Staff Network Annual Conference
Friday 17th March, 2017 9am to 4.30pm Centre R & D, Kingsway

BME Network Annual Conference -Strategy– Development – Coaching – Team-working.

This initial report gives a brief outline of the annual BME Staff Network annual conference. A full report and evaluation will be produced by Harinder Dhaliwal, Assistant Director for Engagement & Inclusion over the coming weeks. This session was facilitated by Rasheed Ogunlaru, experienced life, corporate and business coach / broadcaster and author of Soul Trader – Putting the Heart Back into Your Business.
Please note that the author has tried to use phrases used by the BME network colleagues to capture and do justice to the feedback and discussions taking place during the session

The event was promoted widely across the Trust and senior leaders were asked to nominate/encourage attendance from BME staff in their respective areas to maximise the 'BME voice', staff engagement and representation across the occupations.

Ifti Majid, Acting Chief Executive, champions the BME Staff Network attended the event and shared his commitment to equality and diversity. He listened to the lived experience of BME staff in the Trust and actively participated in the discussions, including the benefits of network, SWOT analysis and action planning. This was included in his weekly Friday email to all staff. A 'we need list' has been included at the end of the document as requested by the Acting CEO to share as part of his update to the Board.

The BME Staff Network dovetails into Trust staff engagement meeting/mechanisms, supports staff survey action plan, Equality Delivery System2, Workforce Race Equality Standard (WRES), and delivery of corporate Equality action plan (via Equality Forum and People & Culture Committee).

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Aims of session:

- An empowering strategic, coaching and planning session to help progress the BME Network, members and supporters.
- Build your personal, career, leadership, team and people skills.

Outcomes:

- Energised, self-empowered, engaged, proactive BME Staff
- Strategic Road Map – mission/purpose, vision, objectives and action plan and steps for the BME network
- Dovetailing with Workforce Race Equality Standard Action Plan and Equality Delivery System (EDS2).


Key headlines and points

Mission: To achieve open and fair access to opportunities, development and progression to ensure equality in career outcomes.

Vision:

- Representation, having a voice and visibility (to be heard, seen and listened to).
- BME staff and wider staff reporting positive working experience and environment. Ensure BME people no longer feel bullied.
- Diverse, skilled, talented and experienced workforce providing quality service based on individual need.
- To have a happy and healthy workforce and community.
- Equality and fairness - recognition by Trust and accessibility.

Objectives (no particular order at this stage - these will be developed into a SMART action plan:

- Accountability from the Board and network – mutual expectation to live the Trust values and a place where you can be yourself (identity), feel valued and sense of belonging. BME people no longer feel excluded or bullied.
- To grow the BME network by (% tbc)
- Equality performance, meeting equality legislation, CQC regulations and benchmarking for equality progress – to support the trust assess and feed into EDS2 annual grading, WRES action plan and staff survey.
- To track BME progression compared to non-BME groups and provides solutions to address gaps and barriers.

- To act as a reference group for on matters of diversity, Equality Impact Analysis and access
- To support Equality Impact Risk Analysis and annual quality audit of EIRA to ensure fair application and outcomes of policy and decisions (equal quality of access, experience and outcomes).
- To have a BME member of staff on (% tbc) on shortlisting, recruitment panels and disciplinary hearings.
- Accessibility – widen access and visibility across the trust to raise profile of BME staff
- Equity at all levels - to ensure the proportionate levels/percentage of staff is representative across all the bands/levels not just Trust representation compared to overall Derbyshire population (skewed by medical workforce and need to look at Derby City and Derbyshire as populations are different). Review against baseline readings and build on these to show progress.
- Increase the positive staff experiences with the Board prioritising BME staff engagement.
- Positive action and access for staff at lower bands – generating greater access for training and development.
- Talent management and succession planning –increase pool and identification of potential BME leaders (particularly bands 7 and 8 for acting up roles etc.) to ensure fair access and progress to senior leadership roles.
- BME workshop and dialogue with board/senior leaders and reverse coaching programme
- Celebrate Black History Month and other key events.

We need list (as requested by Acting CEO)

BME Staff Network:

- Dedicated resources
- Fund refreshments for monthly meetings
- Consistent administration to plan, support note taking and promote network.
- Development of events as per objectives and action plan above.
- To support annual EDS2 and EIRA quality audit
- Time to chair meetings
- Protected time for BME staff to attend from across the Trust and backfill if required to support release of staff.
- Annual BME Staff Network conference and workshops.
- Development programme for BME people that is specific to individual needs, such as attending conferences and sharing with network, leadership, coaching, secondments and acting up.
- Celebrate diversity events such as Black History Month.

Report sponsor: Ifti Majid, Acting Chief Executive.

Report prepared by:
Harinder Dhaliwal, Assistant Director Engagement & Inclusion
20th March, 2017

Appendix 5: Equality Board Assurance Framework April 2017

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

Principal risk:

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

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

Root causes:

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

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating MOD	Likelihood 4	Impact 2	Direction 1st issue	Rating Low	Likelihood 3	Impact 2	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Reporting of approach and progress reported to Board and the People and Culture Committee Detective –Urgent non-compliance addressed and reported to the People and Culture Committee Directive – Full time expertise in post, Launch of a new Equalities Forum,	Self-assessment grading based on equality evidence	Self-assessment grading validated by external stakeholders including HealthWatch (Derby)

Gaps in control:	Actions to close gaps in control:	Action due:	Progress on action:	Risk to delivery:

Delivered equality strategic action plan	Reporting on progress to Equalities Forum, Quality Committee, and People and Culture Committee [ACTION OWNER: DPOE]	31/03/2017	Reporting identifies progress, all objectives on target to achieve amber rating by Q3 17/18	Medium
Evidence of managers supporting staff to work in culturally ways	Delivering equality training. Undertake EDS assessment of services. [ACTION OWNER: DPOE]	Commencing June 2017	Equality training commenced through induction and EIRA training. Plan to deliver managing inclusion workshop. Board Development session planned for April 2017.	Low
Improve recording of service user protected characteristics on clinical systems	Deputy Director of Operations, Chief Nurse, General Manager IM&T and Assistant Director of Engagement and Inclusion to improve data capture though training, improvement of IT systems and performance management [ACTION OWNER: COO|DON|DPOE]	30/09/2017	Plan to be tables at equalities Forum April 2017	Medium
Consistent identification of equality related impact in papers presented to Board and Board level committee papers	Evidence of EIRA compliance across selection of Board and Board level committee papers [ACTION OWNER: DPOE]	30/09/2017	Completion audit of EIRA compliance and reporting progress to Quality Committee	Low
Gaps in assurances:	Actions to close gaps in assurances:	Action due:	Progress on action:	Risk to delivery.
Implementation plan for undertaking EDS2 national performance framework	Plan against EDS2 national performance framework to be developed and implemented [ACTION OWNER: DPOE]	30/09/2017	Plan to be presented to People and Culture Committee and Board April 2017	Low

Board Committee Summary Report to Trust Board
Safeguarding Committee
24 February 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Minutes from Safeguarding Committee held on 4 November 2016	A detailed review of the minutes and actions was undertaken Further improvement in the actions log and updating in advance of the meeting is required by the executive lead	Accuracy was confirmed	None	Ratified and agreed	None
Action Matrix and Policy Matrix	A detailed review of actions was undertaken Review and agenda items noted	Further improvement work required of the executive lead Limited assurance	None	Executive lead agreed to improve practice in this area	None
SAFEGUARDING CHILDREN					
Safeguarding Children Work Plan Update 2016/17	A detailed review of the work plan Challenge by NEDs on the style and the content of the report	Further improvement work required of the safeguarding lead in the front sheet to explain the historical work plan and prospective work plan Significant assurance on progress, further exploration of the future plan for 2017/18	None Potential risks delivery through competing priorities and regulatory activity	Ratified and agreed Head of safeguarding children to schedule revised work plan on the future agenda	None Escalation to executive

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Safeguarding Children Training Update **Safeguarding Children Training Needs Analysis Update**	A detailed review of the paper and findings Medical workforce significant outlier Exploration of information shared with medical workforce and wider challenge, discussion re personal emails to medical staff. Presentation of key issues and risks by Safeguarding Named Doctor.	Limited assurance – medial workforce compliance Significant assurance on progress, further exploration of the future plan for 2017/18	Significant deficits in medical workforce compliance with safety training to protect children. Leading to gaps in current knowledge and competency Culture of compliance with required standards with the medical workforce	Escalation to executive lead for the medical workforce. Immediate action required Requirement to brief chair of safeguarding committee on actions to mitigate and progress prior to the next meeting	Medical workforce non-compliance with Safeguarding Children training
Markers of Good Practice	Completed New date for inspection confirmed	Significant assurance on progress, all actions completed with the trust control	Awaiting NHS England independent investigation TOR for near miss homicide	Executive lead to contact NHS E to confirm progress	None
CQC Safeguarding Children Action Plans	A detailed review of the paper and findings Significant progress on all actions Significant concern re one outstanding action, linked to community care coordinator capacity Additional exploration of other actions which are	Significant assurance on progress Limited assurance – on remaining actions resolution through contracting round	Risks to patient, family and children's safety, Mitigation by Trust management however no full resolution in place to reduce structural deficit in care coordinators currently running at 60 wte deficit This is a known and accepted risk by Lead	Escalation to line manager of individual by Head of Safeguarding on outstanding issues and progress	Escalation to Board Triangulation with BAF quality concerns with commissioning gaps

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	over due		commissioners		
CQC Comprehensive Specific to Safeguarding Children	A summary report of actions and confirmation on progress	Significant assurance on progress	Continuation of embedding into practice	Maintenance of training standards	None
Serious Case Reviews Update	A summary report of current cases, and assessment of potential escalation into learning or SCR	Briefing of the board committee Significant assurance on progress	Identification of risks to be added into the audit work programme and improvement plan	Ratified and agreed Scheduling of future updates	None
SEND inspection in Derbyshire	A summary report of findings Discussion of the learning and impact on strategy and compliance	Briefing of the Committee. Significant assurance on progress	Action plan to mitigate all systems learning to be co-developed and presented at the next meeting Transferring learning from county to potential city inspection		None
Cases of Child Sexual Abuse - Summary of Progress and Bradbury Report	A summary report of findings Discussion of the learning and impact on strategy and work plan	Significant assurance on progress	Developing effective early warning systems to spot abuse of this nature. Additional guidance on work plan	Development of work plan to consider, audit, policy or standards to mitigate this in the Trust	None
Briefing on Child Sexual Abuse in Family Networks	A summary report of findings	Significant assurance on progress	None noted	Development of work plan to consider, audit, policy or standards to mitigate this in the Trust	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Joint Targeted Area Inspections	A summary report of the next expected regulatory inspection Confirmation of theme	Significant assurance on progress	Capacity and preparation	Operational group to develop pre checks, guidance and briefings	None
SAFEGUARDING ADULTS					
Safeguarding Adults Strategy Update Against Workplan and SMART Action Plan Safeguarding Adults Performance Dashboard	A summary report of findings Discussion of the learning and impact on strategy and work plan CQC improvements and actions Draft model of a Safeguarding Adults Performance Dashboard Including high level scrutiny on complex enquiries.	Significant assurance on progress	Capacity and preparation	Exploration of MASH advisors and other mitigation factors to reduce workload and pressure.	None Confidential briefing to Board on complex enquiry non, Trust incident
Operations Group verbal update findings of the MAPPA report	A summary report of findings Briefing on performance	Significant assurance on progress	Detailed work plan with progress to be maintained	Improving performance at MAPPA 2. Back to 100 per cent performance in last quarter	none
Safeguarding Adults Training Update and Progress Update	A summary report of findings	Limited assurance – medial workforce compliance	Risks to patient, family and children's safety due to competence levels of key staff	Continued support by the education team on compliance reports and improvement trajectories	As above training compliance for the medical workforce

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
			Maintaining and improving compliance in this area		
AC Female Report (2013 incident)	A summary report on learning event on draft report and developments	Awaiting full report to be agreed and publications	Delays in completion, awaiting publication to fully implement/ complete all actions on an agreed action plan	Leadership of the safeguarding leads to drive this action plan	**None**
AC Male Report 92010 incident)	Awaiting publication of report	Awaiting full report to be agreed and publications	Delays in completion, awaiting publication to fully implement/ complete all actions on an agreed action plan	Leadership of the safeguarding leads to drive this action plan	
CQC Comprehensive Specific to Safeguarding Adults	As per summary report				
POLICY REVIEW					
Child Visiting to Mental Health Inpatient and Residential areas Policy for ratification	Ratified with minor amendment	Ratification	None	Operational group to lead on full roll out	None
Multi Agency Public Protection Panel Policy and Procedures	Extension until new guidance is changed in line with system changes	Ratification	None	Operational group to lead on redesign and then full roll out	None
Any other business	None Thanks were offered to				

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	Maura Teager as chair for her extensive commitment to Safeguarding Personal thanks were offered by committee members and those in attendance on MT's commitment and personal leadership and support				
Forward Plan	Review and revised				
Meeting Effectiveness	Observed committee with summary of findings by external observer Effectiveness reviewed to be prepared and finalised and offered to chair to complete and review at the next meeting. Team reflections – positive meeting with significant progress on work and a significant pressure from regulatory activity and requirements				

Board Committee Summary Report to Trust Board
Mental Health Act Committee
3 March 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Welcome and Apologies **Minutes from Mental Health Act Committee held 18 November 2016** **Matters Arising – Actions Matrix**	Some items of action matrix did not match current position. To realign for next meeting. ST to escalate to JRS if leads are not responsive	Significant assurance. Realign action matrix – JRS. Escalate non responsive leads to JRS - ST	None	None	None
Consent to Treatment Section 58/T2 and T3 Forms Joint Presentation	Performance has not improved compared to previous audits. A "ward team" approach to be taken. Ward managers engaged. PARIs documentation streamlined and "pop up" reminders in place. Communication with MHA office improved.	Limited assurance. Annual audit with addition of SOAD referral process – EK November 2017	Lack of improvement risks adverse CQC inspection reports. Lack of evidence of person centred care.	Improvements to process noted and agreed.	None
Mental Health Act Committee Report: Seclusion and segregation Pathway update'	Significant decrease in number and length of seclusion. Improvement of Section 132A rights compliance with CTOs (98%).	Significant assurance. CH to further develop report as compliance checks come onstream from PARIS.	Overall compliance is improving. Illegal detentions due to delayed DoLS assessments by LA are outstanding with one	Good progress noted. To continue to receive quarterly reports.	Confirm to Board that illegal detention due to delayed DoLS assessments by LA continued but the trust has improved processes around referral and

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	Performance re SOAD requests to be monitored. DoLS monitoring and other compliance checks flowing through.		patient still waiting after 102 days.		monitoring.
Revised Seclusion and Long Term Segregation Policy	Definition of seclusion and long term segregation has been clarified and reporting improved with pathway mapped onto PARIS.	Significant assurance. Case studies by Heads of Nursing and Lead Pharmacist are required to investigate practice further – RM	Some of our inpatient unit do not have seclusion rooms but nonetheless practice seclusion – very important to scrutinise the practice in these settings.	To continue to receive quarterly reports with exception reporting to Quality Committee.	None
Section 12 Doctors Pilot	Pilot was completed in county and reported to last MHAC. Pilot in City failed due to communication problem.	Retrospective data for City AMHPs activity to be collected by Phil Taylor to send to Gulshan Jan for inclusion in updated report.	AMHPs report difficulty in engaging the 2 doctors necessaryfor MHA assessments. Pilot aims to determine whether having 1 dedicated doctor working with AMHPs would rectify this.	Gulshan Jan to update paper for next MHAC with recommendations to progress issue.	None
CQC's guidance to implementing the Mental Capacity Act	Review of CQC guidance in relation to Best Interest Decisions (excluding DoLS).	MCA manual is in advanced stage of preparation by Ed Komocki and culture of "capacity awareness" is being created. Will for appendix to MCA Policy.	Spot check audits still required to complete CQC Portal actions – see next item	MCA Manual to be received at next MHAC	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
		Clinical skills tutor has been appointed. Manual will form basis for future quality improvement audit.			
Mental Health Act CQC Action Update	MCA/MHA actions from summer CQC inspection presented.	It was noted that original timeframes have slipped on some actions although still rated green as agreed new timescales.	Risk of further slippage.	Report progress to next Quality Committee. BAF risk due for review at next Audit Committee.	None
Mental Health Act/Mental Capacity Act Training	Transition from "once only" training to 3 yearly training has commenced.	Support workers and IAPT should be included in training.	Capacity issues and "stretched resources" within training department noted.	Tracy Shaw and Faith Sango to attend next MHAC to present paper.	None
Police and Crime Act 2017: Monitoring the Mental Health Act in 2015/2016 and state of Care CQC Report	The Bill is anticipated to come into effect in April 2017. S 136 power to detain will be reduced to 24 hours (from 72) and police will have a duty to consult before applying a S136.	136 group to consider what actions are required to meet the changes.	The move away from detaining the mentally ill in police cells is reinforced. Risks centre around 136 staffing and bed availability problems – particularly PICUs.	136 group to address operational issues as a matter of urgency.	None
136 Group Report	A paper was tabled by Tracey Holtom.	The action plan was agreed which includes the operational implementation of the Police and Crime Bill.	As above.	Progress on action plan to be reported to next MHAC.	None

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Derby City AMHP Update including quarterly DOLS report Derbyshire County Council AMHP Update	The joint LA(s) report was noted.	The delay in DoLS assessments was noted.	Illegal detentions due to delay in LA DoLS assessments.	To escalate issue of illegal detentions to Board.	Delay in LA DoLS assessments.
Update from Hospital Managers	A verbal update was received.	Terms of Reference of MHAC to be updated.	None	ToR to be updated.	None
Mental Health Act Committee Year End Effectiveness Report - Terms of Reference Review	Attendance was reviewed, the chair and Medical Director achieving 100%. All Terms of Reference were met.	Mental Health Tribunal and Managers' Hearing to be included in ToR. Attendees to be divided into "essential or required".	None	To update ToR.	None
Any other business	None	None	None	None	None
2017/18 Forward Plan	Noted and agreed	None	None	None	None
Issues escalated to Board, Audit Committee or other Board Committees	Delay in LA DoLS assessments have resulted in illegal detention.				
Meeting effectiveness	Generally good although Exec Lead needs to scrutinise action matrix to ensure "alignment" of action to position as this can change over time.				

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

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Welcome/Apologies Draft Minutes Audit & Risk Committee meeting held 17 Jan 2017 Action Matrix and Matters Arising:	Updates noted and completion dates to be amended to reflect narrative.	'Completed by' column on actions matrix to be updated to align with updates provided – Sue Turner to action by April meeting	NONE	NONE	NONE
Risk 1c Clinical Workforce	Kim Broadbent and Marian on behalf of Amanda Rawlings gave an update on controls, gaps in control, assurance and gaps in assurance. J Tabreham raised the issue of addressing this issue as a wider health care system.	Limited assurance was outlined and it was agreed that this risk should remain scored 4x4 for the 2016/17 close of year position. Progress was noted and the range of actions underway acknowledged. It was noted that the Trust's Workforce Plan (to be presented the People and Culture Committee (PCC) on 15 March) will outline system-wide workforce planning. It was noted that this risk is covered in 2017/18 BAF risks.	Risks as outlined – noting particularly the risks highlighted as gaps in control. Actions were outlined to address these gaps/risks. JT raised the ongoing risk of pressure on current staff.	It was agreed that this risk should remain as 4x4 (16) due to ongoing gaps in control and other assurances in their infancy. It was agreed that timeframes would be added to the workforce plans. There will be ongoing monitoring via PCC Committee and a deep dive undertaken as part of 17/18 BAF programme.	NONE

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Risk 1d Compliance with Mental Health Act/Mental Capacity Act	John Sykes presented an update on actions taken to mitigate this risk including controls, gaps in control, assurance and gaps in assurance.	Limited assurance was received. Assurances and gaps in assurance were outlined. Work of the Mental Health Act (MHA) Committee regarding assurance/oversight of compliance was noted. Additional training programmes and awareness-raising were noted. The work on culture of ensuring compliance was welcomed. Actions and progress were acknowledged. ELT to provide assurance on alternative plan should Deputy Medical Director appointment not be made – Ifti Majid by next April Committee meeting.	Risks as outlined as gaps in controls were noted and actions to close these were outlined. It was noted that the MHA Committee have escalated the issue re local authorities and DoLs to the Board as part of March Committee escalation.	It was noted that the risk was outlined as 3x4 (12) in the presentation but that subsequent ELT conversation had agreed that this risk should remain as 4x4. The Committee agreed the 4x4 rating and the BAF will be duly updated.	NONE
Risk 2a System Change	Lynn Wilmot-Shepherd outlined controls including Trust involvement in consultations, ongoing	No assurance was received on system wide work and limited assurance agreed on the current position on	Gaps in controls and assurance were outlined to include lack of system-wide clarity and impact of the STP	Agreed to keep as 4x4 risk score. Going forward the risk on system wide change is proposed as extreme for	Scenario planning referred for action to F&P

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	stakeholder relationships, STP involvement and work with DCHS on acquisition proposals and back-office functions.	merger work. Assurance on controls and positive assurances were outlined. Agreed that work would be undertaken re scenario planning and referred to Finance and Performance (F&P) meeting Action : Claire Wright to raise at next F&P meeting	'pause'. Mitigation was outlined. J Tabreham raised the issue of 'loss of opportunity' risk from lack of STP progress. Mitigation is also being addressed through models of care work as part of DCHS proposed acquisition. Ongoing risk of lack of clear STP governance.	2017/18 (see next agenda item).	
INTERNAL AUDIT					
Internal Audit Progress Report	Sophie Jenkins outlined the progress report. The BAF/risk review has been completed. The CQC action plan review is in draft. The Internal audit plan will be brought to the April Committee.	Significant assurance (with minor improvements) was received on the outcome of both the CQC and BAF/risk internal audit reviews. CW gave limited assurance about work underway to address off-payroll working (IR35). Sam Harrison gave limited assurance on conflicts of interest policy implementation	The impact of IR35 is yet to be realised.	SH is to report back to the Committee on implementation of new conflicts of interest requirements (May Committee) Management actions agreed arising from the internal audit reviews will be monitored by ELT/A&R Committee	NONE

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
		Action: SH to bring update to May Committee			
Audit & Risk Committee Effectiveness Survey	Sophie Jenkins outlined the results of the Committee effectiveness survey conducted during February/March 2017. Given the changes in Committee membership it was noted that this may be a good baseline for future development,	Significant assurance was received on the effectiveness of the Committee. Positive areas were noted and areas for further improvement, particularly relating to Training and Development of Committee members were noted. Action: Committee chair to review outcomes with members	NONE	It was agreed that learning and development for Committee members would be progressed out of the meeting.	NONE
COUNTER FRAUD					
Local Counter Fraud Specialist Strategic Plan	Laura Weaver outlined the Counter Fraud progress report including details of referrals made.	Significant assurance was given that referrals have not given evidence of fraud. KMPG noted that the comparative number of referrals was good. This was noted to be supported by mandatory training for counter fraud. Request for assurance on secondary	NONE	Laura Weaver is to liaise with Amanda Rawlings and HR team to ensure staff awareness of the referrals process. Ongoing raising of awareness for counter fraud across the Trust was agreed to be important.	NONE

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
		employment to People and Culture Committee Action : Barry Mellor			
Counter Fraud and Bribery policy	Rachel Kempster outlined the revised draft of the policy which incorporated comments from KMPG who had reviewed the policy.	The policy update was agreed. Policy summary to be produced to support staff implementation Action : R Kempster	NONE	It was agreed to triangulate this policy with the conflicts of interest policy update republish in May.	NONE
Review of Draft Annual Report (including Quality Report) Audited Annual Report (including Quality)	Anna Shaw presented the early draft of the Annual Report outlining the structure and sign off process. Darryl Thompson outlined detail of the draft Quality Account.	Significant assurance was received on progress with the annual report. Confirmed content and overall report is to be signed off by Executive Directors. Grant Thornton welcomed the progress made on these documents as early sight is helpful. Amendments/ suggestions to be incorporated into next draft. Balance to reflect range of services (eg children's physical health) in future draft. Action: Anna Shaw by	Risk that validated content is not submitted to required deadline. S Harrison to raise at ELT the importance of Executive Director oversight of relevant content.	To come back to Committee in April and May for sign off as per agreed timetable. Agreed that annual review would not be produced this year due to national requirements that content is further extended. Amendments to report suggested by Committee members were noted.	NONE

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
		April A&R meeting.			
Draft Annual Governance Statement	R Kempster outlined the draft Annual Governance Statement. Noting prescribed requirement for content. It was confirmed that Caroline Maley was to review the full draft annual report and accounts prior to the April A&R meeting.	Significant assurance was received on progress.	NONE	Final draft to be considered at April A&R Committee.	NONE
Board Assurance Framework (BAF): Final issue for 2016/17 and first issue for 2017/18	Sam Harrison outlined the BAF 2016/17 final position noting changes in year and BAF management arrangements that had been undertaken. 2017/18 proposed risks were outlined following discussion at the 8 Feb Board Development Session. R Kempster outlined the risk appetite proposals relating to the risk matrix.	Significant assurance was received that an effective BAF had been in place and managed for 2016/17 and that the BAF had been robustly prepared for 2017/18. Risk scores to be added to future reporting (as well as status descriptor) – Action: R Kempster for April Board report Wording on proposed risk relating to 'Variability of leadership' (3b) to be reviewed to ensure the risk is articulated clearly. Action: R Kempster to confirm with A Rawlings prior to April Board.	BAF risks to be mitigated as outlined. J Tabreham outlined the ongoing pressure on Executive Directors, noting the work falling to the Medical Director as lead and reiterated the importance of ensuring a Deputy is in place.	Approved 16/17 BAF closedown position as outlined. Approved 17/18 BAF (subject to revision of narrative on 3b). Agreement to risk matrix. Agreed that both documents will be presented to the April public Trust Board.	NONE

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Governance Improvement Action Plan (GIAP) Update Report	Sam Harrison presented the GIAP update report, noting work to date by the Committee, and presented 7 blue forms for scrutiny and consideration. The proposed deferral of CorpG7 was outlined to relate to wider work underway within the Trust relating to the Accountability Framework.	Significant assurance was received relating to the blue forms as presented with evidence supporting the detail of actions undertaken. Ongoing monitoring and embedding of work was also outlined. The proposal to defer consideration of CorpG7 was agreed. Action: Sam Harrison to arrange that this blue form is presented to the confidential Trust Board meeting on 29 March 2017. Committee members agreed that the issue of duplication across Committees should be an ongoing area for discussion at Board Committee chairs meetings (held quarterly) Action : All NED members to raise at next Committee Chairs/NED meeting.	Risks associated with embedding agreed actions were noted. These will be monitored on an ongoing basis and through embedding actions in existing processes/business as usual.	The 7 blue completion forms as presented were discussed and agreed. These will be reported into the next Trust Board meeting. The deferred recommendation CorpG7 will be presented directly to this meeting.	NONE

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
EXTERNAL AUDIT					
Update on external audit progress	Joan Barnett outlined the update report. The NHSI quarterly monitoring report was presented for information along with other sector updates.	The interim accounts audit identified no significant matters to report. Significant assurance was given that the implications for the Trust arising from the Policing and Crime Act were being addressed by the Mental Health Act and Quality Committees. Joan Barnett to circulate guidance documents to SH to share with the Board for information.	NONE	The update was noted.	NONE
Key Financial Indicators 2016	Mark Stocks presented the summary showing the Trust's performance in each of 14 indicators	The Trust is an outlier for liquidity although improvement has been seen in year. The Trust is a positive outlier in terms of agency costs as a % of total staff costs. Limited assurance was received on these performance indicators.	NONE	The paper was noted.	NONE

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
External Audit & Risk Assessment	Mark Stocks presented the detail of the audit risk assessment as populated by Trust management.	Committee members confirmed that the report reflected their understanding of the Trust's position.	NONE	The report was approved.	NONE
Results of Interim Accounts Audit Work 2016/17	Mark Stocks presented the findings of interim audit work and the impact of the findings on the audit approach. The value for money review is underway and Sam Harrison is meet with Grant Thornton to provide update on GIAP progress	Significant assurance was presented that no material weaknesses were identified and no concerns were raised.	NONE	The report was noted.	NONE
Implementation of Internal and External Audit Recommendations – Progress update	R Kempster outlined the progress against audit recommendations highlighting those outstanding.	Limited assurance was received on progress as the percentage over deadline has increased. ELT to review outstanding issues on monthly basis. Action: R Kempster/S Harrison to schedule	Non completion of actions leading to organisational risk.	Report update noted and agreed to ongoing reporting on a bimonthly basis.	NONE
CLOSING BUSINESS					
Identification of any issues arising from the meeting for inclusion	NONE	NONE	NONE	NONE	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
or updating in the Board Assurance Framework					
Meeting Effectiveness	Barry Mellor invited comment from all present on meeting effectiveness.	Members agreed that all papers should be taken as read. Papers could be improved in quality of analysis and focus. Deep Dives would benefit from greater focus. Clarity on concluding the level of assurance for each agenda item was welcomed.			

Board Committee Summary Report to Trust Board
Quality Committee - meeting held on 9 March 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
Minutes and Actions matrix **Policy log**	Agreed and ratified Overdue action re GIAP/ QLT will be addressed under the tabled paper	Significant assurance	See minutes for full actions		
CQC **Action Plan**	Significant improvement and pace assurance on progress and the pipeline Of the 164 actions in the improvement notice, 97 are completed, 81 are in progress/on target. There are concerns with 12. 14 actions are late but there is significant assurance of their completion. Each lead with an action rated as a 'concern' has been offered 1:1 support and the Committee was assured that action is underway. Safer Staffing, action with relation to the 136 not having dedicated staff, is without assurance due to lack of investment from	Significant assurance No assurance in actions outside of the Trust control in commissioning intentions.	Risks to delivery – CQC actions not in the control of DHCFT relating to commissioning investment Despite confirmation at the Quality summit of formal support in these areas and formal letters of intent of investment in CQC required actions. Commissioning intentions- 136/ Community staffing and psychological therapy/ SALT in Learning disability are completely absent from contracting settlement at this time	Significant risks to delivery due lack of investment Significant risks to delivery due to failure of commissioners to invest in CQC regulatory issues Action operations team, to develop actions that mitigate this risk, in the operational delivery arm	Mental health act committee to lead the specific assessment and testing of evidence in improvement in the Mental capacity act

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	Commissioners. Community access to psychological therapy is limited/no confidence of resolution with Commissioners and this was escalated to the Trust Board in February. The remaining ten with concerns are related to process and pace relating to the Mental Health Act (MHA) and Mental Capacity Act required improvements.	Limited assurance on sustained performance in named key areas			
Quality Dashboard	Significant improvement Detailed discussion on the information included and actions already in place, demonstrating progress. Further analysis on the use of prone restraint and a longitudinal view	Significant assurance overall with positive upward trajectory	Establishing if prone restraint is increasing in line with concerns re increasing violence	Further analysis of the data in line with the positive and safe strategy	
Patient Experience Report	Nicola Fletcher presented the Patient Experience Report to provide the Committee with assurance regarding themes and changes made to Trust services as a result of feedback on incidents and complaints	Noted Significant assurance based on previous scrutiny by the Patient Experience Committee.	Triangulation/ escalation of concerns and evidence of service improvements to address these issues	Provided feedback on future content and style of the report, requesting that future reports include a higher level summary on lessons learned and achievements.	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	The report also contains analysis and improvement work in all aspects of quality				
Service recipient and Carer feedback	Funding and engagement is 'in turbulence'. The carer support network has been advertised and tendered too Derbyshire Carers' Association. Service User In addition representatives funding and contract will go to Healthwatch on 1 April. For both groups nothing is yet confirmed. The risk to the Trust is that carer and patient organisations are in turbulence and could cease in the next six weeks; and significant level of the Trust's committees and groups have involvement from these groups. The Quality Committee 1. Noted the update from the representatives. 2. Thanked both Sandra Austin and Lynn Gibson for their contribution to their respective organisations and to the	Family and care experience PPI in the trust structures are undergoing substantial change	Confirmation of individual investigation The Committee discussed the potential impact of the acquisition by DCHS on the carer support network In the absence of transitional arrangements all organisational memory could be lost. This creates a risk to the Trust. John Sykes has been advised that some representatives are experiencing deterioration in their mental health and there are concerns raised about the impact.	Escalation to DHCFT Patient experience to confirm follow up on complaint Pharmacy follow up on medicines incident Exploration with carers groups – travel assistance / and how accessible this is The risk of lack of user/carer involvement to be added to the Board Assurance Framework as a risk to involvement. The potential gap of user/carer involvement to be escalated to the Trust Board. Executive leadership to mitigate this action by Carolyn Green John Sykes will alert Commissioners to the potential to learn lessons from this procurement	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	Trust. 3. A celebration event will be scheduled with the Mental Health alliance members following clarification of future services.			process.	
In-patient and Community survey	Bev Green presented the report to provide the Quality Committee with an update on the findings and recommendations in the Inpatient and Community Service 2016 Survey.	Limited assurance	Patient experience Community survey positive In-pt. survey identifying pts. Not feeling safe on the wards in June 2016. Committee reviewed benchmarks and although the safety question may be misunderstood, the findings are still founded and need full actions to improve our performance	Continue patient experience improvement work Mental Health alliance visiting campus areas to explore quality and patient experience. Giving immediate feedback and resolutions Do you feel safe included in ward visits, with action based upon findings?	
Serious incident monthly report	Detailed review of incidents and themes No immediate cluster or concerns Discussion of increasing community activity and suicide rates.	Significant assurance	Close monitoring of serious incidents and death rate	Scrutiny and assurance undertaken	
Prisoner Transition to	Verbal report on progress and written report	Limited assurance, until formal plan emerges. But	Responsiveness and waiting times.	board note with progress update and	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
adult services	presented by John Sykes	positive feedback on work to date and progress	Effective transition from prison to services Significant concerns with neighbourhood services under pressure Known and established commissioning gap, lack of community forensic provision	Nottinghamshire Healthcare joint statement to be included in the Quality position statement	
Health and Safety **6 months report**	Carolyn Green presented the report, on behalf of Carrina Gaunt, to provide the Quality Committee with a half-yearly Health & Safety Report to outline the activities and achievements in fire, health and safety, moving and handling and security management. Fire warden training is above 90% for in-patient areas	Significant assurance was received by the report and another good six monthly report and part year with solid performance for a team that has had significant pressures due to ill health of the team members	Further analysis on DSE outstanding actions which are low risk at the Health and safety operational group level.	Agreed and assurance received.	
Transition from Children to Adult services	This is a CQUIN for 2017/18 In addition Quality Committee had previously been made aware of escalated concerns that a gap analysis of adherence to revised policy standards,	Limited assurance Confidence in emerging improvements will deliver	CQUIN Risks to delivery Neighbourhood capacity and competing priorities CQUIN mitigation plan in development	The intention is to have a draft policy and quantifiable gap analysis aligned to the service areas ready to report back in May	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	due to practice, capacity and policy compliance				
Deep Dive into BAF Risk 1E. **Compliance with the civil contingencies act**	The lack of an effective policy and procedure triggered the addition of this risk to the BAF in October 2016. Deep dive and improvement plan and controls explored.	Significant assurance now achieved	Team capacity and maintenance of this achievement Medium risk confirmed	Agreed and assurance received.	
Physical Healthcare position statement against regulatory requirements	Hayley Darn provided the Quality Committee with an update on the standards for physical healthcare, current challenges and direction. Physical healthcare is a Trust quality priority and is likely to continue into 2017/18 as the current CQUINs are out to consultation nationally and a further repeat of the Royal College of Psychiatrists audit is being suggested as a key area.	Limited assurance	A significant challenge to physical healthcare is resource. There is limited training resource with a single trainer to cover inpatient and community services which impacts on the ability to deliver/maintain training Further investment in resources and training to reach required levels Hayley Darn confirmed that there are concerns with regard to Venous thromboembolism (VTE) is the formation of blood clots in the vein. VTE screening to ensure compliance and improvement in this area	Carolyn Green added that assurance is required from People & Culture Committee that there is a plan in place to address this.	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
			Carolyn Green suggested that the indicator from PARIS/ clinical information risk was of sufficient concern to be added to the Quality Dashboard for monitoring under the Physical health quality priorities.		
Governance Improvement Action plan	Reviewed the content of the update and received assurance.	Limited assurance. Improved performance of one QLT Some improvement of the Neighbourhood and campus QLT with a priorities plan and improvement work	Delivery of QLT effectiveness and improvement for one QLT. Significant risk to delivery Risks to delivery of the TMT, due to additional coverage to the Campus and Neighbourhood QLT on quality governance will be required	Further performance management and sustained development and support to the teams performance by directors to improve this situation	
Equalities public sector duties	Implementing the annual EDS2 16/17 grading event, progress around REGARDS Equality Impact Risk Analysis implementation and the Draft Corporate Equality Action Plan 16/17 due to be ratified at the People & Culture Committee on the 21 February 2017	Significant assurance now achieved	NED challenge encourages to provide additional scrutiny feedback to the April Quality Committee on the meaningful completion of the EDS section of committee papers and scrutinise the quality of cover sheets completed for the April meeting. Bringing challenge and improved effectiveness to	Noted the pace and whole system pragmatic focus on progressing equality agenda and compliance through implementing the EDS2	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
			the group		
Childrens and Central services	Richard Morrow confirmed the QLT has met as planned. The SMT and QLT for Children's have combined into one meeting structure effective 31 January.	Significant assurance	No issues to escalate from the QLT Priority work plan discussed Group advised of risk based wider governance actions may be required to be re-prioritised.	Formal report received.	
Information governance report	Q4 Information Governance (IG) report on progress towards meeting the requirements of the 2016/17 Version 14 IG toolkit, as well as the work of the IG Committee and IG breach monitoring	Full assurance	No significant risks	Compliance and performance stable continue with current systems.	
Trust policy supporting the privacy and dignity needs of transgender people	Noted the policy and its contents.	Was assured that the reviewed policy supports the delivery of privacy and dignity for people using Trust services.	No significant risks	Approved the revised policy.	
Any other business and effectiveness	Children and Family Court Advisory and Support Service (Cafcass) Meeting was on time	Carolyn Green reported she had been approached by Cafcass regarding delays in signing an information sharing agreement.	Delays in signing an information sharing agreement.	This will be expedited by information governance group and mitigated.	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other committee)
	Challenge and involvement of members Executive and non-executive challenge				
With thanks	Maura Teager was noted as chairing her last Quality committee Thanks were offered to Maura for her longstanding and extensive commitment to Quality				Thanks offered to Maura for her longstanding and extensive commitment to Quality. All members noted their thanks to Maura

Board Committee Summary Report to Trust Board
People & Culture Committee 15 March 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Welcome and Apologies **Minutes of People & Culture Committee held 21 February 2017** **Actions Matrix and Matters Arising**	• People Plan – plan on a page ready and shared at the TMT • NED training • DNA training – April • Volunteer support capacity – Move to cover in the workforce strategy	N/A	• Resources to increase the size of our volunteer support	• Closed action on People plan on a page	N/A
Staff Story	• Personal experience of going through the capability process	• Not presented for assurance but provided a positive insight to improving performance	N/A	N/A	N/A
Matters arising at the Governance Committee	• MSC programme with Derby University • Training budgets for medics in comparison with other trusts	• This is being built into the workforce plan for consideration plus how we can bring in more newly qualified staff into post • Built a framework to look at recruitment and retention incentives	N/A	N/A	N/A

Strategic Workforce Report	• Overview of GIAP actions • Update on Workforce and OD team restructure • People management development update • Agency changes • IR35	• Committee reviewed all the points presented	N/A	N/A	N/A
GIAP Trajectory/Closure and Review the blue forms for recommendations RC1, WOD2, PC2	• HR 3 & 4 • WOD 6 all to April • PC2 approved • WOD2 approved • RC1 approved	• Positive assurance taken on WOD6, PC2 and RC1 progress to close actions and recommend to the board for approval	N/A	N/A	• PC2, WOD2 and RC1 approved at the committee for the board to now approve
Draft Workforce Plan	• The plan was discussed with committee members having the chance to shape the next version for April	• Committee reviewed the draft plan and contributed the shape of the new version	N/A	N/A	N/A
Culture Development and Staff Engagement	• Paper brings together our work plan on staff engagement and culture	• Assurance taken to support the closure of PC2 and on the actions for 2017 linked to the People Plan	N/A	N/A	N/A
Workforce Supply Update	• Update on recruitment open day on 11 March in the	• Positive assurance was taken the trust attracted 260	N/A	N/A	• Board to receive a costed workforce plan in the next 8

	South of the county	applicants to the open day			weeks
People Performance Report	• Slight improvement in the month. TRAC launch imminent	N/A	N/A	N/A	N/A
Analysis of Medical Job Plans	• Policy ratified, two adjustments on timing and implementation plan	• Positive assurance taken	N/A	N/A	N/A
Staff Recognition and Reward Report	• The current schemes were acknowledged. Need to focus on the local manager to employee at the time thank you	• Current schemes were acknowledged	N/A	N/A	N/A
Any Other Business	N/A	N/A	N/A	N/A	N/A
Forward Plan	Plan was reviewed. AR and ST to update	N/A	N/A	N/A	N/A
Items escalated to the Board or other Committees **Identified Risks** **Meeting effectiveness**	N/A	N/A	N/A	N/A	N/A

Board Committee Summary Report to Trust Board
People & Culture Committee 20 April 2017

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
Minutes of People & Culture Committee held 15 March 2017 Actions Matrix and Matters Arising	• Recruitment review was closed as now part of the workforce plan • Mindful Health and Wellbeing Strategy delayed • Safe guarding training update for May committee • GIAP R5 update to go to board	• N/A	• N/A	• To close the recruitment review action	GIAP R5
Staff Story	• Outcome of conduct issue with a MH Nurse	• Assurance received regarding the approach we took to support a member of staff through a conduct issue	N/A	N/A	N/A
Strategic Workforce Report	• Update on Pay Review Body 1/4/17 1% • E Midlands Stream Lining impact on the trust • Talent Management	• Leadership development uptake to be discussed at board – limited assurance with 22.7% who have not attended the training • Gen4change was	• Building leadership capability across the Trust • To look to embed the learning from the Gen4 change project		• Leadership development uptake

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	progress • Gen4change – Derbyshire wide project • Leadership development training	well received will be shared wider across the Trust			• Gen4change report
GIAP Trajectory/Closure and Review the blue forms for recommendations RC1, WOD2, PC2	• HR 3 & 4 approved • WOD 6 to be checked • WOD 5 approved	• Agreement to present to board HR3, HR4, WOD5 with WOD6 to be checked for purpose	• N/A	• N/A	• HR3, HR4, WOD5 approved to pass to board and WOD 6 to be checked for clarity of its meaning
Equalities Update	• Update on the people plan actions • BME conference • Grading from EDS2 event	• Positive assurance received on progress on all actions	• N/A	• N/A	• N/A
Draft Workforce Plan	• An ideal plan has been developed, further work with ELT and senior clinical staff to refine into priorities and year on year delivery plan	• Board development session in April 2017 supported the progress report	• N/A	• N/A	• N/A
People Performance Report	• Focus on the teams with ongoing attendance issues to see what can be done to improve this	• Progress being made across most of the people metrics	• N/A	• N/A	• N/A

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	position • Detailed vacancy figures from May from TRAC				
People and Culture Year End Effectiveness Report	• Report received couple of minor additions before progressing to Audit for approval	• Report approved to progress to the Audit Committee	• N/A	• N/A	• N/A
Recruitment Progress Update	• Deep dive into medical vacancies • Are we doing effective on boarding and how do we ensure leaders follow up • Discussion ways to reach candidates	• Limited assurance, progress noted but scale of challenge remains	• N/A	• N/A	• N/A
Any Other Business	• N/A	• N/A	• N/A	• N/A	• N/A
Forward Plan	• Agreed	• N/A	• N/A	• N/A	• N/A
Items escalated to the Board or other Committees **Identified Risks** **Meeting effectiveness**	• Leadership Development participation rate	• N/A	• N/A	• N/A	• N/A

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 26 April 2017

Measuring the Trust Strategy – Year One (2016/17)

Purpose of Report:

To update the Trust Board on the Strategy Dashboard

Executive Summary

The Trust Strategy 2016-21 was approved by the Board in May 2016. In November 2016 draft measures were presented to the Trust Board where it was agreed that the integrated performance report would be used for on-going monitoring of the strategy. It was also agreed that the Executive Leadership Team should discuss the most appropriate way of showing real progress towards achieving the strategy.

In December 2016 a verbal update on progress was presented. The Board were in agreement that we should use one or two key measures for each strategic aim, with a report being produced annually.

Owing to the timing of key information it is suggested that the report should be presented at the April Board each year.

This report gives an update on year 1 of the Trust Strategy 2016-21.

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

(Board) Assurances

The Board Assurance Framework for 2017/18 has been updated to reflect the strategy implementation process and the links to the STP. Risks have been aligned to all four strategic objectives.

Consultation

The dashboard has been discussed by the Trust Board, the Executive Leadership Team and their respective teams.

Governance or Legal Issues

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

Equality Delivery System

This report has a neutral impact on REGARDS groups.

Recommendations

The Board of Directors is requested to:

1) Note the achievements to-date
2) Accept an annual update at the April Board each year

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

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

Measuring the Trust Strategy – Revised Dashboard

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

Measure

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

- 2016/17 – achieved top 50%
- By 2020/21 we will have received at least 'good' in the CQC ratings.
  - 2016/17 – CQC overall rating was 'Requires Improvement'
- A 20% year on year increase in the volume of 'Friends and Family' test feedback reporting 'extremely likely/likely' to recommend our services

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

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

Measure

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

- 29 Trusts – in 2016/17 the top score was 3.95 (5 being the maximum)
- The lowest score was 3.64

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

Partnerships – develop partnerships which enhance service delivery and foster a system wide approach in line with the Sustainability and Transformation Plan.

Measure

Qualitative feedback will be given on an annual basis

- Report to F&P on 22 May

Transformation – our plans will be both internally and externally focused, aimed at ensuring a sustainable long-term future for the organisation and the health and care economy in which we work.

Measure

Control Total	Baseline	2016/17	2017/18	2018/19	2019/20	2020/21
Target	£2.530m	£2.530m	£2.764m	£3.022m	£3.022m	£3.022m
Achieved		**Achieved**				

Achievement of the organisational control total

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 26 April 2017

Acute Inpatient Areas Deep Dive

Purpose of Report

To provide the board with an overview of the Key achievements and challenges within the Acute inpatient areas following the CQC inspection in June 2016 and commissioning changes relating to Acute out of Area placements.

Executive Summary

- To consider the key achievements
- To consider the key challenges
- To consider the plans for future improvement against key challenges.
- To consider the changes in commissioning

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

(Board) Assurances

- The deep dive should be considered in relation to the key risks identified in the BAF
- The report provides assurance across several BAF risks relating to workforce, operational performance, clinical quality and financial performance

Consultation

- ASMs
- Inpatient Teams
- CQC Inspection report dated September 2016 for Acute Inpatients

Governance or Legal Issues

- CQC Regulations

Equality Delivery System

- No Impact

Recommendations

The Board of Directors is requested to consider the content of the presentation by the Acute Inpatient team.

Report presented by: Tracey Holtom General Manager
Michelle Hague Area Service Manager
Hannah Burton Area Service Manager

Report prepared by: Tracey Holtom General Manager
Michelle Hague Area Service Manager
Hannah Burton Area Service Manager

Derbyshire Healthcare
NHS Foundation Trust

Acute Inpatient Services Review

Report to Trust Board - 26th April 2017

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Acute Inpatients Services

- 2 Units
- Hartington based at Chesterfield 56 beds male and female
- Radbourne Unit 80 beds male and female
- Plus 10 Enhanced Care Beds that are based at Radbourne that are pan Derbyshire.
- Admit 18 years plus for care and treatment of acute mental illness

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Key achievements

- Re-instigation of Schwartz rounds to support supervision.
- Appointment of flow coordinators and PICU complex case managers to support both units and Bleep holders. Over recruitment of HCA's
- Trip Denmark re: at safe wards.
- Refurbishment of de-escalation rooms on Hartington unit.
- Implementation of Broset Violence Checklist pilot on the Enhanced care ward.

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Challenges

- CQC visit 2016 highlighted key themes
- Staffing and high use of bank and agency.
- Supervision and Appraisal compliance.
- Seclusion pathway and Rapid Tranquilisation.
- Mental Capacity Act – staff understanding and reliance on medical staff.
- Management of Out of Area placements

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Plans for future improvement

- On going recruitment of nursing and medical staff. Process being put in place to recruit from abroad, commenced for Medics in process for nursing. Attendance at recruitment fairs within the EU. On going monitoring of staffing risk assessments. New ways of working and planning for new roles. eg Medicine Optimisation Technicians, Advanced Clinical Practioners. Over recruitment of HCA's to support teams carrying vacancy, flow coordinators that support bleep holder function. Campus will participate in the newly launched Recruitment and Retention group which focuses on mid to longer term actions
- Supervision and appraisal – action plans in place. Appraisal on improvement trajectory. Supervision has improved but remains a challenge, drop in sessions have been arranged at Radbourne and Hartington Unit, Schwarz rounds have been reintroduced at Hartington.
- Seclusion and Rapid Traqu. – Policy revision in line with chapter 26 MHA code of practice, ongoing audit of both seclusion pathway and rapid traqu. To monitor and action adherence to policies. Seclusion now recorded on PARIS. Attendance at PDG by pharmacy. Use of MOT's. Implementation of safe wards. Broset checklist.
- Mental Capacity Act- training sessions arranged for staff to attend in house, staff have reviewed pod cast , on going in PDG . Records audit. RM heading care plan group.
- Management of out of area placements. Implementation of BOB.

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Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 26 April 2017

Plan on a Page Business Plan 2017-18

Purpose of Report:

This paper provides the Trust Board with a consolidated summary of each division and corporate directorate's business plan for year two of the five year Trust strategy.

Executive Summary

- There are a number of published plans and documents that contain implications for clinical and corporate areas across the Trust. This paper seeks to consolidate the objectives and milestones from within each of these documents into a single business plan:

STP Business Cases	Divisional Business Plans
Trust Strategy	Trust Operational Plan (submitted to NHSI on 23 December 2016)
National Mandates	Five year Forward View for Mental Health

- The onus has been placed on each corporate directorate and division to produce their own 'Plan on a Page' with support from the Strategy team, that answers a number of questions:
    - What are the priorities for the year?
    - What actions are to be taken to achieve these objectives?
    - When are these actions/priorities expected to be completed?
    - What will success look like?
    - Links with the wider system

- This paper contains a summary for each of the divisions and directorates below:

Central Services	Childrens and CAMHS	Neighbourhoods	Campus
Strategy	Pharmacy	Finance	HR and Workforce
Estates and Facilities	Information Management, Technology and Patient Records		

- Please note the following:
    - Priorities that are considered to be objectives for us all have been included in 'Trust-wide' pages
    - The content and format of the divisional and directorate plans have now all been agreed by their respective leads
    - Following discussions at TMT, Quality priorities have been integrated into divisional plans
    - A Glossary of terms has been included at the end

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

(Board) Assurances

- The plans have been produced and agreed by each area respectively with support from the strategy team, containing clear actions and milestones set for 17/18.
- The plans were developed by triangulating the key information from the STP business cases, divisional business plans, the Trust Strategy, the Operational Plan, the Five Year Forward View for Mental Health and national mandates.
- Although the plan relates to all of the risks within the Board Assurance Framework to varying degrees, the three key identified risks are as follows:

Ref	Principal risk	Director Lead	Current rating
Strategic Outcome 2: We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time			
2a	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME
Strategic Outcome 4. We will transform services to achieve long-term financial sustainability			
4a	Failure to deliver financial plans	Executive Director of Finance	EXTREME
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	EXTREME

Consultation

This paper has been presented to the Trust Management Team on 13 March and 10 April, and the Executive Leadership Team on 3 April, prior to being presented at the Trust Board.

Governance or Legal Issues

There are no legal/governance issues to note.

Equality Delivery System

This report has a neutral impact on REGARDS groups. However, the objectives identified in the plan will need to include appropriate equality impact assessments as required.

Recommendations

The Board of Directors is requested to:

1) Approve the business plan for 2017-18
2) Accept quarterly updates on progress

Report presented by:	**Lynn Wilmott-Shepherd** **Interim Director of Strategic Development**
Report prepared by:	**Tom Foster** **Strategic Business and Partnership Manager**

Derbyshire Healthcare
NHS Foundation Trust

Business Plan 2017/18

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FOREWORD

Research tells us that there is a significant link between staff having a clear understanding of the direction of travel for their service areas, improving staff morale and ultimately ensuring people who use our services get better outcomes. I also recognise that involving our staff in developing those objectives ensures they are meaningful, achievable and truly add value – that is why I am so excited about the approach we have taken as we move into year 2 of our Trust Strategy 2016-21.

You will see that we have identified a Lead Director for each area however if we are going to successfully build on our improvements during 2016/17 in both quality delivery and corporate/clinical governance local ownership is key, we all have a vital part to play. I am delighted that you can for this year see your service objectives in the context of what is expected of others, something we haven't had as clearly before.

It is a fast moving game working in the NHS at the moment and so whilst our plans contained in this document deliver our requirements today, we may need to alter them as we move through the year as new policy emerges or we need to shift our internal focus perhaps following regulator or commissioner directives.

I really hope we can use this plan to ‘connect the organisation’. The Trust Management Team will oversee day to day delivery receiving reports on progress from service areas with a quarterly highlight report going to Trust Board.

Delivering our strategy means constantly looking forward and we will be starting to think about next year in September and as with this year, your involvement in that is vital. I am convinced that developing this approach will put us in a strong place to ensure we do the thing that binds us all together – *ensuring that people who use our services get the best possible outcomes*.

Ifti Majid

Acting Chief Executive

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INTRODUCTION

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

Central Services	**Children's and CAMHS**	**Neighbourhoods**	**Campus**
Strategy	**Pharmacy**	**Finance**	**Human Resources and Workforce**
Estates and Facilities	**Information Management, Technology (IMT) and Patient Records**		

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Plan on a Page – Objectives for Us All (Trust wide)

Enc J

Our Priorities for 2017/18	How we will deliver our priorities	Lead Director
• Increase productivity/quality target	• Meet Cost Improvement Programme (CIP) target of £3.85m	• Chief Operating Officer
• Succession planning – management and leadership	• Develop succession plan and workforce plan linking with other areas	• Director of People and Organisational Effectiveness
• Delivery of clinical efficacy / evidence based care across all clinical areas	• Develop and rollout implementation strategies following the 'five steps to evidence based care' model	• Director of Nursing and Patient Experience
• Staff health and wellbeing improvements	• Each Senior leadership Team (SLT), integrated Quality Leadership Team (QLT) and senior operations team will review its staff survey for this area, write an improvement plan with wellbeing leads, and achieve the relevant Commissioning for Quality and Innovation National goal (CQUIN) • Banning of price promotions on sugary drinks and foods high in fat, sugar or salt • Improving the uptake of flu vaccinations for frontline clinical staff driven by SLT and Infection Control Team	• Director of People and Organisational Effectiveness
• Rollout Sign up to Safety initiatives and NICE Guidelines	• Implement the 5 pledges made as part of the Sign up to Safety Campaign <https://www.england.nhs.uk/signuptosafety/> • Demonstrate appropriate implementation plans for all NICE guidance, and demonstrate that risk assessments have been undertaken on any areas of non-compliance	• Director of Nursing and Patient Experience
• Improved uptake of autism awareness training for all staff	• Provision of autism awareness training package available to all staff with quarterly updates on progress • Provision of role specific training packages to be made available to relevant staff groups	• Director of People and Organisational Effectiveness
• Safe Services: Implementing the final year of our Positive and Safe Strategy to minimise and reduce restrictive practices	• Rollout the strategy including gathering routinized feedback from each care pathway service, agreed by their Positive and Safe lead, producing a quarterly report on progress	• Director of Nursing and Patient Experience
• Work with teams to agree key areas of change identified within the staff survey	• Positive engagement with teams to identify 3 or 4 areas which are of concern to staff and where a real difference can be made	• Director of People and Organisational Effectiveness
• Progress the Equalities Agenda within Derbyshire Healthcare NHS Foundation Trust (DHcFT)	• Allocate corporate resources	• Director of People and Organisational Effectiveness
• EDS2 (Equality Delivery System) Assessments	• No Red ratings by 31st March 2018, 70% Green by 2019, and 100% Green by 2020	• Director of People and Organisational Effectiveness

Our Priorities for 2017/18	How we will deliver our priorities	Lead Director
• To become a person-centred and recovery focused organisation demonstrated in practice, including improvements in personalised care planning	• Improving education, including the provision of recovery specific education, establishing peer education work in medical education provision • Embedding patient reported outcome measures and PAMs • Recovery focused approaches will be factored into quality visits and in the clinical performance management of teams • Regular update reports regarding care planning will be presented at Quality Committee, and at completion of the rollout of full electronic records, care planning will be measured in our integrated performance dashboards	• Director of Nursing and Patient Experience
• To minimise clinical variation in the assessment and recording of capacity and consent, and demonstrating quality improvement	• Full patient record roll-out and the patient record measure will be included in the integrated performance dashboards • Regular reports will be presented to the Quality Committee	• Director of Nursing and Patient Experience
• Provide safe assurance with regards to caseload thresholds	• Clinical skill mix reviews and improvement action plans • Community dashboards to monitor capacity, flow progression and transition pressures • Quality impact assessment of increasing access criteria and thresholds with recommendations • Additional monitoring and support to community working age adult mental health, psychological therapies and children's teams with quality improvement support	• Director of Nursing and Patient Experience
• DHcFT/DCHS merger by acquisition	• Complete the outline business case (OBC) • Complete the full business case (FBC) • Complete the sign-off process and agree the final outcome at both Boards and Council of Governors	• Acting Chief Executive Officer
• Leadership	• A training needs analysis and training plan for management and leadership competencies • Delivery of training needs analysis against defined training plan and offer -- performance • Modelling and support of a collective and accountable leadership model – accountability framework	• Director of People and Organisational Effectiveness

Unforeseen Risks	How will we manage unforeseen risks?
• It is recognised that in year risks may impact on the objectives set-out in this plan	• Risks may be at operational level – these will be managed through operational teams and where they are likely to have an impact on the delivery of the plan be escalated to Trust Management Team (TMT) in order that any necessary changes are agreed and signed-off • System level influences are identified within the plan. Where changes impact on the plan this will be escalated to TMT, Executive Leadership Team (ELT) or Board, as appropriate to agree the actions required • National level influences - Where changes impact on the plan this will be escalated to TMT, ELT or Board, as appropriate to agree the actions required

These actions will be completed throughout 17/18, and progress will be monitored through TMT

OPERATIONAL DIVISIONS

Better together

Plan on a Page – Central Services

Enc J

Our Priorities for 2017/18	How we will deliver our priorities	By When	Success will be
Improving Access to Psychological Therapies (IAPT) • To achieve service viability through innovating / evolving the model • To expand into Serious Mental illness (SMI) step 3+ services • To offer greater choice for types and modes of treatment	• Develop model of service to ensure sustainability • Complete Business Case to ensure new model will be viable • Develop Business Case to expand into SMI step 3+ services • Develop treatment options • Pilot options	• Q2	• A sustainable IAPT service
Specialist Psychological Therapies • Review model and skill mix • Develop leadership structure	• Develop service specification • Workforce planning and organisational change	• Q3	• Physiotherapy and dietetics integrated into MDT's
Physiotherapy & Dietetics • Develop an Allied Health Professional (AHP) hub and align the AHP agendas • Develop physiotherapy and dietetic service role in multi-disciplinary teams (MDT) • Develop / revise service specifications and (form and function)	• Benchmark work of other physiotherapy and dietetics teams for both systems and activity • Liaise with Neighbourhood teams and stakeholders to develop a service model which utilises physiotherapy and dietetic skills i.e. where pain or diet and nutrition may impact on physical and mental health • Work with other teams to explore the most appropriate ways of developing a MDT approach • Implement new models	• Q2	• Physiotherapy and dietetics integrated into MDT's
Substance Misuse • Implementation of integrated drug and alcohol treatment provision • Further development of New Psychoactive Substance (NPS) support and treatment	• Complete the implementation of an integrated drug and alcohol service (Derbyshire Recovery Partnership) with partner organisations • Implement organisational development to embed new ways of working • Produce an evaluation of the new service and new ways of working – lessons learnt, after 6 months	• Q1	• Substance misuse new contract and development of model
Learning Disabilities (LD) • To meet the objectives of Transforming Care Partnerships (TCP) and development of service specifications • Alignment with neighbourhood model • Further develop Commissioning Differently	• Complete clinical pathways work • Review skill mix (form and function) including medics • Develop specialist and operational model in line with Transforming Care • Evaluate the Commissioning Differently programme • Develop a joint plan to align (integration where appropriate) with neighbourhood and campus model	• Q3	• TCP delivered and fit for purpose LD service with closer DCHS links

Our Priorities for 2017/18	How we will deliver our priorities	By When	Success will be
Perinatal • Achieve accreditation standards • Develop work on service philosophy • Develop voluntary sector links	• Undergo accreditation process • Undertake at least 3 methods of working with patient and partners to gain feedback on service developments • Review service models based on feedback, to assist in managing increased demand, including on-line therapy work with at least 2 voluntary sector partners to develop pathways	• Q3	• Accredited perinatal service
Eating Disorders • To continue to offer innovative clinical interventions • To develop links with the Child and Adolescent Mental Health Services (CAMHs) eating disorders services across Derbyshire • To work with neighbourhood and campus model	• Establish an effective use of outcome measures • Develop plan for an ageless service working with CAMHs • Develop plans to work with the neighbourhood and campus teams	• Q3	• Eating disorders CAMHs and adult pathway
Autistic Spectrum Disorder (ASD) Assessment Service • To undertake ASD assessments in line with commissioned arrangements (18+ without a learning disability) • To provide a programme of training within the Trust (that does not impact on ability to deliver contracted number of assessments) • To continue to promote the need for a commissioned post-diagnostic service	• To undertake comprehensive and detailed assessments in the newly formed specialist ASD assessment service • To develop and deliver a programme of training; to include basic autism awareness and more advanced skilled base training • To work with commissioners, develop links with other providers and highlight client needs following diagnosis	• Q2	• 312 ASD assessments completed in 17/18 • Increase awareness and education within workforce • Strong provider and voluntary sector relationships
Health Psychology • To continue to provide psychological interventions, consultation, supervision and teaching in Cancer, Pain Management, HIV/Genito Urinary Medicine (GUM) and Psychological Sexual Health in line with commissioned arrangements • To work with health care partners to promote a closer integration of psychological and physical healthcare and seek opportunities to develop this	• To work as integral members of the wider physical healthcare teams (where these exist) within our partner agencies and review the type of work undertaken and level of activity • To continue to contribute to the development of psychologically informed models of care within physical healthcare settings, with a view to looking to develop specialist psychological provision	• Q3	• An updated service specification and expansion of services with agreed newly commissioned activity

Links to wider system	Learning Disabilities STP	Transforming Care programme	Commissioner QIPP programme	National 'must do's' for Perinatal and IAPT	DCHS Learning Disabilities services	Substance misuse agenda	AHP strategy / physical care strategy	Perinatal network

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Plan on a Page – Children's and CAMHs

Enc J

Our Priorities for 2017/18	How we will deliver our priorities	By When
• To support the development of Future in Mind Plan	• To deliver services as commissioned by the Future in Mind Plan	• 31st March 2018
• Reduce reliance on Tier 4 and out of authority placements	• Support skills development within CAMHs and wider Children's workforce • Clarify the process to access an inpatient bed within DHcFT	• 31st March 2018 • 30th June 2017
• To develop Integrated Care Pathways	• Develop an integrated Neurodevelopment pathway across services within DHcFT and with wider service providers • To work with partners on delivery of a regional Sexual Assault Referral Centre (SARC) service	• 31st March 2018 • 30th September 2017
• To support the development of the future service model as outlined in the STP	• To work with commissioners who are seeking to invest £200k n CAMHs Intensive Home Treatment Service • Support development of 'place' and multi-agency single points of access	• 30th September 2017 • 31st March 2018
• To provide cost efficient services	• Ongoing review of skill mix within services • Medicines management / pharmacy input into teams	• 31st March 2018 • April 2018
• To provide effective and evidence based service	• Review of all service specifications with commissioners	• 31st December 2017
• Improving the experience and outcomes for young people transitioning out of Children and Young People's (C&YP) mental health services	• Develop transitions process for C&YP from children's/CAMHs services to Adult Services, including a casenote audit to assess joint planning, and surveys regarding transition experience for Young People before and after the point of transition	• 30th September 2017

Our Priorities for 2017/18	How we will deliver our priorities	By When
		Enc J
• To provide a responsive service	• To work with commissioners on clarifying role and subsequent service delivery of Primary mental Health Workers (PMHW) within CAMHs services • Develop an integrated Neurodevelopment pathway across services within DHcFT and with wider service providers • To work with partners on delivery of a regional SARC service • Increase the number of Non-Medical prescribers (NMPs)	• 30th September 2018 • 31st March 2018 • 30th September 2017 • 30th September 2017
• Service development will incorporate Early Help, Resilience, prevention and Self-Management	• Support development of 'place' and multi-agency single points of access	• 31st March 2018

Links to wider system	STP for Children's and Maternity	Local Authority	Commissioner QIPP programme	National 'must do's'	DTHFT / Children's Emergency Department	DCHS	Adult Mental Health services	Third sector

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

Plan on a Page – Neighbourhoods

Enc J

Our Priorities for 2017/18	How we will deliver our priorities	By When
• Review achievements of Neighbourhoods and plan next phase – including proposals for more services to join Neighbourhoods • Prioritise the service for people with severe, enduring and chronic mental health conditions and review and implement a new Care Programme Approach (CPA) policy and procedures to secure best outcomes for this cohort • To define, develop and deliver the next phase of Neighbourhood services – to deliver safe, effective and timely treatment and care	• Identify gains within the model • Review the model within the current context & health and social care environment • Review of CPA policy and processes – design training to support implementation – deliver training – implement policy and procedures – evaluate and audit implementation • Review and improve key processes to deliver more capacity and flow • Deliver an improved training schedule for all staff • Develop advanced mental health worker roles and pathway leads • Progress the Memory Assessment Service (MAS) nurse led diagnosis service • Work to deliver the finalised North 21st Century Healthcare (21C) plan • Robust medicines management / pharmacy support into teams • Improved and more robust patient / carer medicines-related support (helpline / medicines information service)	• May 2017 • April 2017 – October 2017 • June 2017 • Sept 2017 • April 2017-Oct 2017 • April 2017 • March 2018
• Work with 'Place' to ensure alignment of Neighbourhood next phase into a model of service that delivers to demand for specialist mental health service and puts that service at the best point of an individuals pathway • Work within Place to deliver the outcomes identified by each area	• Improve primary care interface and whole person management – engage with 'Place' • Secure resource to deliver more at Place level to benefit whole systems	• Ongoing • April 2018
• Lead and develop partnerships and models of service through the STP - Enhanced Neighbourhood Pathway, Enhanced Dementia & Delirium Pathway and The Primary Care Pathway for Mental health	• Build and lead Delirium response across all providers • Work with the STP planning • Building community resilience integrated care team links and Occupational Therapy (OT) leading partnership development	• Ongoing • Ongoing • Ongoing
• Deliver a framework for Recovery Led Services and work with the emerging model of day services to enable the pathway from specialist to self-care, and including improvements in personalised care planning	• Build and embed the Recovery Strategy – all ages	• Ongoing
• Redesign specialist Day Services for older people with dementia and with functional needs	• Deliver the proposed day hospital transformation in the south of Derbyshire and Derby City	• August 2017

Our Priorities for 2017/18	How we will deliver our priorities	By When
		Enc J
• Continue to review gaps in service and challenges, eg Community Forensic/Community Rehab/Personality Disorder (PD) pathway	• Secure appropriate resource for PD and forensic response in Neighbourhoods – workforce and training • PD Pathway full funding • Safer staffing level of funding of community resource – confirm referral trajectory and update commissioner paper • Building community resilience integrated care team links and OT leading partnership development • Crisis/Rapid response Team for Functional illness Older Adults funding	• April 2018 • April 2018 • April 2018 • August 2017
• Improving physical healthcare to reduce premature mortality in people with SMI	• Work towards providing cardio metabolic assessment and treatment for patients with psychoses in all community based mental health services and Early Intervention in Psychosis (EIP), and provide the GP with an up to date copy of the patient's care plan/CPA review letter or discharge summary	• Ongoing
• Improving the experience and outcomes for young people transitioning out of Children and Young People's mental health services	• Work with Childrens and CAMHs to complete a casenote audit to assess the extent of joint-agency planning for transitioning young people, and complete surveys of young peoples' transition experiences both before and after the point of transition	• 30th September 2017

Links to wider system	**STP for Mental Health / Dementia and Delirium / Primary Care**	**Social Care**	**Commissioner QIPP programme**	**National 'must do's'**	**DTHFT / Emergency Department (ED)**	**DCHS**
Success will be	**Neighbourhoods model next phase described and implemented, fits with Place**	**New services integrated into Neighbourhoods Dementia and functional Day Service Implemented**	**Training schedule in operation**	**Advanced practitioners in post and delivering capacity and leading clinical excellence**	**MAS transformation complete**	
	Shared care agreement with Primary care (PC) for physical health care	**Improved patient outcomes in relation to Body Mass Index (BMI) and smoking cessation**	**Pharmacy integrated into MDTs with routine on-site presence**	**The development of a jointly developed plan between CAMHS and Neighbourhoods, with a joint lead and joint reporting**	**Delirium training whole community – DHCFT pathway lead**	

Please note that due to the multi-agency nature of many of these priorities and actions, it is not currently in the division's gift to specify precise timeframes. Additionally, many actions are already underway at the time of producing the plan

Plan on a Page - Campus

Enc J

Our Priorities for 2017/18	How we will deliver our priorities:	By when:
• Improve accessibility to bedded care for those with a clinical need	• Ensuring that alternative and least restrictive options to bedded care are explored, link to Crisis and Right Care, Right Time, Right Place agenda • Temporary closure of ward 2 in support of least restrictive options for older adult patients including home treatment • Flow coordinators in post to support a more robust process of patient flow management	• Ongoing • April 2017
• Reduction of acute out of area placements and Psychiatric Intensive Care Unit (PICU) use	• Ensure that there are robust processes in placement to minimise and monitor the use of acute out of area beds • Bed Optimisation Board • Crisis Resolution & Home Treatment (CRHT) - Project to support crisis and home treatment to deliver robust gatekeeping function and deliver model in line with policy implementation guidance	• Ongoing
• Support the reduction in unnecessary delays in A&E and delays to appropriate provision	• Participate in 12 hour breach reviews and develop models for long wait avoidance • Consider the implementation of an ED based, psychiatric decision unit style offer in support of the STP Urgent care workstream	• Ongoing
• Participate in and support the plans for an effective place of safety as part of MH Urgent Care Hub 24/7 • Work with commissioners to develop an appropriate, fully funded Mental Health Advice & Assessment Hub (MHAAH) model	• Active Partners within crisis care concordat • Evaluation of MHAAH and service redesign, and delivery of model with agreed level of funding / delivery of Crisis Care Concordat action plan • Support the STP to deliver an options appraisal for both places of safety and safe places	• Ongoing
• Lead and develop partnerships and models of service through the STP leading or contributing to the Urgent Care pathway	• Continue to develop networks and relationships with commissioners and stakeholders which will contribute to improved service delivery	• Ongoing
• Work with partners to develop new models for rehabilitation and recovery to allow patients to be repatriated	• Continue to work with the STP to look at transformation of the rehab services to deliver new models of care • Review commissioned therapy levels to address the need to increase levels of psychology available at Audrey house and Cherry Tree	• December 2017
• Liaison and diversion - deliver new service model	• Deliver project plan for new liaison and diversion specification	• Ongoing
• Review new ways of working	• Enhanced prescribing functions for healthcare professionals, and enhanced pharmacy roles e.g. Medicines Optimisation Technicians and introduce advanced clinical practitioners, • Enhanced pharmacist role to support medical and nursing staff on ward 35 and in liaison south services	• Ongoing

Our Priorities for 2017/18	How we will deliver our priorities:	By when:
• Low Secure - Enhancement of the environment, staffing and skill mix in support of continuing to improve service delivery to patient • Building external partnerships with the recovery network	• Deliver Kedleston refurbishment plan	• December 2017
• Ensure physical health needs are met to reduce premature mortality in people with SMI – developing Advanced Clinical practitioner (ACP) role	• Ensuring that we are meeting our key performance indicator on CPA and discharge summaries • Monitoring our compliance with physical healthcare standards with use of clinical audit	• Ongoing
• Preventing ill health by risky behaviours, alcohol and tobacco	• Provide tobacco and alcohol screenings on admission • Offer smoking cessation and/or alcohol intervention • Upskill staff in offering brief advice and interventions	• Ongoing
• Focus on enhancing leadership framework	• Utilised temporary Assistant Service Manager (ASM) post, senior nurse acting up to ASM post • Supporting staff to act up where possible • Supporting sabbatical, ensuring staff understand leadership academy offers of Elizabeth Garrett Anderson and Mary Seacole programmes	• Ongoing
• Improving recruitment and retention rates across nursing and medical staff	• Supporting trips external to the country, working with HR to improve job descriptions and adverts • Increasing access to robust preceptorship and upskilling leadership skills • Greater opportunities internal to organisation, explore development roles • Reviewing nursing workload regarding levels of patient contact	• Ongoing
• Reduce agency spend	• Developing and recruiting to the ACP role • Explore enhancement of medical staffing by looking at alternative responsible clinician roles	• September 2017
• Support equity between older adults and adults services	• Secure Crisis Team for Functional illness Older Adults funding	• August 2017

Links to wider system	STP for MH	STP for medicines management & pharmacy	Commissioner QIPP programme	National 'must do's'	EMAS	DTHFT	CRH	Police	DHU	Adult care	CQC

Success will be	Acute out of area and PICU usage reduction	Reduction of inpatient beds	Reduction in length of stay	Reduction in MH related A&E breaches	Improved patient outcomes in relation to BMI and smoking cessation

Please note that due to the multi-agency nature of many of these priorities and actions, it is not currently in the division's gift to specify precise timeframes. Additionally, many actions are already underway at the time of producing the plan

CORPORATE DIVISIONS

Better together

Enc J

Plan on a Page – Strategic Development

Our Priorities for 2017/18	How we will deliver our priorities	By When
• Deliver Procurement CIP of £192k for other departments	• £106k of £192k savings already identified and delivered - additional projects include Collaborative chilled and Frozen mini-competition with DCHS	• March 2018
• Achieve accreditation to Level 1 of National Procurement standards	• Mobile Telecoms renegotiation	• June 2017
• Review internal procurement function	• Category spend and contracts analysis is ongoing to identify further opportunities	• March 2018
• Continue working with DCHS to achieve greater alignment of the Procurement function	• National Procurement standards - Initial external pre-assessment of progress against Level 1	• April 2017 (initial); October 2017 (Final)
• Provide assurance on all main contracts	• Procurement alignment with DCHS savings	• March 2018
• Review all contracts to align financial payments	• Actively participate in contractual meetings and further develop commissioner relationships	• March 2018
• Implementation of a SharePoint site to provide contract and business planning advice	• Deliver a functioning SharePoint site to provide information and advice	• June 2017
• Deliver CIP of at least £8,164	• Work with Divisions to upskill them on contracts and business planning	• March 2018
• Build business planning and contracting capability within the trust	• Review all contracts and prioritise according to value and risk	• March 2018

Success will be	**Procurement CIP of £192k and Directorate CIP of £8,614 by March 2018.**	**Level 1 accreditation against the National Procurement Standards by October 2017.**	**Divisions confidently using the SharePoint site**	**80% of contracts are income assured**	**Staff survey results show a positive improvement**
Links to wider system	**Carter Review**	**Wider integration project with DCHS**	**STP procurement project**	**Wider STP**	**CCG Turnaround position**

Plan on a Page – People Plan

Enc J

Our Priorities for 2017/18	How we will deliver our priorities	By When	Success will be:
• Effective workforce planning and development to meet our current and future patient needs	• Develop an integrated workforce plan that identifies current and future workforce needs, including comprehensive flexible and temporary staffing resources. Developing options and costs to build a sustainable solution • Develop strategies that tackle recruitment challenges, support the reduction in agency spend and improve staff retention • Develop an approach to talent management and succession planning	• 2017/18 • 2017/18 • 1st March 2017	• Increased clinical variation, advanced roles across professions • Developed bank provisions • Reduced agency spend & Improved retention and recruitment • Establish development pathways, and an embedded appraisal process
• Get the basics right	• Establish mechanisms to action plan and achieve the below objectives • Build efficient and effective people management policies, procedures systems and processes, by critiquing all HR policies and processes, increasing efficiency and implementation of E-Rostering systems, simplify the Trust approach to Lean thinking and automate the recruitment process to save time	• 31st March 2017 • 31st March 2018	• Up to date and relevant policy profile, compliant with equality, diversity and inclusion strategy • E-rostering systems used to full capacity • The rollout of new strategies that will better support both the Trust and workforce
• Develop and embed a meaningful and effective appraisal process	• Review and refresh the appraisal process to make it simpler and ensure it addresses the key aspects of support and development, including a revision of documentation, training of leaders and implementing an effective tracking and reminder system for appraisals	• 12th January – 16th March 2017	• On-going monitoring to achieve a compliance rate of 90% for appraisals
• Increase the engagement and involvement of staff	• Develop an effective approach to staff engagement in partnership with the staff engagement group, including adopting examples of best practice, developing a staff engagement strategy, utilise data from the staff survey and work with teams to focus developments, and develop a people dashboard	• January – July 2017	• Improved staff survey results and pulse check responses

Our Priorities for 2017/18	How we will deliver our priorities	By When	Success will be Enc J
• Support the wellbeing of our staff	• Develop a health and wellbeing strategy that is responsive to the needs of our staff. To link with national support and resources. Engage with staff to better understand reasons for absence	• 31st March – 1st April 2017	• Decreased absence rates • Delivering on the staff wellbeing CQUIN
• Effective and visible leadership	• Support leaders with the training and development required	• 31st January – 23rd March	• Improved staff satisfaction due to effective leadership monitored through staff survey and pulse check results
• Equalities, diversity and inclusion	• Ensure the Trust meets and exceeds legal compliance with the Equality Act 2010 • Implement the EDS2 national equality performance toolkit & develop an action plan to progress the Trust from under-development to achieving EDS2 • Benchmarking performance against national good practice standards to demonstrate progress, re-establish status on the national arena and evidence exemplar equality employer status • Embed the equalities Forum via the corporate Equalities Action Plan and strengthen governance and accountability around the functions	• April 2017 • February 2017 • June 2017 • Ongoing	• EDS2 Assessment – No Red ratings by 31st March 2018, 70% Green by 2019, and 100% Green by 2020

Links to wider system	NHS Improvement (NHSI) Agency Agenda	DCHS HR function	National regulations	Her Majesty's Revenue & Customs (HMRC)	Workforce Optimisation STP workstream	HR Governing Bodies	Health Education England	NHS Employers	DTHFT

Business Plan Summary - Pharmacy

Enc J

Our Priorities for 2017/18	How we will deliver our priorities	By When	Success will be:
• To deliver on Care Quality Commissioner (CQC) medicines-related priorities	• By working with clinical teams to provide targeted, funded medicines management support where required, and support areas of concern	• Ongoing	• All CQC medicines management - related actions addressed satisfactorily & in a timely manner
• To continue to improve the provision of pharmacy / medicines management services within all clinical areas serviced by the Trust	• By working with the Trust & Commissioners to address gaps in medicines management services within neighbourhoods & specialist areas e.g. LD, CAMHS	• April 2018	• Provision of good quality, patient-centred medicines management services across all clinical areas
• To continue to improve service receiver and carer medicines-related education and information provision/support	• By developing a dedicated Medicines Information service for healthcare staff and service receivers / carers	• April 2018	• Development of a Medicines Information service
• To continue to develop innovative, new ways of working in order to support clinical areas e.g. Pharmacist Non Medical Prescribing and Medicines Optimisation Technician roles	• By working with clinical teams to realise opportunities for pharmacist Non Medical Prescribing roles and Medicines Optimisation Technician roles	• Ongoing	• Effective use of pharmacy staff skills in order to support patient safety, and positive patient experience and outcomes, as an integrated part of MDTs
• To review of Out-of-Hours Pharmacy Services	• Re-designing pharmacy out-of-hour services thus ensuring delivery of service needs and patient safety requirements, whilst also offering value for money	• Ongoing	• Provision of a safe & robust out-of-hours service
• Pharmacy - ongoing departmental review to ensure the continued cost effective use of resources (this may be aligned with DCHS going forward). Workforce plan	• Ensuring the workforce plan is delivered in order to support service developments relating to pharmacy staff	• Ongoing	• Development of a high quality pharmacy team with the capacity, skills, experience & expertise to support new ways of working within the Trust - in line with the Workforce plan
• Devolving medicines budgets to clinical areas to facilitate the delivery of local efficiencies	• Working in conjunction with the medical director / teams / prescribers. clinical areas, finance and IMT	• April 2018	• Devolved medicine budgets in place

Links to wider system	Carter review	Wider integration project with DCHS	STP pharmacy & medicines management projects	Wider STP	CCG	CQC

Plan on a Page – Finance

Our Priorities for 2017/18	How we will deliver our priorities	By When	Success will be:
• To support the delivery of the short term and long term financial plans	• Continue to provide a responsive service to budget holders and senior managers across the Trust to enable them to effectively manage their budgets	• March 2018	• Achievement of control total for 2017/18
• Support the OBC and FBC process for acquisition	• Work with DCHS in completion of the Long Term Financial model (LTFM)	• March 2018	• Completion of strong LTFM to support OBC and FBC
• Contribute and support the Costing Transformation Programme	• Involvement in the National Costing Transformation Programme groups • On-going development of PLICS (Patient level information costing systems)	• March 2019	• PLICS system in line with national timescales
• Work closely with Commissioners in supporting them to understanding the costs of our services	• Provide Commissioners with a cost for each service and share on an o-going basis cost information	• 1st April 2017- ongoing March 2018	• Cost information completed and shared with Commissioners

Links to wider system	Wider integration project with DCHS	CCG Turnaround position	QIPP	CIP

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

Our Priorities for 2017/18	How we will deliver our priorities	By When
• Fully Implement an electronic record in all care settings including inpatients	• PARIS used in all mental health teams across the Trust with the exception of the Radbourne Unit. Plan to roll out into the Radbourne Unit by July 2017	• July 2017
• Migrate the Trust to NHS. Mail	• NHS. Mail Transfer Project to be established by April 2017	• April 2017
• Provide reliable technical environments and support services	• Rigorous service management	• April 2018
• Respond efficiently and affectively to any issues or enhancements raised by the Trust	• Maintain an effective and efficient department of highly motivated staff	• April 2018
• Deliver all NHS England or CCG mandated information on time and of the required quality	• Create and submit information when required	• April 2018
• Establish closer working with DCHS	• Establish closer working practices with DCHS	• April 2018
• Maintain our Information Governance excellence	• Define and implement the Information Governance operational plan	• April 2018
• Ensure patients have appropriate access to their records	• Respond effectively to patients access requests	• April 2018
• Ensure patients paper records are efficiently processed and stored	• Manage on and off-site paper record storage	• April 2018
• Provide access to SystmOne or PARIS to ensure clinicians can access records when appropriate	• All PARIS users have read-only access to SystmOne	• Subject to business case
• Continue to enhance integration within the Trust and with other organisations to make the Trust more efficient	• Integration established with Royal Derby Hospital	• Subject to business case

Success will be:	**Electronic recording in all care settings**	**Secure email in place**	**Systems stable**	**CIP Delivered**	**All required reporting needs internally and externally met**	**Information Governance (IG) compliance target met**	**Blood results available within PARIS**	**All Paris users to have access to SystmOne**
Links to wider system	**Carter review**	**Wider integration project with DCHS**	**NHSI monitoring**	**Wider trust CIPs**	**CCG contract management**	**Estate rationalisation**	**Patient empowerment**	

Plan on a Page – EFM

Enc J

Our Priorities for 2017/18	How we will deliver our priorities	By When	Success will be:
• Estates & Facilities Operations to work with DCHS as part of the Trusts Back Office Collaboration	• Working with DCHS, following an agreed timescale to merge staff & services,. • DHCFT to draw up Service Level Specification for the service required, introducing Key Performance Indicators (KPIs), to ensure governance requirements are met. • Following agreed HR processes in the Transfer of Staff	• Summer 2017 & on-going	• Fully transparent Estates & Facilities Operations • Governance of service • Private Finance Initiative (PFI) and Service level Agreements (SLAs) to be managed in-house by DHCFT
• Optimise use and develop Estate	• Working with DCHS and the One Public Health Groups	• On-going	• Shared accommodation between Trusts, greater utilisation of buildings
• Delivery of Estates Capital Programme	• In-house Capital Team and external consultants & contractors	• March 2018	• Good, Value for Money Indicators (VFM) Projects delivered on time and budget
• Review and ensure compliance on all legislative requirements	• Compliance project being undertaking at present	• April 2018	• Completion of the NHS Project Assurance Model (PAM) for Facilities and Estates
• Undertake a variety audit/inspections throughout out the year to assess quality standards	• Various inspections and audits through out the year independently carried out including - Patient-Led Assessments of the Care Environment (PLACE) - Cleaning Audits - Environmental Health Officer (EHO) inspections - Authorised Engineer reports - Food hygiene scores	• On-going	• Assurance of high quality services for the Trust, patients and staff

Links to wider system	Public health Groups (councils, wider NHS GPs)	Various legislative bodies	Derbyshire Mental Health Alliance	EHO	DCHS	HR	External contractors and consultants (Capital programme)

GLOSSARY OF TERMS

21C	21st Century Healthcare Programme
ACP	Advanced Clinical Practitioner
AHP	Allied Health Professional
ASM	Assistant Service Manager
BMI	Body Mass Index
C&YP	Children & Young People
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation National Goals
CRH	Chesterfield Royal Hospital NHS FT
CRHT	Crisis Resolution & Home Treatment

DCHS	Derbyshire Community Health Services NHS FT
DHU	Derbyshire Health United
DTHFT	Derby Teaching Hospitals NHS FT
ED	Emergency Department
EDS2	Equality Delivery System
EHO	Environmental Health Officer
EIP	Early Intervention in Psychosis
EMAS	East Midlands Ambulance Service
FYFVMH	Five Year Forward View for Mental Health
HMRC	Her Majesty’s Revenue & Customs
IAPT	Improving Access to Psychological Therapies
IG	Information Governance
IM&T	Information Management & Technology

KPI	Key Performance Indicator
LTFM	Long Term Financial Model
MAS	Memory Assessment Service
MDT	Multi-Disciplinary Team
MHAAH	Mental Health Advice & Assessment Hub
NHSI	NHS Improvement
NMP	Non-Medical Prescriber
NPS	New Psychoactive Substance
OBC/FBC	Outline/Full Business Case
OT	Occupational Therapy
PAM	Patient Activation Measure
PC	Primary Care
PD	Personality Disorders

PICU	Psychiatric Intensive Care Unit
PMHW	Primary Mental Health Worker
QIPP	Quality, Innovation, Productivity & Prevention Programmes
QLT	Quality Leadership Team
SARC	Sexual Assault Referral Centre
SLA	Service Level Agreement
SLT	Senior Leadership Team
SMI	Serious Mental Illness
STP	Sustainability and Transformation Plan
TCP	Transforming Care Partnership
VFM	Value for Money Indicators

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors - 26 April 2017

Corporate Governance
Register of Directors' Interests 2016-17

Purpose of Report

This report provides the Trust Board with an account of directors' interests during 2016/17.

Executive Summary

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

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

Board Assurances

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

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

Governance or Legal issues

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

Equality Delivery System

This report has a neutral impact on REGARDS groups

Recommendations

The Board of Directors are requested to:

1) Approve and record the declarations of interest as disclosed. These will be recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's annual report and accounts for 2016/17.
2) Record that all directors have signed as to compliance with the NHS Codes of Conduct and Accountability and Nolan principles; no relevant audit matters have been declared.

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

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

Declaration of Interests Register 2016-17

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	Director, Organisation Change Solutions Limited Non-Executive Director, Derwent Living	(a, b)
Caroline Maley Acting Trust Chair	Director – C D Maley Ltd Trustee – Vocaleyes Ltd.	(a) (a, d)
Barry Mellor Non-Executive Director	Non-Executive Director, Rotherham NHS Foundation Trust Trustee, Rotherham Hospital Charity Mrs Mellor is a befriender with Age UK	(a, d)
Amanda Rawlings Director of People and Organisational Effectiveness (DHcFT)	Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) Co-optee Cross Keys Homes, Peterborough	(a, d)
Dr Julia Tabreham Deputy Trust Chair and Non-Executive Director	Non-Executive Director, Parliamentary and Health Service Ombudsman Director of Research and Ambassador Carers Federation Leads the Parliamentary and Health Service Ombudsman's contribution to establishing NHS complaints advocacy support in Ireland	(a, d)
Richard Wright Non-Executive Director	Director, Sheffield Chamber of Commerce Chair, The Sheffield College Multi Academy Trust Chair Sheffield University Technical College Member of Advisory Board of Sheffield National Centre for Sport and Exercise Medicine	(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) Any connection with a voluntary or other organisation contracting for NHS services.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 26 April 2017

Register of Trust Sealings 2016-17

Purpose of Report

This report provides the Trust Board with an account of the authorised use of the Foundation Trust Seal during 2016-17.

Executive Summary

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

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

There were three entries made to the Register of Trust Sealings for 2016/17. The Trust Seal was affixed as follows:

- Licence relating to St Andrew's House car park on 16 August 2016 (seal number DHCFT42)
- Deed of Surrender for Bingham House on 22 December 2016 (seal number DHCFT43)
- Renewal to lease of mews, first and ground floor, Ripley on 15 January 2017 (seal number DHCFT44)

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

Governance or Legal issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Orders of the Foundation Trust.

Equality Delivery System

This report has a neutral impact on REGARDS groups

Recommendations

The Board of Directors are requested to note the authorised use of the Foundation Trust Seal during 2016-17.

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors 26 April 2017

Governance Improvement Action Plan (GIAP)

Purpose of Report

As described in the GIAP Governance and Delivery framework, the Board has overall responsibility for ensuring that the GIAP is delivered.

Therefore, the purpose of this paper is as follows:

1. To provide Board members with an update on progress on the delivery of the GIAP, including the identification of tasks and recommendations that are off track.

2. To receive assurances on delivery and risk mitigation from Board Committees and Lead Directors.

3. To enable Board members to constructively challenge each other to establish whether sufficient evidence has been provided for completed actions.

4. To decide whether tasks and recommendations can be closed and archived.

Executive Summary

This paper provides the Board with an update on the progress of delivering the GIAP.

The governance of each core area is as follows:

Core	Committee	Lead Director
Core 1 - HR and associated Functions	People and Culture	Interim Director of People and Organisational Effectiveness
Core 2 - People and Culture	People and Culture	Interim Director of People and Organisational Effectiveness
Core 3 - Clinical Governance	Quality	Director of Nursing and Patient Experience
Core 4 - Corporate Governance	Audit & Risk	Director of Corporate Affairs
Core 5 - Council of Governors	Council of Governors	Director of Corporate Affairs
Core 6 - Roles and Responsibilities of Board Members	Remuneration and Appointments	Director of Corporate Affairs
Core 7 - HR and OD	People and Culture	Interim Director of People and Organisational Effectiveness
Core 8 - Raising concerns at work	People and Culture	Director of Corporate Affairs
Core 9 - Fit and Proper	Remuneration and Appointments	Director of Corporate Affairs
Core 10 - CQC	People and Culture	Interim Director of People and Organisational Effectiveness
Core 11 - NHS improvement undertakings	Board of Directors	Director of Corporate Affairs

The summary table below provides Board members with an overview of performance against all 53 recommendations, set against each respective core area and from the perspective of the oversight Committees.

Core	Number of Recommendations	Off Track	Some Issues	On Track	Completed
Core 1 - HR and Associated Functions	5	0	0	0	5
Core 2 - People and Culture	6	0	0	0	6
Core 3 - Clinical Governance	3	0	0	0	3
Core 4 - Corporate Governance	13	0	0	0	13
Core 5 - Council of Governors	3	0	0	0	3
Core 6 - Roles and Responsibilities of Board Members	5	0	0	0	5
Core 7 - HR and OD	8	0	0	0	8
Core 8 - Raising concerns at work	1	0	0	0	1
Core 9 - Fit and Proper	1	0	0	0	1
Core 10 - CQC	2	0	0	0	2
Core 11 - NHS improvement undertakings	6	0	0	2	4
Total	53	0	0	2	51

All recommendations are complete for Core areas 2, 5, 8, 9 and 10. There are **14** blue forms to present to the Board.

HR3, HR4, WOD5 and WOD6 blue forms are included, pending consideration at the People and Culture Committee on 20 April 2017. A verbal update will be given on these recommendations.

Recommendations that are due to be considered by the Remuneration and Appointments Committee to held on 26 April (prior to the Public Trust Board meeting) are also included pending consideration and verbal feedback from the Committee. These are: RR1,RR2, RR3, RR5.

GIAP Recommendations Approval Pipeline, January – May 2017
The approval pipeline as at 18.04.17 is attached for information.

There are currently no recommendations that are rated as ‘off track’ or ‘some issues’.

Strategic considerations Delivery of the GIAP links directly to NHS Improvement's enforcement action and associated licence undertakings	
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	

Board Assurances

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

3a: There is a risk that the NHSI enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work

3b: Risk of a loss of confidence by staff in the leadership of the organisation at all levels

Consultation

Core areas have been discussed at respective Board Committees

Governance or Legal Issues

This paper links directly to NHSI enforcement action and associated licence Undertakings

Equality Delivery System

Delivery of elements of the GIAP is likely to have a positive impact on outcomes for certain REGARDS groups

Recommendations

The Board of Directors is asked to:

1) Note the progress made against addressing GIAP recommendations
2) Formally approve the **14** blue forms as presented and confirm that this is provides assurance of completion, namely:

   - **HR3 - pending verbal update from People and Culture Committee**
   - **HR4 - pending verbal update from People and Culture Committee**
   - **CLING1**
   - **CORPG7**
   - **WOD5 - pending verbal update from People and Culture Committee**
   - **WOD6 - pending verbal update from People and Culture Committee**
   - **M2**
   - **M4**
   - **M5**
   - **M6**
   - **RR1 – pending verbal update from Remuneration and Appointments Committee**
   - **RR2 - pending verbal update from Remuneration and Appointments Committee**
   - **RR3 - pending verbal update from Remuneration and Appointments Committee**
   - **RR5 - pending verbal update from Remuneration and Appointments Committee**

3) Agree at the end of the Board meeting whether any further changes are required to the GIAP following presentation of papers, outcomes of item specific discussions and/or other assurances provided throughout the meeting

Report presented by:	**Kelly Sims (CQC and Governance Coordinator)**
Report prepared by:	**Samantha Harrison (Director of Corporate Affairs and Trust Secretary)**

Introduction

The Board summary table provides Board members with an overview of performance against all 53 recommendations, set against each respective core area. Detailed below are updates against Core areas where there have been notable decisions made with respect to actions required to confirm completion of recommendations and scheduled dates identified for these to be brought to respective Committees and the Trust Board:

Core 1 – HR and Associated Functions
Blue forms for HR3 and HR4 are attached for approval – these are to be presented to the People & Culture Committee on 20 April; a verbal update will be given and subject to this, the blue forms considered for approval by the Board.

Core 3 – Clinical Governance
Following debate over several meetings, the April Quality Committee considered and approved the completion of recommendation ClinG1.

Core 4 – Corporate Governance
As agreed at the Audit and Risk Committee at its March meeting, it was proposed that the blue form for CORPG7 will be presented to the Trust Board and incorporate further debate on the Accountability framework as agreed at the April Quality Committee (see also ref CLING1).

Core 6 - Roles and Responsibilities of Board Members
Recommendations RR1, RR2, RR3 and RR5 are due for consideration by the Remuneration and Appointments Committee on 26 April. The forms are included with Board papers for consideration by the Board subject to verbal update from the Committee.

Core 7 – Workforce and OD
Blue forms for WOD5 and WOD6 are attached for approval – these are to be presented to the People & Culture Committee on 20 April; a verbal update will be given and subject to this, the blue forms considered for approval by the Board.
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Core 11 - NHS Enforcement Undertakings
The Responsible Director has reviewed progress against the recommendations within Core 11 and four blue completion forms are attached to reflect work undertaken against the stated actions.

The remaining outstanding recommendations in this core area are:

- ***M1*** *- The Trust will deliver a Governance Improvement Action Plan (GIAP) to address the findings and recommendations from the Employment Tribunal Investigation, Deloitte report, and the CQC focused inspection*

  Closure of this recommendation requires full completion and delivery of the GIAP. This is planned for May 2017.

- ***M3*** *- The Trust will undertake to gain external assurance that the Governance Improvement Action Plan has been implemented in full or that it can be implemented in full*

  Deloitte LLP have undertaken an external assurance review and we await receipt of the final report (due 24.04.17).

GIAP Recommendations: Approval Pipeline January - May 2017

Pipeline as at 18.04.17

Core	Total	Off Track	Some Issues	On track	Com-plete	Programme for Blue Forms to Board					
						Jan	Feb	01 Mar	29 Mar	Apr	May
Core 1 - HR and associated Functions Director of People and Organisational Effectiveness	5	0	0	2	3	HR1 HR2 HR5				***HR3*** ***HR4***	
Core 2 - People and Culture Lead - Director of People and Organisational Effectiveness	6	0	0	0	6	PC1 PC6		PC3 PC4 PC5	PC2		
Core 3 - Clinical Governance Lead - Director of Nursing	3	0	1	0	2		ClinG2	*ClinG3*		***ClinG1***	
Core 4 - Corporate Governance Lead – Director of Corporate Affairs	13	0	0	1	12	CorpG2 CorpG10 CorpG12 CorpG13 Corp G9			CorpG1 CorpG3 CorpG4 CorpG5 CorpG6 CorpG8 CorpG11	***CorpG7***	
Core 5 - Council of Governors Lead – Director of Corporate Affairs	3	0	0	0	3						
Core 6 - Roles and Responsibilities of Board Members Lead – Director of Corporate Affairs	5	0	1	3	1				RR4	***RR1*** ***RR2*** ***RR3*** ***RR5***	
Core 7 - HR and OD Lead - Director of People and Organisational Effectiveness	8	0	0	2	6			WOD1 WOD3 WOD4 WOD7 WOD8	WOD2	WOD5 ***WOD6***	
Core 8 - Raising concerns at work Lead - Director of People and Organisational Effectiveness	1	0	0	0	1				RC1		
Core 9 - Fit and Proper Lead – Director of Corporate Affairs	1	0	0	0	1						
Core 10 – CQC Lead – Acting Chief Operating Officer	2	0	0	0	2	CQC 1		CQC2			
Core 11 - NHS improvement undertakings Lead - Chief Executive/Director of Corporate Affairs	6	0	0	3	3					***M2*** ***M4*** ***M5*** ***M6***	M1 M3
Total	**53**	**0**	**2**	**11**	**40**	**11**	**1**	**10**	**11**	**14**	**2**

Recommendation:	Current BRAG Rating	Recommended BRAG Rating
HR3 - Undertake an exercise to update the model for HR. Utilising the model as a guide, expertise and best practice across the LHE, and beyond. As a priority the Trust should focus on establishing clear foundations, utilising key building blocks to create sustainability in the long term	**Complete**	**Assurance Received**

Detail

During 2016 some refinements to the HR and Workforce Team structure was undertaken which included the alignment of the Principle HR Managers to service areas. P&CC received a paper in June 2016 outlining a proposed future model for the function and it was agreed that more work should be undertaken to progress this to a full business case.

During the summer of 2016 a national mandate was received regarding the focus on back office consolidation and rationalisation across the NHS. The Director of Workforce, OD and Culture left the Trust in August 2016 and the Trust entered into an agreement to work with DCHS to look at all the back office functions to look at sharing where appropriate. The Director of People and Organisational Effectiveness from DCHS joined the Trust in September 2016 as a shared director for both Trusts.

In October 2016 P&CC received an HR Status report as assurance on how the staff in the structure where aligned to the organisation's key priorities and the plan for the structure going forward.

In March 2017 the Finance and Performance Committee and Trust Board received a business case outlining a new shared service structure for the HR/Workforce team for DCHS/DHCFT hosted by DCHS. This was a phase 1 business case starting with the senior team restructure and shape of the future service. The Phase 2 business case is in development and will be presented in May/June 2017 for approval.

Deloitte have reviewed the new model at the one to one meeting with the Director of People and Organisational Effectiveness held on 22 March 2017.

Evidence

1.7 HR status report presented to P&CC, October 2016
1.8 Front sheet - HR model and metrics June 2016 report
1.9 Front sheet - HR model and metrics July 2016 report
1.10 HR practice model
1.11 Ratified P&CC minutes, June 2016
1.12 What does the model mean in practice?
Business case presented to F&P, March 2017
Trust Board minutes, 29 March 2017
Specifications reviewed with Executive Directors on 03.04.17

On-going Monitoring Arrangements

As part of the new shared function each team has a detailed service specification

and a set of KPI's that will be reviewed and monitored as part of the ongoing back office governance arrangements.			
Executive Director Responsible	Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People and Culture Committee

Recommendation:	Current BRAG Rating	Recommended BRAG Rating
HR4 - Define a new structure for HR and its related functions with a priority on operational efficiency and strategic impact taking into account the refreshed People Strategy and revised model for HR and related functions	**Complete**	**Assurance Received**

Detail

A revised HR model based on the one suggested by Deloitte was presented to P&CC in June 2016. The Committee acknowledged the paper and agreed a further paper would be presented to the Committee which set out additional detail. A further paper was discussed and approved by P&CC in July 2016, with an agreement that the team would progress as quickly as possible to embed the new way of working which resulted in the Principle HR and OD Managers being aligned to Service areas.

In October 2016 P&CC received a paper with a proposed way forward for the function which included the additional capacity that the Trust had invested in to support the GIAP actions and for workforce supply – including both permanent and temporary resourcing. This paper provided assurance to the Committee that the resources of the team where aligned and focused on the organisation's priorities.

The 2017 People Plan was presented to P&CC in January 2017 with the work programme for the year which has seven focus areas to meet the strategic needs of the Trust and each one has designated lead.

In March 2017 the Finance & Performance Committee and Trust Board received a new structure for HR and Workforce which is progressing now to implementation. The structure is designed to provide increased value and efficiency for the Trust and has increased focus on the Trust's people priorities.

Evidence

1.8 Front sheet - HR model and metrics June 2016 report
1.9 Front sheet - HR model and metrics July 2016 report
1.10 HR practice model
1.11 Ratified PCC minutes, June 2016
1.12 'What does the model mean in practice?'
1.13 a, b People Plan as presented to January P&CC
1.14 Paper to P&CC – HR Status Report, October 2016
New HR structure presented to F&P and P&CC, March 2017
Trust Board minutes, 29 March 2017
Specifications reviewed with Executive Directors on 03.04.17

On-going Monitoring Arrangements

The Trust People Performance report is presented to P&CC each month (part of annual Committee workplan)

The recruitment progress report is presented to P&CC each month (part of annual Committee workplan)

People Plan progress reports and deep dives are provided to P&CC each month and quarterly progress reports are submitted (part of annual Committee workplan). The service specifications for each team in the new HR structure and KPI's was agreed at ELT on 03.04.17, to be monitored through the back office governance.

Executive Director Responsible	Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People and Culture Committee

Derbyshire Healthcare NHS Foundation Trust

Blue Completion Form

Recommendation **CLING1** - Refresh the role of Quality Leadership Teams to increase their effectiveness as core quality governance forums	Current BRAG Rating **Complete**	Recommended BRAG Rating **Assurance Received**

Detail

The Director of Nursing and the Medical Director met with the Chairs of the QLTs, and plans were put in place for further collective and individual development. Additional development in quality governance and monitoring of the CQC regulations were noted as required.

Quality Committee reviewed this recommendation at their September 2016 meeting. Concerns were raised regarding the effectiveness of the current QLTs. QC members agreed that this recommendation was no longer on track and that there were some issues that required resolution. QC requested that in order to address the issues that QLT chairs were required to attend QC, QLTs should provide minutes and escalations via the agreed escalation template and that the wider issue of QLT effectiveness be incorporated as part of the Trust-wide accountability framework which was set for agreement by the end of October 2016

November 2016: The DoN has continued with unannounced visits to QLTs. QLT governance structures continue to be developed and embedded but assurance is still required that work plans and action plans are being followed. Recent visits confirm that the right information is being discussed at QLT level but more proactive decision making is required and a wider monitoring role of QLTs in not just receiving information but monitoring information, quality indicators and making decisions to mitigate issues or escalate to senior managers if additional support is required.

Discussed at ELT 20.02.17 and action plan agreed, and further discussed at Quality Committee on 14.03.17. Agreed that Terms of Reference, purpose and reporting arrangements will be reported back to 13.04.17 Quality Committee to reflect revised arrangements agreed. The revised accountability arrangements. Paper being presented to Trust management team and structures.

The Trust Management Team is fully operational and is supporting integrated quality leadership teams to develop fully into their roles of quality governance.

In spring/summer the TMT will have an annual planner which indicates when all TMT members will attend a performance management review function, when a collective leadership model will present their progress against their area plan on a page and integrated priorities. This will be an integrated leadership slide pack/presentation and performance review, driving a shared quad or triumvirate collective model of accountability and exception reporting against agreed quality governance targets against the agreed plan on a page priorities. This includes a section on risk based issues that are determined at national, local or generated by the clinical and

operational front line.

Paper on the Divisional Leadership Teams presented to Quality Committee in April 2017 and agreed.

Evidence

Minutes of Quality Leadership Teams November 2016

Minutes of ELT on 20.2.17

Minutes of Quality Committee on 14.03.17

Model of deep dive/ plan on a page- service areas, performance management review.

On-going Monitoring Arrangements

Accountability Framework to be reviewed annually - this is included within the Trust Management Team's terms of reference

ELT to review effectiveness of TMT on a six monthly basis

Assurance report to be presented to Quality Committee in September 2016

A review of effectiveness of the Accountability Framework is listed for consideration as part of the internal audit programme for 2017/18

Executive Director Responsible	Director of Nursing & Patient Experience	**Responsible Assurance Committee**	Quality Committee

Recommendation	Current BRAG Rating	Recommended BRAG rating
CorpG7 – In light of the changing governance and accountability structures (such as neighbourhoods, campuses and QLTs) an accountability framework should be designed to fully engage staff in how these changes will affect ways of working, performance management structures and desired behaviours moving forward	**Complete**	**Assurance Received**

Detail

This recommendation relates to the alignment of the Trust's Accountability Framework to the Trust's revised Corporate Governance Framework (as approved by the Board in July 2016). A review of the former structure was undertaken by the Executive Leadership Team and the Senior Leadership Team (SLT) which identified that a new structure was required. An Accountability Framework has subsequently been developed and approved in the confidential session of the Trust Board meeting held on 2 November 2016.

The Trust Management Team (TMT) has been in operation since January 2017 and has a pivotal role in the Accountability Framework. The Team oversees a range of operational and performance areas and escalates issues and reports into the Executive Leadership Team following each meeting. At subsequent meetings on 27 February and 13 March, the detail of the governance structure sitting below the TMT was discussed. This was also discussed at the Quality Committee as part of the recommendation ClinG1, which also relates to the effective implementation of the Accountability Framework as TMT supports the Divisional leadership teams to develop fully into their roles of quality governance.

In spring/summer TMT will have an annual planner which indicates when all TMT members will attend a performance management review, when a collective leadership model will present their progress against their area plan on a page and integrated priorities. This will be an integrated leadership slide pack/presentation and performance review, driving a shared quad or triumvirate collective model of accountability and exception reporting against agreed quality governance targets against the agreed plan on a page priorities. This includes a section on risk based issues that are determined at national or local level or generated by the clinical and operational front line.

These proposals were presented and agreed at the Quality Committee in April as part of the update on progress against ClinG1. This included example Divisional Management Team's terms of reference to be replicated across all divisions.

Evidence

Accountability framework report to TMT 27 February 2017

On-going Monitoring Arrangement

Accountability Framework to be reviewed annually - this is included within the Trust Management Team's terms of reference

ELT to review effectiveness of TMT on a six monthly basis

Assurance report to be presented to Quality Committee in September 2016

A review of effectiveness of the Accountability Framework is listed for consideration as part of the internal audit programme for 2017/18

Executive Director Responsible	Acting Chief Operating Officer/Director of Corporate Affairs	**Responsible Assurance Committee**	Audit and Risk Committee

Recommendation WOD5: Consider a range of development interventions for the operational HR team to ensure employment law risks are mitigated	**Current BRAG Rating**	**Recommended BRAG Rating**
	Completed	**Assurance Received**

Detail

As part of the wider HR development programme delivery of specific interventions on employment law are required.

Employment Law Training for the Workforce and Organisational Development Team and Staffside was commissioned with Capsticks Solicitors and took place on 16 March 2017.

The training session provided all attendees with an update on employment law including, TUPE, Equality Act, Flexible Working, Subject Access Requests and Disciplinary and Grievance.

Members of the Workforce and Organisational Development Team and Staff Side colleagues had the opportunity to present questions to Capsticks to obtain advice and guidance on a range of employment law matters to ensure that employment legislation is adhered to and best practice is achieved.

Further training sessions on managing sickness absence and on disciplinaries and grievances have been arranged as follows:

- 29 March 2017 at 12.30 pm in Meeting Room 14, Kingsway House, Kingsway Hospital - Equality Act and managing sickness absence
- 10 April 2017 at 1pm in Meeting Room 2, Albany House, Kingsway Hospital - Disciplinary and Grievances

Evidence

7.3 Capsticks training agenda for the employment law training, 16 March 2017

7.4 Capsticks training signing-in sheet, 16 March 2017

On-going Monitoring Arrangements

Monitoring arrangements will be undertaken through the Workforce Policy Review Group, which is a structured mechanism for the review and development of workforce policies in accordance with employment legislation. This allows for Managers, Workforce Managers and staff side representatives to discuss and review any areas of learning from past cases. The Workforce and OD Team ensure Group and 1:1 Supervision sessions take place on a regular basis which allows for reflection, support and development to be provided regarding case management. A monthly case review meeting provides a further opportunity for staff side representatives and Workforce and OD Managers to collectively discuss ongoing cases in accordance with policy and employment legislation with the opportunity to monitor adherence to policies across the Trust.

Further training sessions:

- 29 March 2017 at 12.30 pm in Meeting Room 14, Kingsway House, Kingsway Hospital - Equality Act and managing sickness absence
- 10 April 2017 at 1pm in Meeting Room 2, Albany House, Kingsway Hospital - Disciplinary and Grievances

Executive Director Responsible	Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People & Culture Committee

Recommendation WOD6: Consider mechanisms to regularly seek feedback from the HR function on the extent to which the candour, openness, honesty, transparency and challenge to poor performance are the norm, e.g. through monthly pulse checks	**Current BRAG Rating**	**Recommended BRAG Rating**
	Completed	**Assurance Received**

Detail

A paper was delivered to the People and Culture Committee in May 2016 which outlined the approach and broad areas of development for the HR team.

Using existing survey software already available to the Trust at no additional cost, a 'monthly' Workforce &OD Service Satisfaction & Improvement survey was created. The survey is run during the first week of every month and covers nature of query, service received rating and a free text section for comments/compliments and suggestions for improvement. The survey link is sent to a sample of employees who have made contact with the Workforce & OD team either by telephone, email, in writing or in person during the survey week. Employees then complete and submit the survey should they wish to. The first monthly survey ran from 6 to 10 March 2017 and the results were reviewed at the following senior team meeting. The survey continues to be run during the first week of every month.

To further ensure that mechanisms are in place to regularly seek feedback from the HR function on the extent to which the candour, openness, honesty, transparency and challenge to poor performance are the norm, an additional 'anytime' Workforce &OD Service Satisfaction & Improvement survey has been created and embedded within the W&OD web page on Connect. The 'anytime' survey covers the same questions as the monthly survey, i.e. nature of query, service received rating and a free text section for comments/compliments and suggestions for improvement. The 'anytime' survey is available for staff to complete 24 hours a day, 7 days a week, 365 days a year. The 'anytime' survey results will be reviewed quarterly at the W&OD senior team meeting and run alongside the proactive monthly survey.

Evidence

7.17 Example of 'Monthly' Workforce &OD Service Satisfaction & Improvement survey (runs first week of each month)

7.18 'Anytime' Workforce &OD Service Satisfaction & Improvement survey (open all year and accessible via Workforce &OD intranet page)

7.19 a, b Results for both surveys are reviewed at Workforce & OD senior team meetings

Ongoing Monitoring Arrangements

'Monthly' and ongoing 'anytime' Workforce &OD Service Satisfaction & Improvement survey (runs first week of each month) reviewed at Workforce and OD team meetings

Derbyshire Healthcare NHS Foundation Trust

Executive Director Responsible	Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	People and Culture Committee

Derbyshire Healthcare NHS Foundation Trust

Blue Completion Form

Recommendation **M2** - The Governance Improvement Action Plan will be updated to reflect material matters arising from the HR investigation	**Current BRAG Rating** **Complete**	**Recommended BRAG Rating** **Assurance Received**

Detail

The HR investigation report was reviewed during the development of the GIAP and there were no material issues not already included in the GIAP.

The Trust Board approved closure of this recommendation on 27.04.16.

Evidence

GIAP – March 2016 version

On-going Monitoring Arrangements

GIAP actions have been monitored and overseen as part of overall GIAP programme management during 2016/17, and will continue until all recommendations are completed.

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Board of Directors

Derbyshire Healthcare NHS Foundation Trust

Blue Completion Form

Recommendation **M4** - The Trust will implement Programme management and Governance arrangements to ensure the delivery of the Governance Action Plan	**Current BRAG Rating** **Complete**	**Recommended BRAG Rating** **Assurance Received**

Detail

The governance and delivery framework was agreed in April 2016. This has been effectively followed throughout 2016/17 with reporting regularly to oversight Board Committees, the Trust Board, Council of Governors and regulators.

Robust project management arrangements have been followed to ensure a clear audit trail of evidence. Document management and use of a pipeline tool were implemented to allow overview of progress and completion of actions to fulfil recommendations.

A Programme Manager was recruited for six months starting April 2016. Further programme support was set in place from September 2016, reporting to a designated responsible Director.

The Board agreed closure of this recommendation at the April 2016 meeting.

Evidence

Governance delivery framework
GIAP documentation – March 2016 version
Electronic records – Evidence library/GIAP drive link
Board reporting – pick one from evidence index

On-going Monitoring Arrangements
All recommendations require detail of ongoing monitoring and embeddedness of actions, which have been agreed as part of the completion and approval process. These will be monitored for each recommendation on an ongoing basis during 2017/18.

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Board of Directors

Derbyshire Healthcare NHS Foundation Trust

Blue Completion Form

Recommendation **M5** - The Trust will provide regular reports to Monitor	**Current BRAG Rating** **Complete**	**Recommended BRAG Rating** **Assurance Received**

Detail

Reports have been provided to NHSI as part of regular performance review meetings (PRM), generally held monthly, which are attended by the CQC.

The GIAP has been a standing agenda item for these meetings and progress and risks have been discussed in detail.

Evidence

PRM letter, April 2016

On-going Monitoring Arrangements

GIAP will continue to be discussed at PRM meetings into 2017/18.

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Board of Directors

Derbyshire Healthcare NHS Foundation Trust

Blue Completion Form

Recommendation	Current BRAG Rating	Recommended BRAG Rating
M6 - The Licensee will, by 18 March 2016 or such other date as agreed with Monitor, develop and submit to Monitor a timetable for making permanent appointments to all director roles which are currently vacant and/or filled on an interim basis. It will, by a date to be agreed with Monitor, revise that timetable in response to any comments made on it by Monitor	**Complete**	**Assurance Received**

Detail

The Remuneration and Appointments Committee agreed the timetable for recruitment of all Board level posts outlined and these were recruited to successfully.

Trust Board agreed closure of this recommendation at its April 2016 meeting.

Evidence

Recruitment timetable – ask Sue T for this, ?Dec 15/early 16

On-going Monitoring Arrangements

Regular review of composition of the Board is a stated role of the Remuneration and Appointments Committee, to be undertaken on an annual basis (included on the forward plan).

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Board of Directors

Derbyshire Healthcare
NHS Foundation Trust

Blue Completion Form

Recommendation RR1: Implement proposals to improve succession planning at Board level, including ensuring that Governors are adequately engaged in this process. Alongside this, develop processes for succession planning for Senior Leader positions	**Current BRAG Rating**	**Recommended BRAG Rating**
	Complete	**Assurance Received**

Detail

A mitigation plan was agreed at October's Remuneration & Appointments Committee, with succession planning process being led by Amanda Rawlings and Ifti Majid. Further development of the succession plan was discussed at the November and December Remuneration and Appointments Committee, agreed as off-track, and proposed to be deferred until the new year due to priorities of other work areas and the launch and embedding of the new appraisal process.

The status was reported and noted at the January Board meeting and agreed following recommendation of the Remuneration and Appointments committee held in February that the status of this action be amended to 'Some Issues' reflecting the reprioritised timeline of April 2017.

Work is underway throughout the Trust to identify succession plans and talent ratings for all staff band 7 and above and this will be complete by the end of April 2017 to be discussed with Executive Directors and the Remuneration and Appointments Committee in April 2017.

Evidence

Succession planning report to Remuneration and Appointment Committee, April 2017

On-going Monitoring Arrangements

The outcome of the initial succession planning process will inform the Leadership Development Strategy for PCC in May.

The Remuneration and Appointments Committee will receive annual reports and the process will be operationalised with the Executive Leadership Team and their senior team members.

Executive Director Responsible	Director of People and Organisational Effectiveness	**Responsible Assurance Committee**	Remuneration and Appointments Committee

Recommendation RR2: **Deloitte 5** - Agree a programme of Board development work which includes a mix of internal and externally facilitated sessions, is clearly aligned to the combined governance action plan. The Board Development plan should consider: •More detailed consideration of the governance action plan •A focus on Board challenge, including assurance, reassurance and the role of the corporate director •Facilitated 360 feedback •Board cohesion and dynamics •Use of external speakers to add insight and prompt debate •Joint sessions with governors •engagement from senior Trust leaders **CQC 3** - The trust should ensure that all Board members and the council of governors undertake a robust development plan (Link to CG2)	**Current BRAG Rating** **Complete**	**Recommended BRAG Rating** **Assurance Received**

Detail

The Board agreed a development programme in March 2016, linked to both the Governance Improvement Action Plan (GIAP) recommendations and strategic priorities, and this has been delivered as per the summary report previously presented to the Committee in December 2016.

The programme has been revisited and revised in year, with updates agreed by the Committee. The programme was reviewed in Autumn 2016 to ensure that topics reflected current priorities and challenges. This was particularly relevant considering the four new Non-Executive Directors and appointment of Acting/Interim Directors. It was also important to ensure that development sessions reflected the CQC inspection outcomes and help ensure that Board members are well informed on issues relating to the proposed collaboration arrangements with Derbyshire Community Health Services NHS Foundation Trust.

The revised programme was presented to the December Committee. A KPI on attendance was agreed at this time. A target of attendance at 77% of sessions was set. At the January meeting it was also agreed that further reports summarising Board Development Sessions held during 2016/17 would include noting attendance to be able to provide evidence that this recommendation had been satisfied. As previously agreed by the Committee, attendance that falls below the target attendance is dealt with via relevant line management.

Evaluation forms have been introduced from January 2017 to ensure ongoing learning and feedback to inform the future programme.

The December Committee confirmed that receipt of a report outlining the completed 2016/17 programme including noting attendance would provide assurance that this recommendation had been met. The Committee agreed at the February 2017 meeting that the development of this programme for 2017/18 is to be taken forward as business as usual as this is not a requirement for completion of the GIAP recommendation.
Evidence
4.18 Board Development Programme 2016/17 Attendance log for Board Development Session 2016/17
On-going Monitoring Arrangements Monthly Board Development session scheduled throughout 2017/18 as part of ongoing business as usual for the Board

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Board of Directors

Derbyshire Healthcare NHS Foundation Trust

Blue Completion Form

Recommendation RR3	Current BRAG Rating	Recommended BRAG Rating
Deloitte 6 - Complete the full process of 360 feedback for all Board Members and utilise the outcome to set clear objectives in relation to portfolio areas (for EDs) as well as in relation to the role of the corporate director and contribution to the Board **CQC 8** - The Trust should introduce and effectively monitor 360 degree feedback for all senior managers and directors	**Complete**	**Assurance Received**

Detail

360 degree appraisals were undertaken in 2016 for three Non-Executive Directors (Caroline Maley, Maura Teager and Jim Dixon) and the Acting CEO. The Council of Governors Nominations and Remunerations Committee agreed the paperwork and framework for this process and reviewed the outcome of the appraisals, which were in turn reported to the full Council of Governors.

The Board Development programme was approved at the Trust Board in March 2016, which included a balance of operational and strategic items relating to board member development. This has been successfully implemented during 2016/17.

A revised process for 360 degree appraisals was agreed at the December 2016 Remuneration and Appointments Committee meeting. 360 degree appraisals were undertaken for all Executive Directors during March and early April 2017. The Chief Executive's 360 appraisal took place on 18 April 2017. Objectives have been set for each Director as part of this process and a process of regular 1:1 sessions is undertaken on an ongoing basis.

Themes arising from the Executive Director appraisals will be outlined in a summary report to the Committee in May 2017.

Non-Executive appraisals are to be completed on a rolling basis, aligned to terms of service start dates, and will be reviewed by the Governors Nominations and Remunerations Committee.

Evidence

6.3 360 feedback paperwork as approved by the Committee in December 2016

Derbyshire Healthcare NHS Foundation Trust

On-going Monitoring Arrangements

- 360 feedback appraisals are to be repeated on an annual basis.
- 1:1 sessions will continue on an ongoing basis throughout the year for all Board members.

Executive Director Responsible	Director of Corporate Affairs	**Responsible Assurance Committee**	Remuneration and Appointments Committee

Derbyshire Healthcare NHS Foundation Trust

Blue Completion Form

Recommendation RR5: The Trust should ensure that training passports for directors reflect development required for their corporate roles	**Current BRAG Rating**	**Recommended BRAG Rating**
	Complete	**Assurance Received**

Detail

A report on Board member training was presented to the Remuneration and Appointments Committee in December 2016. This report provided assurance on recording on mandatory and CPD training processes. It was agreed that mandatory training reports would be received by the Committee on a quarterly basis.

An on-going review of Non-Executive Director mandatory training requirements is underway to ensure that training requirements are appropriate and this is being considered as part of the Trust-wide training framework, falling under the remit of the People and Culture Committee.

The Committee agreed at the January 2017 meeting that along with the assurances outlined in the December 2016 report relating to CPD and ongoing training and development for Board members, receipt of a satisfactory end of year mandatory training compliance report in April 2017 would meet the evidence requirements that actions were complete and embedded in an ongoing process.

Issues relating to non-compliance are taken forwards as part of line management arrangements.

Evidence

6.6 Report of training passport compliance for all Board members as at 5 April 2017

Report on mandatory training and CPD as presented to the Committee meeting in December 2016

On-going Monitoring Arrangements

Six monthly reporting to the Remuneration and Appointments Committee on mandatory training compliance

Review of training and development as standard part of 1:1 line management conversations and appraisal reviews

Executive Director Responsible	Acting Chief Executive / Chair	**Responsible Assurance Committee**	Remuneration and Appointments Committee

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 26 April 2017

Report from Council of Governors – 7 March 2017

The Council of Governors met on 7 March 2017 at the Ilkeston Resource Centre, Ilkeston Community Hospital. The meeting was chaired by Caroline Maley, Acting Trust Chair. Seventeen governors were in attendance. The Council of Governors discussed agenda items, including:

SELECTION OF QUALITY INDICATORS

According to the formal duty of the Council of Governors to take advice from external auditors to understand their choice of indicators and formally vote on the selection of indicators, Ian Barber from Grant Thornton, the Trust's external auditors attended the meeting for this item.

The indicators set by NHS Improvement include two categories, mandated indicators and local indicators. Following discussion Governors resolved to select the following indicators:

Mandated Indicators:

1. 100 % enhanced care programme approach patients receiving follow-up contact within seven days of discharge from hospital.
2. Minimising delayed transfers of care.

Local Indicator:

3. Patients who have had a review of their care plan in the last 12 months.

ACTING CHIEF EXECUTIVE'S REPORT

The report updated governors on the Policing and Crime Bill and the impact on Mental Health. Dr Anne Wright assured Governors that the Mental Health Act Committee will be considering the implications of the Bill for the Trust. The report also highlighted current areas of pressure within Clinical Services, particularly the Community Team capacity and associated waiting lists.

COLLABORATION WITH DCHS

Caroline Maley gave an overview of relevant developments to date, including the development of the Strategic Options Case (SOC) as presented to the Council of Governors to Board session on 27 October 2016. Governors' questions regarding the SOC had been discussed at the Council of Governors meeting on the 24 November 2016 and at the meeting of 19 January 2017 Governors received a summary document of the current status of the acquisition with clarity on roles and responsibilities in the transaction process.

The first meeting of the Joint Integration Programme Committee was highlighted to be scheduled for 8 March 2017, and it was noted that a procurement process had been followed to appoint consultants to support the transaction process. Individual work-streams including Governance, Workforce and Finance have begun to meet to set their programmes of work.

Ifti Majid explained that Governors will receive information from the Board in order to hold the Non-Executive Directors to account for the process and the transaction. The Board will work with Governors to ensure that they receive the right information in order to fulfil this role. Governors were updated on the proposed timeline for the transaction including development of the Outline Business Base and Full Business Case.

The Council of Governors agreed to hold Confidential Meetings on a bi-monthly basis to focus on acquisition issues.

STAFF ENGAGEMENT SURVEY 2016

Margaret Gildea, Non-Executive Director and Chair of the People and Culture Committee presented the summary results of the NHS Staff Survey 2016. Governors received details of the response rate, the overall engagement rating for staff, and areas where the Trust had responses that were significantly better and worse than previous surveys. It was highlighted that the Staff Engagement Group has been meeting to address the results of the survey with actions and progress overseen by the People and Culture Committee.

Governors were updated that areas for focus in 2017/18 had been agreed as the employee voice, tools for the job, leadership engagement and staffing/resources. The Council of Governors will continue to be updated on staff engagement throughout the year.

NON EXECUTIVE DIRECTOR UPDATE – PEOPLE AND CULTURE COMMITTEE

Margaret Gildea gave an update on her work as Chair of the People and Culture Committee, highlighting the focus of the Committee to include addressing issues as raised through the Staff Survey and on Recruitment and Retention to ensure appropriate resourcing for the Trust's services.

INTEGRATED PERFORMANCE REPORT

Mark Powell highlighted key areas contained in the report, which gave the Governors an overview of performance as at the end of January 2017 with regards to Workforce, Finance, Operational Delivery and Quality Improvement. Key themes identified to the Council of Governors were the pressures on services and mitigations and actions being put in place. The report illustrated a good performance against a number of indicators, acknowledging the areas where challenge remains. It was agreed that a Governor Development Session would be scheduled focusing on the Integrated Performance Report to provide useful reference and information to Governors regarding some of the challenges faced by the Trust.

ELECTION OF LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR

The Council of Governors resolved to accept the recommendation to appoint John Morrissey as Lead Governor and Carole Riley as Deputy Lead Governor for the remaining period of their Governor terms.

GOVERNANCE COMMITTEE REPORT

The Governance Committee reported on its activities and discussions from the meeting held on 15 February 2017, which was chaired by Carole Riley.

GOVERNANCE IMPROVEMENT ACTION PLAN

Samantha Harrison presented an update on the delivery of the Governance Improvement Action Plan and Governors were assured on the process being followed by the Board on oversight of completion and embeddedness of recommendations. Governors were informed that good progress continues to be made. An update was given on the current external assurance process underway by Deloitte LLP, whose work includes a focus group of Governors to input to the review and give views of what has changed within the Trust as the result of implementation of the GIAP.

ANY OTHER BUSINESS

The Board and Council of Governors thanked Maura Teager for her seven years of dedicated and loyal service to the Trust as a Non-Executive Director.

RECOMMENDATION

The Board of Directors is requested to note and receive assurance on the breadth of key topics presented to and discussed by the Council of Governors.

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

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 26 April 2017

Board Assurance Framework (BAF)
- **Final issue for 2016/17**
- **First issue for 2017/18**

Purpose of Report: To meet the requirement for Boards to produce an Assurance Framework. This report details the final issue of the BAF for 2016/17 and the first issue of the 2017/18 BAF.

Executive Summary

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 final formal presentation of the Board Assurance Framework to Board for 2016/17 and the first issue of the BAF for 2017/18.

Final issue of 2016/17 Board Assurance Framework

- Since Issue 4 of the BAF for 2016/17 was reviewed by the Board in Feb 2017, the risk rating of three risks has been further reduced.
  - Risk 1e) 'Lack of compliance with the Civil Contingencies Act as a category 2 responder. Risk identified through 2016/17 EPRR Assurance Process' has reduced from high to moderate due to mitigation in place and CCG formal notification of compliance
  - Risk 3b) 'Risk of a loss of confidence by staff in the leadership of the organisation at all levels' has reduced from high to moderate due to stability in senior leadership team and increased confidence of regulators, and
  - Risk 4a) 'Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation' has reduced from high to moderate due to confidence in year-end financial forecast.
- As a result, at year end five risks remain graded as high risk and five as moderate risk to the achievement of the Trust's strategic objectives.
- All 'deep dives' to the relevant responsible Board Committee have been completed in year as planned.

First issue of 2017/18 Board Assurance Framework

- At the Board Development session on 8 February 2017, Board members identified the significant risks for 2017/18 which were then reviewed and the BAF populated by Executive Directors
- Eleven risks have been identified for 2017/18. Three are currently graded as extreme, six as high, and two as moderate.
- Following feedback from Board Committees and KMPG, the BAF for 2017/18 has been significantly amended in terms of both format and content.

- The risks in this first issue 2017/18 have been scrutinised by the Executive Leadership Team and Audit and Risk Committee. As a result further changes have been made.

KPMG Board Assurance Framework and Risk Management audit
The report provided an assurance rating of *significant assurance with minor improvement opportunities* and concluded that the Trust has embedded risk management arrangements throughout the organisation and has a 'live' BAF which is fit for purpose.

The Board will continue to receive the BAF four times during the year, in line with NHS Improvements governance guidance

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

Consultation

Board members through Board Development session 8 February 2017
Individual Executive Directors – during February 2017
Executive Leadership Team - 6 March 2017
Audit and Risk Committee - 14 March 2017

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

Equality Delivery System

There are none

Recommendations

The Board of Directors are requested to:

1) Approve the final issue of the BAF for 2016/17
2) Approve the content of this first issue of the BAF for 2017/18, including the revised format and additional fields
3) Approve ongoing reporting and monitoring arrangements as outlined

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

Report prepared by: **Rachel Kempster, Risk and Assurance Manager**

Board Assurance Framework (BAF) update for 2016/17 (final issue) and 2017/18 (first issue)

1) Final Issue for 2017/17

1a) Overview

Since Issue 4 of the BAF for 2016/17 was reviewed by the Board in Feb 2017, no new risks have been added or removed. However, the risk rating of three risks has been reduced.

BAF ID	Risk title	Executive Director Lead	Current risk rating	Prev risk rating	Rationale
1e	Lack of compliance with the Civil Contingencies Act as a category 2 responder. Risk identified through 2016/17 EPRR Assurance Process	Acting Chief Operating Officer	**MOD**	**HIGH**	Impact reduced from 5 to 3 due to mitigation in place and CCG formal notification of compliance
3b	Risk of a loss of confidence by staff in the leadership of the organisation at all levels	Director of People and Organisational Effectiveness	**MOD**	**HIGH**	Impact reduced from 5 to 4 due to stability in senior leadership team and increased confidence of regulators
4a	Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation	Director of Finance	**MOD**	**HIGH**	Likelihood reduced from 3 to 2 due to confidence in year-end financial forecast

At year end five risks remain graded as high risk to the achievement of the Trust's strategic objectives and five as moderate risk.

Changes since Issue 4 are highlighted in blue text in the detailed spreadsheet attached.

1b) 2016/17 BAF Summary

A summary of all risks currently identified in the 2016/17 BAF at year end is shown below together with the risk rating identified at the outset of the year or when the risk was added to the BAF

BAF ID	Risk title	Director Lead	Risk rating at outset of year	Risk rating
1a	Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff	Director of Nursing and Patient Experience	**MODERATE**	**HIGH**
1b	There is a risk that the Trust does not operate inclusivity and may be unable to deliver equity of outcomes for staff and service users.	Director of People and Organisational Effectiveness	**HIGH New risk from Nov16**	**MODERATE**
1c	Risk to delivery of safe, effective and person centred care due to the Trust being unable to source sufficient permanent and temporary clinical staff	Director of People and Organisational Effectiveness	**HIGH New risk from Nov16**	**HIGH**
1d	The Trust does not fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA) which has resulted in a 'requires improvement' action from the CQC and an impact on person centred care.	Medical Director	**HIGH New risk from Feb 17**	**HIGH**
1e	Lack of compliance with the Civil Contingencies Act as a category 2 responder. Risk identified through 2016/17 EPRR Assurance Process	Acting Chief Operating Officer	**HIGH New risk from Feb 17**	**MODERATE**
2a	Risk to delivery of national and local system wide change. If not delivered this could cause the Trust's financial position to deteriorate resulting in regulatory action	Interim Director of Strategic Development	**HIGH**	**HIGH**
3a	There is a risk that the NHSI enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work.	Acting Chief Executive	**HIGH**	**MODERATE**
3b	Risk of a loss of confidence by staff in the leadership of the organisation at all levels	Director of People and Organisational Effectiveness	**HIGH**	**MODERATE**
3c	There is a risk that turnover of the Board members could adversely affect delivery of the organisational strategy due to loss of specialist organisational knowledge, capacity and stability	Director of Corporate Affairs and Trust Secretary	**MODERATE New risk from Nov16**	**Risk removed Feb 17**
4a	Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation	Director of Finance	**HIGH**	**MODERATE**
4b	Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk	Interim Director of Strategic Development	**HIGH**	**HIGH**

1c) Deep dives

Deep dives are fully embedded in the BAF process to enable review and challenge of the controls and assurances associated with each risk and are undertaken by the lead responsible Board Committee for each risk.

The programme for deep dives for 2016/17 has been completed as planned.

BAF ID	Subject of risk	Director Lead	Dates completed
1a	Clinical Quality	Carolyn Green	December 2016 Audit and Risk Committee
1b	Equality	Amanda Rawlings	February 2017 People and Culture Committee
1c	Clinical workforce	Amanda Rawlings	March 2017 Audit and Risk Committee
1d	Compliance with MHA/MCA	Dr John Sykes	March 2017 Audit and Risk Committee
1e	EPRR compliance	Mark Powell	March 2017 Quality Committee
2a	System change	Lynn Wilmott-Shepherd	March 2017 Audit and Risk Committee
3a	Regulatory compliance	Ifti Majid	January 2017 Audit and Risk Committee
3b	Loss of confidence in leadership	Amanda Rawlings	January 2017 Audit and Risk Committee
4a	Financial plan	Claire Wright	October 2016 Audit and Risk Committee
4b	Transformation	Lynn Wilmott-Shepherd (completed by Mark Powell)	July 2016 Audit and Risk Committee

2) First issue for 2017/18

A Board Development session, facilitated by KMPG was undertaken on 8 February 2017. The session enabled board members to identify the most significant risks for 2017/18 and these were considered and reviewed alongside the four strategic objectives for the Trust.
Following this session and in year feedback from Board Committees, the BAF for 17/18 has been significantly amended in both format and content. The main changes are:

- A significant change to the format of the BAF from a tabular format in an Excel spreadsheet to a linear format in Word. This change has enabled additional fields to be included and improved the readability of the document.
- Additional fields included for 2017/18 are:

    - Risk detailed by both impact and root causes
    - Inherent risk rating
    - Target risk rating
    - Risk appetite
    - Controls identified as to if they are: preventive, detective, directive or corrective, so as to enable easier identification of gaps in controls
    - Direct read across from gaps in controls and gaps in assurance to actions identified to close gaps
    - Risk to delivery of action
    - Acton owners

2017/18 Summary BAF risks

BAF ID	Risk title	Director Lead	Risk rating (Lxl)
1a	Failure to achieve clinical quality safety standards required by our regulators	Director of Nursing and Patient Experience	HIGH (4x4)
1b	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients	Director of Nursing and Patient Experience	HIGH (4x4)
1c	Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)
1d	Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident	Acting Chief Operating Officer	MODERATE (3x3)
2a	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME (4x5)
3a	Ability to attract and retain high quality clinical staff across all professions	Director of People and Organisational Effectiveness	HIGH (4x5)
3b	There is a risk to staff engagement and wellbeing by the Trust not having supportive and engaging leaders	Director of People and Organisational Effectiveness	HIGH (4x4)
3c	There is a risk that the Trust will continue to be subject to NHSI enforcement action and CQC requirement/warning notices	Acting Chief Executive	MODERATE (3x4)
4a	Failure to deliver financial plans	Director of Finance	EXTREME (4x5)
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	EXTREME (4x5)
4c	That the process leading to acquisition of DHCFT by DCHS may have a detrimental impact on the Trust's ability to manage day to day performance due to increased capacity demands on senior leaders and directors	Acting Chief Executive	HIGH (4x4)

The risks have been mapped against the 2016/17 BAF risks to ensure all key areas have been included going forward.

3) KMPG Board Assurance Framework and Risk Management Audit

During January and February 2017 KPMG undertook an audit to review the processes for managing risk, reviewing the BAF and completing 'deep dive' reviews on the risk register which underpin the BAF.

The report provided an assurance rating of *significant assurance with minor improvement opportunities* and concluded the Trust has embedded risk management arrangements throughout the organisation, with Datix used effectively to manage risks and incidents. In addition the report identified that the BAF is reviewed regularly by the Board and relevant Board Committees and is used as a live document. Four recommendations were identified, one moderate risk and three low risks. These were in relation to: timely review of risks overdue; understanding of some terminology in the BAF; ensuring all risks have identified controls; and providing training for risk handlers. All have been accepted and actions are in progress.

Summary of Board Assurance Framework Risks 2017/18. Issue 1.

Ref	Principal risk	Director Lead	Current rating
Strategic Outcome 1. We will deliver quality in everything we do providing safe, effective and person centred care			
1a	Failure to achieve clinical quality safety standards required by our regulators	Executive Director of Nursing and Patient Experience	HIGH
1b	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients	Executive Director of Nursing and Patient Experience	HIGH
1c	Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)	Medical Director	HIGH
1d	Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident	Acting Chief Operating Officer	MODERATE
Strategic Outcome 2: We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time			
2a	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME
Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff			
3a	Ability to attract and retain high quality clinical staff across all professions	Interim Director of People and Organisational Effectiveness	HIGH
3b	There is a risk to staff engagement and wellbeing by the trust not having supportive and engaging leaders	Interim Director of People and Organisational Effectiveness	HIGH
3c	There is a risk that the Trust will continue to be subject to NHSI enforcement action and CQC requirement/warning notices	Acting Chief Executive	MODERATE
3d	There is a risk that the Trust does not operate inclusively and may be unable to deliver equity of outcomes for staff and service users	Interim Director of People and Organisational Effectiveness	MODERATE
Strategic Outcome 4. We will transform services to achieve long-term financial sustainability			
4a	Failure to deliver financial plans	Executive Director of Finance	EXTREME
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	EXTREME
4c	That the process leading to acquisition of DHCFT by DCHS may have a detrimental impact on the Trust's ability to manage day to day performance due to increased capacity demands on senior leaders and directors	Acting Chief Executive	HIGH

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

Principal risk:

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

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

Root causes:

a) Financial settlement in contracts chronically underfunded
b) Workforce supply
c) Substantial increase in clinical demand
d) Increasing service user and family expectations of service
e) Changing demographics of population
f) Stability of clinical leadership at all levels

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

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

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Quality governance structures and processes to identify quality related issues; Implementation of Safe Wards programme; Induction and mandatory training; 'Duty of Candour' processes Detective – Quality dashboard reporting; Quality visit programme; Incident, complaints and risk investigation and learning - including monitoring actions plans; Annual Training Needs Analysis;	Quality dashboard Clinical analysis and triangulation from across governance reports leading to actions to rectify clinical practice concerns through Patient Experience Reports to be followed by QUEST model reporting	National enquiry into suicide and homicide identifies rates lower than national average Safety Thermometer identifies positive position against national benchmark Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review identified 4 services

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Directive – Quality Framework (Strategy) outlining how quality is managed within the Trust Corrective – Board committee structures and processes ensuring escalation of quality issues; Annual skill mix review; CQC and GIAP action plans; Incident investigation and learning; Actions following clinical and compliance audits; Workforce issues escalation procedures.		rated as 'good' for safety 2016/17 BAF and Risk Register Review

Gaps in control:	Actions to close gaps in control:	Action due:	Progress on action:	Risk to delivery:
Ability to recruit and retain adequate numbers of staff to ensure safe practice	Workforce plan to be completed [ACTION OWNER DPOE] Develop and implement training plan to increase number of staff trained to deliver psychological therapy in the community. [ACTION OWNER DPOE/DON] Test model of Advanced Clinical Practitioner role in community setting to mitigate vacancies in psychiatry. [ACTION OWNER DON]	31/12/2017		HIGH
Commissioner commitment to invest in mental health and children's services	Commissioner lobbying and provision of evidence to support need to increase funding or to provide an alternative strategic plan [ACTION OWNER DON]	30/06/2017		HIGH
Stable clinical workforce in neighbourhood, children's services, crisis services, psychology and forensic services and model	Clinical and operational leadership to develop an improvement plan [ACTION OWNER DPOE/DON]	30/04/2017		HIGH
Seclusion room at Kedleston Unit not fit for purpose	Rebuild underway to meet standards required [ACTION OWNER DOF]	31/05/2017		LOW
Staff competence and knowledge in suicide prevention	Suicide reduction strategy in place and roll out of patient safety planning to be completed [ACTION OWNER DON]	31/03/2018		MEDIUM
Early warning signs of service failure and independent service modelling	Plans in place to implement QUEST from 1/5/17. Explore and commission remodelling exercise of community mental health services and inpatient beds [ACTION OWNER DON]	31/05/2017		MEDIUM
Non commissioned services for Derbyshire	Improvement plan with commissioners in place	30/06/2017		MEDIUM

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based PICU beds and a secure and effective forensic pathway, and CAMHS Tier 4 beds	[ACTION OWNER DON]			
Embedded security and safeguarding culture	Complete security action plan and ongoing investigations [ACTION OWNER DON]	30/06/2017		LOW
Compliance with medicines management code, including storage compliance	Improvement plan in place to deliver [ACTION OWNER DON]	30/06/2017		MEDIUM
Lack of effective forensic clinical service pathway following prison release	Interagency solutions being sought, including proposal for commissioner solutions including benchmarking and mitigation plans	31/08/2017		HIGH
Gaps in assurances:	Actions to close gaps in assurances:	Action: due	Progress on action:	Risk to delivery.
CQC comprehensive review identified 6 services as 'requires improvement' for safety	Fully implement CQC actions plan, with subsequent plan to raise all services identified as requires improvement to a rating of good [ACTION OWNER DON]	31/03/2018		MEDIUM
Effective plan to ensure ability to achieve quality priorities, CQUIN and Non CQUIN targets	Implement CQC action plan. Identify ring fenced resources to ensure implementation of required targets.[ACTION OWNER DOF/ DON] Implement CQUIN improvement plan including 'Sign up to Safety'. Each integrated quality leadership team to complete one quality improvement project of their design [ACTION OWNER DON]	31/04/2017 31/03/2018		HIGH

Related operational high/extreme risks:

3385	Neighbourhood Services - City	Clinical risk - Other	Waiting Times for Psychological Assessment and Intervention
3386	Campus - Radbourne Unit	Clinical - Staffing levels	Vacancies, reduced leadership, capacity for succession planning
3410	Campus - Radbourne Unit	Clinical - Staffing levels	Vacancy levels above 30%
20857	Neighbourhood Services - North	Clinical risk - Other	Transfer of patients through the change in neighbourhood boundaries
20867	Learning Disabilities Services	Clinical - Therapeutic activity	Lengthy waiting times for psychological involvement
20908	Substance Misuse Services	Clinical risk - Other	Communication of information regarding patients on discharge from Royal Derby Hospital
20928	Neighbourhood Services - North	Clinical - Staffing levels	Long waiting times for MAS Diagnosis
20988	Neighbourhood Services - City	Clinical - Staffing levels	Not enough nurses to manage the initial assessments, waiting list for community intervention and to cover long term sickness
21013	Campus - Radbourne Unit	H&S - Violence and Aggression	Sec 136 suite

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	20120	Children in Care	Clinical - Staffing levels	Staffing Levels
	21031	Neighbourhood Services - City	Clinical risk - Other	Non-Adherence to Waiting List Management Policy and Procedure
	21044	Neighbourhood Services - North	Clinical - Staffing levels	Reduction in medical support
	21049	Campus - Radbourne Unit	Clinical risk - Other	Limited access to safe and secure transport
	21050	Neighbourhood Services - North	Clinical - Staffing levels	Low staffing levels
	21055	Neighbourhood Services	Operational risk - Other	Waiting for care coordination
	21070	Neighbourhood Services - North	Clinical - Staffing levels	Extreme Pressures in team

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

Principal risk:

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

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

Root causes:

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

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

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

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Quality governance structures and processes in to manage quality related issues; engagement with clinical audit and research programmes Detective – Quality visit programme; HoNoS clustering; CAMHS IAPT measures; use of EPR to identify gaps in effectiveness through compliance checks Directive – Quality Framework (Strategy) outlining how quality is managed within the trust,	Clinical Audit Programme and action plans where gaps identified	National Community Patient Survey results (above average results) National Inpatient survey (above average results) CQC comprehensive inspection identified 8 services as 'good' and 2 as 'outstanding' for caring and 3 services 'good' for effectiveness Mental Health Benchmarking Scorecard from NHS England identifies the Trust as 12/58 on effectiveness

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Agreed clinical policies and standards, available to all staff via Connect. Corrective – Board committee structures and processes ensuring escalation of quality issues;		

Gaps in control:	Actions to close gaps in control:	Action due:	Progress on action:	Risk to delivery:
Clinical buy in to review of NICE guidelines	Implement NICE improvement action plan including review of resources required to support [ACTION OWNER DON]	30/06/2017		HIGH
Embeddedness of integrated clinical/leadership teams	CPD support plan for Chairs of integrated quality meetings [ACTION OWNER DON]	30/06/2017		HIGH
Embedded personalised care planning, physical health cheeks and clinical standards	Implement CQC action plan around care planning [ACTION OWNER DON]	30/06/2017		HIGH
Demands of the Derbyshire population out strips capacity in particular community teams paediatrics, psychological therapies and fast track PREVENT referrals.	Gap analysis and training needs analysis with investment plan to increase psychological therapies in neighbourhoods [ACTION OWNER DON/COO]	31/08/2017		HIGH
Learning from Serious Case and Homicide Reviews	Review of CPA policy. Review adequacy of family support services through triangle of care implementation plan [ACTION OWNER DON]	30/09/2017		MEDIUM
Effective patient reported outcome measures which actively involves service users	Implementation plan for roll out of ReQoL and Patient Activation Measure (PAM) [ACTION OWNER DON]	31/10/2017		MEDIUM
Potential lack of formal patient and public involvement following external tender process	New provider identified, DON meeting to provide support through transition [ACTION OWNER DON]	31/07/2017		MEDIUM
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action: due**	**Progress on action:**	**Risk to delivery.**
CQC inspection comprehensive review identified 9 services as requiring improvement for effectiveness	Fully implement CQC actions plan, with subsequent plan to raise all services identified as requires improvement to a rating of good [ACTION OWNER DON]	31/08/2017		HIGH

Related operational high/extreme risks:

3260	Neighbourhood Services	Commissioning Risk	Lack of ADHD service for adults
3314	Neighbourhood Services - City	Commissioning Risk	Lack of pathway for patients discharged from prisons
20819	Neighbourhood Services - City	Operational - Business Continuity	Waiting lists for assessment and interventions
21071	IM & T	Operational risk - Other	SystmOne prescribing: financial, governance, clinical and reputational risks

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21070	Neighbourhood Services - North	Clinical - Staffing levels	Extreme Pressures in team
21068	Pharmacy	Clinical - Medication/ Pharmaceutical	Medicines Management - providing effective care for patients

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

Principal risk:

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

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

Root causes:

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

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

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

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Comprehensive training plan supported by MCA Training Manual developed by trust clinicians; Increased general awareness of issues (inc. podcasts) amongst clinicians with multidisciplinary team approach; Enhanced junior doctor training; Single place created in PARIS to record MCA assessments Detective – Rolling compliance checks; Programme of quality improvement audits; Regular feedback on compliance to executive	Reporting of training compliance against plan to MHA Committee Range of compliance checks and audits agreed in MHA Committee forward plan and clinical audit programme	CQC note improvement with compliance with MCA with gaps remaining to close

directors via next in line managers; Improved monitoring and reporting processes for seclusion and long term segregation following revision of policy Directive – MHA and MCA policies and procedures; Lead director accountability and chain of accountability through to consultants senior nurse; Designated MCA medical lead Corrective – MHA Committee oversight of dynamic application of MHA/MCA		

Gaps in control:	Actions to close gaps in control:	Action due:	Progress on action:	Risk to delivery:
Electronic reminders to undertake assessments	Develop electronic reminders for capacity assessments and Best Interest assessments [ACTION OWNER MD]	30/06/2017		MODERATE
Appointment of Deputy Medical Director to lead on compliance reporting from clinical directors	Appointment of a Deputy Medical Director [ACTION OWNER MD]	30/04/2017		LOW
Consistent application of seclusion and segregation	Embed consistent application in clinical practice led by Chief Nurse [ACTION OWNER DON] Improve training for junior doctors regarding seclusion reviews [ACTION OWNER MD]	30/06/2017 30/06/2017		MODERATE
Delays by local authorities in undertaking DoLS assessments	Continue to monitor and report compliance to the MHA Committee including where escalation to local authorities where illegal detention is a risk [ACTION OWNER MD]	30/04/2017 and ongoing		LOW
Monitoring of application of MHA against equality standards	Year-end analysis to be completed and presented to MHA Committee May 2017 [ACTION OWNER MD]	31/05/2017		LOW
Staff competence and checking for compliance with CTO's, Best Interest Assessments and Capacity Assessments	Delivery of CQC action plan in relation to MHA/MCA actions [ACTION OWNER MD]	31/05/2017		MODERATE
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action: due**	**Progress on action:**	**Risk to delivery.**
Completion of all actions in relation to 2016/17 Section 132 Rights internal audit	Reporting functionality in PARIS to be developed [ACTION OWNER MD/COO]	31/05/2017		MODERATE

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Assurance of junior doctor supervision taking place, which includes focus on MHA/MCA compliance	Improving systems to consistently record supervision [ACTION OWNER MD]	30/06/2017		MODERATE
Related operational high/extreme risks: None specifically identified				

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

Principal risk:

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

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

Root causes:

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

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 3	Impact 5	Rating MOD	Likelihood 3	Impact 3	Direction 1st issue	Rating LOW	Likelihood 2	Impact 3	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – On-call training, table top major incident scenario exercises, fire training and drills, incident/near miss reporting and escalation, risk management processes. Range of defences against cyber-attack including: virus updates and patching of laptops and servers, prevention of use of unencrypted USB devices, email filtering , IT firewall and filters Detective – IT systems testing, incident response plan testing , IM&T Rigor meeting to test strength of protection	EPRR Annual Report to Trust Board and periodic reports to Quality Committee and Trust Management Team evidence the overall actual performance against national Core Standards for EPRR, rated against a compliance scale from non-compliant to fully compliant Includes several sections covering the efficacy of controls include: a) Leadership b) Business Impact Assessments c) Business Continuity Planning d) Incident Response Plan	CCG confirm and challenge process against all Core Standards – substantial compliance IT penetration test undertaken by CareCert 31/3/17 – 1/2/17. Final report produced 2/3/17 (undergoing accuracy checks within the Trust and GEM)

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Directive – Emergency Plan, Business Continuity Plan, Lockdown Policy, disconnection of IT devices not regularly connected to the network, Corrective – Use of extra training, further practice to aid understanding and confidence, GEM employment of security experts to review processes, plan to reduce time (from 90 to 45 days) before disconnection of IT devices not regularly connected to the network	e) Training needs and delivery	

Gaps in control:	Actions to close gaps in control:	Action due:	Progress on action:	Risk to delivery:
Not all staff who undertake management on-call duties have received approved training	Ensure there is sufficient training opportunities for both silver and gold command.[ACTION OWNER: COO] Training being delivered during March and further sessions will be provided before the end of June 2017	30/06/17		Low
As identified in CareCert 'Penetration Trust Report' 02/03/17	Complete actions identified in CareCert report. Action due date to be agreed in line with actions identified. .[ACTION OWNER: COO]	30/09/17		Low
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action: due**	**Progress on action:**	**Risk to delivery.**
4 Core standards remain amber, resulting in the Trust being graded as substantial compliance and not fully complaint	Deliver actions set out in Core Standards action plan and embed ongoing review process, via EPRR steering group, for all standards. [ACTION OWNER: COO] Progress reported to TMT and QC via EPRR reporting process	30/06/17		Low

Related operational high/extreme risks:

3386	Campus - Radbourne Unit	Clinical - Staffing levels	Vacancies, reduced leadership, capacity for succession planning

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

Principal risk:

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

Impact:

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

Root causes:

k) Financial constraints nationally and locally
l) Lack of confidence by Acute providers in the delivery of local STP outcomes
m) Lack of system wide leadership and 'grip'
n) Changing national directives
o) Regulatory bodies imposing different rules and boundaries

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

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

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative - Maintenance of strong relationships with commissioners; Full involvement with appropriate system wide groups; Maintenance of strong relationships with other providers; Service User engagement Detective - Scrutiny of national directives; Translation to local action i.e. are national directives being adhered to?	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	NHSE/I agreement of plans Minutes of CMB

Directive- National agreement of Derbyshire's STP; Reforming of structure for delivery of STP Corrective- Ongoing discussions with key stakeholders on proposed changes, progress, establishment of partnerships etc. ; Engagement and consultation with patients, carers, public and staff as appropriate	feedback and update them on progress Engagement with staff though managers, staff side, focus groups etc.	

Gaps in control:	Actions to close gaps in control:	Action due:	Progress on action:	Risk to delivery:
Unclear system wide governance to oversee the STP	Work with system leaders and other senior stakeholders to be integral in the design of a governance structure [ACTION OWNER DSD]	Ongoing. Review by 30/06/2017		High
Lack of clarity around collaboration and competition	Continue working with NHSI to gain clarity [ACTION OWNER DSD]	30/06/2017		Medium
Issues of communication owing to divergent messages between NHSE and NHSI	Communication between differing groups – replay the message [ACTION OWNER DSD]	30/06/2017		High
Lack of long term strategic partnerships to deliver quality, sustainable services	Aim to develop partnerships through collaborative working [ACTION OWNER DSD]	30/06/2017		Medium
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action: due**	**Progress on action:**	**Risk to delivery.**
Feedback from system wide groups	Maintenance of relationships and involvement in relevant groups [ACTION OWNER CO/DSD]	30/06/2017		Medium
The provision of reliable system wide information	Maintenance of relationships and involvement in relevant groups [ACTION OWNER CO/DSD]	30/06/2017		Medium
Clear and consistent feedback from NHSE and NHSI	Be consistent and clear on messages fed back [ACTION OWNER CO/DSD]	30/06/2017		High

Related operational high/extreme risks:

3260	Neighbourhood Services	Commissioning Risk	Lack of ADHD service for adults
3314	Neighbourhood Services - City	Commissioning Risk	Lack of pathway for patients discharged from prisons
3385	Neighbourhood Services - City	Clinical risk - Other	Waiting Times for Psychological Assessment and Intervention
20819	Neighbourhood Services - City	Operational - Business Continuity	Waiting lists for assessment and interventions

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20857	Neighbourhood Services - North	Clinical risk - Other	Transfer of patients through the change in neighbourhood boundaries	
20867	Learning Disabilities Services	Clinical - Therapeutic activity	Lengthy waiting times for psychological involvement	
20988	Neighbourhood Services - City	Clinical - Staffing levels	Not enough nurses to manage the initial assessments, waiting list for community intervention and to cover long term sicl	
21049	Campus - Radbourne Unit	Clinical risk - Other	Limited access to safe and secure transport	
21055	Neighbourhood Services	Operational risk - Other	Waiting for care coordination	
21070	Neighbourhood Services - North	Clinical - Staffing levels	Extreme Pressures in team	

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

Principal risk:

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

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

Root causes:

a) National shortage of key occupations
b) Future commissions of key posts insufficient for current and expected demand
c) Trust reputation as a place to work
d) Trust seen as small with limited development opportunities
e) Lack of a workforce plan and sufficient funding to accelerate the introduction of alternative workforce models
f) Organisational appetite to try and test alternative workforce models
g) Turnover of key personnel/professions

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

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

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Recruitment campaigns. Detective – Reflection and action taken following staff survey, Performance Reports, Quarterly Pulse Checks Directive – Executive led weekly meeting using collaborative approach to reduce recruitment	Recruitment tracker reporting to People and Culture Committee and Board Success reporting to from specific recruitment campaigns Financial impact tracking on agency spend through Board	HEEM (Health Education East Midlands) quality assurance visit, to test infrastructure and support mechanisms are sufficient for people in training [potential assurance] Staff survey results and Pulse Checks[potential assurance]

gaps Corrective – Additional capacity to lead recruitment campaigns. Focused recruitment campaigns i.e. India, and further afield.	Quarterly staff 'pulse checks'	

Gaps in control:	Actions to close gaps in control:	Action due:	Progress on action:	Risk to delivery:
Workforce plan to include alternative workforce models	Develop a precise workforce plan to include a bottom up workforce plan with owners of new roles that is costed with a timeline as to what the trust can afford to implement and by when [ACTION OWNER DPOE] In development. To be considered by People and Culture Committee March 2017	31/04/2017		Medium
Appeal of the trust as a place to work	Develop programme of incentives for key national occupational shortages [ACTION OWNER DPOE] Incentives scheme agreed by Executive Leadership Team	Roll out from April 2017		Medium
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action: due**	**Progress on action:**	**Risk to delivery.**
Funding and commitment to local STP (Sustainability and Transformation Plan) collaboration	To be undertaken in collaboration with the Local Workforce Advisory Board to support new models of care i.e. Place [ACTION OWNER DPOE]	30/06/2017		High

Related operational high/extreme risks:

3262	Community Paediatrics	Clinical - Staffing levels	Long waiting lists following reduction in staffing levels
3386	Campus - Radbourne Unit	Clinical - Staffing levels	Vacancies, reduced leadership, capacity for succession planning
3410	Campus - Radbourne Unit	Clinical - Staffing levels	Vacancy levels above 30%
20928	Neighbourhood Services - North	Clinical - Staffing levels	Long waiting times for MAS Diagnosis
20988	Neighbourhood Services - City	Clinical - Staffing levels	Not enough nurses to manage the initial assessments, waiting list for community intervention and to cover long term sickness

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20120	Children in Care	Clinical - Staffing levels	Staffing Levels
21050	Neighbourhood Services - North	Clinical - Staffing levels	low staffing levels
21070	Neighbourhood Services - North	Clinical - Staffing levels	Extreme Pressures in team

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

Principal risk:

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

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

Root causes:

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

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

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

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Spotlight on our Leaders events to engage leaders, Membership of East Midlands Leadership Academy offering leadership development menu Detective – Staff survey results year on year, quarterly pulse check quarterly, people metrics tracked monthly.	Quarterly Pulse check	

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Directive – Leadership development training supporting managers to implement policies Corrective – appraisal and supervision processes				
Gaps in control:	Actions to close gaps in control:	Action due:	Progress on action:	Risk to delivery:
Recruiting leaders for their leadership talents	Develop leadership recruitment process [ACTION OWNER DPOE]	30/06/2017		Medium
Clearly defined leadership expectations, monitored via appraisals and the detective tools	Develop a leadership expectation guide and leadership induction process [ACTION OWNER DPOE]	31/08/2017		Medium
Coaching/mentoring and development/improvement plans for leaders that need support.	Build infrastructure and menu of offer for leaders [ACTION OWNER DPOE]	30/09/2017		Medium
Gaps in assurances:	Actions to close gaps in assurances:	Action due:	Progress on action:	Risk to delivery.
Annual staff survey	Actions to be focused on: ensuring staff have 'tools to do the job', ensuring staff have a voice, staffing, leadership development [ACTION OWNER DPOE]	30/09/2017		Medium
Related operational high/extreme risks: None specifically although links to risks raised in relation to work related stress, workplace environments and staff.				

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

Principal risk:

Risk: **There is a risk that the Trust will continue to be subject to NHSI enforcement action and CQC requirement/warning notices**

Impact: If this risk is not reduced it could lead to ongoing negative media attention, a loss of public confidence in our services and in the Trust as a place to work.

Root causes:

a) Outcome of NHSI/CQC joint well led review following high profile employment tribunal outcome
b) Lack of embedded and mature governance systems and culture
c) CQC comprehensive inspection identifying areas for improvement and variable outcomes for services ranging from Excellent to Inadequate

BAF ref: **3c**	**Director Lead**: Ifti Majid, Acting Chief Executive	**Responsible Committee**: Audit and Risk Committee	Datix ID: 20834

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 3	Impact 5	Rating MOD	Likelihood 3	Impact 4	Direction 1st issue	Rating MOD	Likelihood 2	Impact 4	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Engagement and communication with workforce, ongoing engagement with regulators Detective – Action pipeline presented to ELT to identify risks to action closure Directive - Governance committees and structures, with clear responsibility to lead on specific GIAP actions, Governance processes to	Well led self-assessment Reporting through CQC portal providing live assurances against actual performance. Scrutiny by Board of 'blue forms' detailing assurances on completed GIAP actions. Media monitoring report provided monthly to Board	NHSI agreement of governance improvement action plan DHCFT Quality Summit, +ve feedback Deloitte and CQC reports 2016/17 External Deloitte Governance and improvement action plan review /well led review (planned)

deliver the governance improvement action plan including reporting to ELT and monthly reporting to Board, 'Blue Form' final sign off of GIAP actions to Board Corrective – People and Culture Committee, with clear responsibility to lead on specific GIAP actions, including full review of progress Nov 16, Formal reporting to regulators on a monthly basis, CQC assurance reporting to the Quality Committee,		2016/17 CQC action plan (completed, awaiting final report) 2016/17 Compliance with HR policies and procedures (completed, medium risk) 2016/17 BAF and Risk Management (completed, significant assurance with minor improvements required)

Gaps in control:	Actions to close gaps in control:	Action due:	Progress on action:	Risk to delivery:
Identified in the governance improvement action plan.	Implement actions from Governance Improvement Action Plan [ACTION OWNER CEO]	31/05/2017	Number of 'off track actions' significantly reduced. Last planned 'blue form' to Board due May 2017	Medium
Identified in the CQC comprehensive reports and the separate warning notice received from the CQC	190 actions detailed in the CQC action plan hosted on the CQC portal [ACTION OWNER DON]	31/05/17	As of April 17, 109 actions have been completed, 76 are in progress and on target, and there are concerns for 5	Medium
Deloitte well led report, CQC reports, Yates report	As above. Also, NHSI to undertake licence review Q4 16/17 [ACTION OWNER CEO]	30/06/2017	Working with Deloitte and NHSI on revised plan for further review. Expected Q1 17/18	Medium
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action: due**	**Progress on action:**	**Risk to delivery.**
Initial outcomes from Deloitte and CQC reviews	Agree framework with Deloitte over remaining quarters of the year to undertake a full well led review [ACTION OWNER CEO]	31/03/2017	The GIAP and CQC Improvement plans have not yet fully delivered and hence we are not ready to have external assurance from Deloitte/CQC that gaps have been closed. Planned for Q4 16/17 and now underway.	Low
Fully delivered GIAP and CQC improvement plans	Fully deliver GIAP and CQC improvement plans [ACTION OWNER CEO]	31/05/2017	Ongoing improvement work detailed earlier in risk, monitored on a monthly basis by Board Committees, Board and externally by the PRM process with	Medium

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			NHSI/CQC. Last 'blue form' on GIAP action planned for May 2017. CQC feedback re warning notice planned end Jan/Feb 17. Ratings reviewed by CQC for service areas rated as inadequate. Have improved.	
Fully delivered GIAP and CQC improvement plans	Internal audits to be undertaken on key areas identified in the governance improvement action plan, i.e. compliance with policies and procedures [ACTION OWNER CEO]	Completed		Completed
Related operational high/extreme risks: None specifically identified				

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

Principal risk:

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

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

Root causes:

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

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating MOD	Likelihood 4	Impact 2	Direction 1st issue	Rating Low	Likelihood 3	Impact 2	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Reporting of approach and progress reported to Board and the People and Culture Committee Detective –Urgent non-compliance addressed and reported to the People and Culture Committee Directive – Full time expertise in post, Launch of a new Equalities Forum,	Self-assessment grading based on equality evidence	Self-assessment grading validated by external stakeholders including HealthWatch (Derby)

Gaps in control:	Actions to close gaps in control:	Action due:	Progress on action:	Risk to delivery:
Delivered equality strategic action plan	Reporting on progress to Equalities Forum, Quality Committee, and People and Culture Committee	31/03/2017	Reporting identifies progress, all objectives on target to achieve amber rating by Q3	Medium

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	[ACTION OWNER: DPOE]		17/18	
Evidence of managers supporting staff to work in culturally ways	Delivering equality training. Undertake EDS assessment of services. [ACTION OWNER: DPOE]	Commencing June 2017	Equality training commenced through induction and EIRA training. Plan to deliver managing inclusion workshop. Board Development session planned for April 2017.	Low
Improve recording of service user protected characteristics on clinical systems	Deputy Director of Operations, Chief Nurse, General Manager IM&T and Assistant Director of Engagement and Inclusion to improve data capture though training, improvement of IT systems and performance management [ACTION OWNER: COO|DON|DPOE]	30/09/2017	Plan to be tables at equalities Forum April 2017	Medium
Consistent identification of equality related impact in papers presented to Board and Board level committee papers	Evidence of EIRA compliance across selection of Board and Board level committee papers [ACTION OWNER: DPOE]	30/09/2017	Completion audit of EIRA compliance and reporting progress to Quality Committee	Low
Gaps in assurances:	Actions to close gaps in assurances:	Action due:	Progress on action:	Risk to delivery.
Implementation plan for undertaking EDS2 national performance framework	Plan against EDS2 national performance framework to be developed and implemented [ACTION OWNER: DPOE]	30/09/2017	Plan to be presented to People and Culture Committee and Board April 2017	Low
Related operational high/extreme risks: None specifically identified				

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

Principal risk:

Risk: **Failure to deliver financial plans**

Impact: Trust becomes financially unsustainable.

Root causes:

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

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

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

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Budget training, segregation of duties, contract with commissioners to reach mutual agreement on QIPP disinvestment Detective –Scrutiny of financial delivery, bank reconciliations, scrutiny of CIP delivery Directive – Standing financial instructions, budget control, delegated limits, non-PO no pay rules, agency staff approval controls, approval to appoint process, business case approval process (e.g. back office), CIP targets issued Corrective – corrective management action, use of contingency reserve, disaster recovery plan	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: f) CIP delivery achievement g) Agency expenditure h) Balance sheet cash value The Integrated Performance Report evidences delivery of services, workforce information, quality information set against the financial performance evidencing whether we deliver services within our resources Service Line Reporting define financial	Internal Audits– low risk findings on 2016/17 Key Financial Systems - data analysis External Audits – strong record of high quality statutory reporting (gap: VFM impact) Grant Thornton shows good benchmarking for key financial metrics (gap: liquidity) NHSI Use of Resources Metrics – shows good performance (gap: agency metric) National Fraud Initiative – no areas of concern Local Counterfraud work – no significant concerns

implementation	performance for each service line.			
Gaps in control:	**Actions to close gaps in control:**	**Action due:**	**Progress on action:**	**Risk to delivery:**
The current agency approval controls are failing to reduce agency expenditure – we continue to pay in excess of capped rates for come roles. Also the volume of agency usage is increasing because we have not yet succeeded in improving recruitment and retention	Executives continue to have weekly meetings.[ACTION OWNER: COO] Implement a collective approach to holding the line on paying cap rates only for medical staff is being explored aim to be introduced [ACTION OWNER: MD] AIM: achieve £250k per month agency spend (or less)	30/09/2017	This is not yet improving. This gap may not fully close: The ability to exert maximum control on agency is undermined by the override of patient safety and delivery of services. Until recruitment to substantive roles is more successful the Trust will continue to choose to engage agency staff rather than deliver unsafe services	High
The CIP targets that have been issued do not yet have approved plans for the total CIP requirement and they have not yet been quality impact assessed	Increased CIP meetings and project scrutiny, management action via TMT {ACTION OWNER – COO] AIM: full CIP programme, quality assured	30/04/2017	CIP progress reported each F&P and Board meeting	Medium
Commissioners appear to not be following the 'QIPP' approach that was agreed as part of contract sign off	Continued negotiation, potential future need to resort to arbitration/mediation [ACTION OWNER DSD] AIM: agreed plan showing income reduction is matched by cost reduction	30/04/2017	Negotiations and weekly meetings	Medium
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action: due**	**Progress on action:**	**Risk to delivery.**
Agency costs exceed NHSI ceiling by >50% and generate 'use of resources' agency score of 4.	Weekly agency meetings to reduce costs. Implementation of recruitment drive and incentives AIM: To have a UoR agency score of 2 or 3 for agency as a minimum)[ACTION OWNER: COO]	30/09/2016	Evidence reported to F&P, Board and People and Culture committee evidences no improvement in performance	High
Liquidity is below peer levels	Continued strategic objective to increase cash through retention of disposals and limiting capex programme. AIM: Reach a 'sufficient' cash balance of £18m [ACTION OWNER DOF]	31/03/2018	Improving quarter on quarter cash balance	Low
Adverse VFM opinion from External Auditors for 15/16 and 16/17 accounts	Complete CQC action plan and governance improvement plan AIM 1: Trust released from NHSI licence conditions and	Aim 1: 30/09/2016 for licence and segment	Improving performance. Strong pipeline of delivery against GIAP AND CQC requirements. Positive discussions with NHSI and CQC on	Low

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	rated as segment 1 or 2. [ACTION OWNER: DCA&TS] AIM 2: Clean VFM opinion for 17/18 accounts [ACTION OWNER: DCA&TS]	Aim 2: 31/03/2018 for updated audit opinion	satisfaction with progress	
Related operational high/extreme risks: None specifically identified				

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

Principal risk:

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

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

Root causes:

a) Lack of capacity within Transformational Team
b) Lack of capacity in the Business Development Team to support managers
c) Capacity and capability of managers to deliver change programmes
d) Lack of staff, vacant posts and lack of investment
e) Impact of CIP

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

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

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative - Robust project assurance process; Regular reporting to F&P showing progress on internal transformation linked to system change; Maintenance of strong links to system wide change including STP, Commissioners and other partners; Full involvement with appropriate system wide groups which translate to internal changes; Maintenance of strong relationships with other providers; Service User engagement Detective -5 year Trust wide strategy; Performance management of annual business plans; Scrutiny on the performance of national	Reports to Board regarding any system wide changes or risks which may impact on internal transformation Regular feedback to F&P showing progress on internal transformation linked to system change Updates and feedback at TMT and ELT on progress on internal transformation linked to system change together with 'barriers' to change Engagement with Governors in order to update	Reporting to NHSI Updates to CMDG/CMB

'must do's' Directive - Clear alignment of internal transformational plans to the Derbyshire's STP; Clear alignment to CIP i.e. transform to improve quality and reduce costs Corrective - Ongoing discussions on transformational change with key managers; Ongoing discussions transformational change with key stakeholders; Engagement and consultation with patients, public and staff as appropriate	them and gain feedback Engagement with staff though managers, staff side, focus groups etc.	

Gaps in control:	Actions to close gaps in control:	Action due:	Progress on action:	Risk to delivery:
No clear links to external transformation	Be proactive in STP programme [ACTION OWNER DSD]	June 2017		Medium
Managers and clinicians not actively involved	Review new accountability framework and TMT as a way of ensuring transformational change is viewed as an imperative [ACTION OWNER DSD]	June 2017		Medium
'Must do's' are not being met or have slipped when previously being met.	Performance management via TMT, CMDG and CMB [ACTION OWNER DSD]	June 2017		High
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action: due**	**Progress on action:**	**Risk to delivery.**
Evidence of real change	Implementation of PDSA cycles and rapid improvement [ACTION OWNER DSD]	June 2017		Medium
Feedback from project groups	Clear project management structures [ACTION OWNER DSD]	Ongoing. Review by 30/06/2017		Medium

Related operational high/extreme risks:

21031	Neighbourhood Services - City	Clinical risk - Other	Non-Adherence to Waiting List Management Policy and Procedure

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

Principal risk:

Risk: **That the process leading to acquisition of DHCFT by DCHS may have a detrimental impact on the Trusts ability to manage day to day performance due to increased capacity demands on senior leaders and directors.**

Impact: This may lead to a breach of the Trusts regulatory/contractual obligations (quality, operational and financial performance) and/or a failure to provide sound internal due diligence on the benefits, process and outcomes associated with the acquisition.

Root causes:

a) Unclear programme governance structure
b) Unrealistic timeline
c) Insufficient defined capacity to deliver demands of acquisition and maintain business as usual controls
d) Staff Anxiety around the impact and associated processes of the acquisition leading to distraction, reduced performance and potentially staff leaving Organisation
e) Stakeholder and regulator nervousness and interpretation of causes/requirements about the acquisition process and potential outcome
f) Costs of transaction become unaffordable

BAF ref: **4c**	**Director Lead** Ifti Majid, Acting Chief Executive	**Responsible Committee**: Audit and Risk Committee	Datix ID: xx

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

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Engagement of specialist advisors with significant experience of supporting m&a, strong relationship with regional regulators, agreed governance structure in place and regularly reviewed. Staff receive supervision that gives early warning of dissatisfaction/anxiety Detective – programme risk register to identify and mitigate risks. Programme performance reporting to Joint Integration Committee giving	Monthly Integrated Performance report to Board providing early indication of service performance variation 'Deep dives' to Board based on performance concerns Quarterly 'pulse check' survey of staff Joint Integration Programme Committee	External due diligence process (planned) PRM feedback letters CQC revisit reports for Older adult services and low secure services

early risk identification. Datix system giving early warning of risks associated with decreased performance. Analysis of compliments and complaints through reporting to quality committee as early warning Directive – Agreed Strategic Options Case (SOC) agreed across both Boards and Council of Governors (CoG's) approved by NHSI , agreed programme governance structure, People Strategy approaches to staff involvement. Engagement Strategy defining ways of communicating with staff communications strategy for programme to reduce organisational anxiety. In date active supervision, appraisal policies. Corrective – Joint Integration Programme Committee reporting to both Boards and CoG's proving updates on current risks, director engagement visits with staff, weekly bulletins from Chief Executive informing staff on progress, Board level mitigation/plan b planning session.	reporting to Board Evidence of current effective leadership such as Board effectiveness survey, Board member appraisals and 360 feedbacks	

Gaps in control:	Actions to close gaps in control:	Action due:	Progress on action:	Risk to delivery:
Clear communication and engagement plan	Joint communication plan being developed [ACTION OWNER: DCA&TS]	30/06/2017		Low
Clear communication and engagement plan	Chair and Chief Executive led Q&A sessions[ACTION OWNER:CEO]	30/06/2017		Moderate
Increasing pressure on senior leaders who are already delivering at full capacity	Map individuals against governance programme roles in order to identify and release capacity required to deliver programme [ACTION OWNER:CEO]	30/06/2017		High
	Review priorities of Directors and senior leaders to	30/06/17		High

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	meet current and anticipated demands (Action Owner :CEO)			
Detailed analysis of capacity required to run programme	Engage with specialist advisors regarding capacity requirements [ACTION OWNER:CEO]	30/06/2017		High
Supervision compliance is not consistent	Increase delivery and capacity for supervision n clinical and operational teams [Action Owner :DPOE]	31/05/16		Moderate
Lack of capacity in operational HR department to deliver requirements of the clinical business case	Delivery of revised model for operational HR [Action Owner :DPOE]	31/05/17		Moderate
Non-disclosure agreement not yet agreed between both parties	Delivery of non-disclosure agreement and heads of terms for back office integration [Action Owner DCA&TS]	30/04/17		
Gaps in assurances:	Actions to close gaps in assurances:	Action: due	Progress on action:	Risk to delivery.
Staff survey reported February 2017	Delivery of all components of staff survey action plan (Owner :DPOE)	October 2017		Moderate
Related operational high/extreme risks: None specifically identified				

Abbreviations: Action owners

CEO Acting Chief Executive

COO Acting Chief Operating Officer

DCA&TS Director of Corporate Affairs and Trust Secretary

DON Executive Director of Nursing and Patient Experience

DOF Executive Director of Finance

DPOE Interim Director of People and Organisational Effectiveness

DSD Interim Director of Strategic Development

MD Medical Director

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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

BOARD ASSURANCE FRAMEWORK 2016/2017 v5.2 Year End

Definitions:
Strategic Outcomes: What the organisation aims to deliver
Principal Risk: What could prevent this objective being achieved. Specify impact.
Director Lead: Lead Director for reporting into the BAF. Other Directors may also have responsibility for managing the risk
Key controls: What controls/systems we have in place to assist in securing delivery of our objective (Describe process rather than management groups)
Assurances on Controls: Where can we gain evidence that our controls/systems on which we place reliance, are effective
Positive Assurances: We have evidence that shows we are reasonably managing our risks and objectives are being delivered
Gaps in Control: Where are we failing to put control/systems in place? Where are we failing in making them effective?
Gaps in Assurance: Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective

Key:
Internal Audits Reports16/17
Clinical Audit Programme 16/17
Changes since last reviewed by Board, Feb 2017
Cross reference to ID of related operational high/extreme risk (see summary at end of report)

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

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
1a	Failure to achieve clinical quality standards required by our regulators which may lead to harm to service users and/or staff	Executive Director of Nursing and Patient Experience Quality Committee	HIGH	4	4	1) Quality Framework (Strategy) outlining how quality is managed within the trust 2) Board committee structures and processes ensuring escalation of quality issues 3) Quality governance structures and processes in to manage quality related issues 4) Quality visit programme 5) Incident, complaints and risk investigation and learning, including robust mechanisms for monitoring resulting actions plans 6) Agreed clinical policies and standards, available to all staff via Connect. Policy governance reporting to Quality Committee. 7) Engagement with clinical audit and research programmes 8) 'Duty of Candour' monitoring and reporting processes 9) Annual skill mix review 10) CQC and GIAP action plans	Clinical buy in to review of NICE guidelines Embeddedness of QLT's Embedded personalised care planning, physical health cheeks and clinical standards Compliance with medicines management policy, including storage compliance and gaps in capacity of pharmacy team (21068) (21071) Demands of the Derbyshire population out strips capacity (3260) (20908), in particular community teams (20988) (20131) (20928) (21044) (21050) (21055) (21070), paediatrics, psychological therapies and fast track PREVENT referrals. Ability to recruit and retain adequate numbers of staff to ensure safe practice i.e. inpatient wards at Radbourne and Hartington Units, (3386) (3410) (2801) (2797) paediatricians (3262), CMHT (20857) (20819) (20988), psychology (20867) (3385), CAMHS/children in care (20120) Clinical dashboards to monitor early warning signs of service failure (1565) Non commissioned services for Derbyshire based PICU beds (3314) and a secure and effective forensic pathway (21049), and CAMHS Tier 4 beds Learning from Serious Case and Homicide Reviews Embedded security and safeguarding culture	Service improvement mapping and contributions i.e. positive and safe, reduction in the use of seclusion Clinical Audit Programme and action plans where gaps identified Audits of compliance with NICE Guidelines National Audits i.e. National Audit of Schizophrenia and POMH UK Audits 'Clinical interest' led audits focused on local resolution of issues	National Community Patient Survey results (above average results) National Inpatient survey (above average results) Benchmarking data identifying higher than average qualified to unqualified staffing ration on inpatient wards CQC inspection comprehensive review identified good feedback from families, individuals and carers re service experience.	CQC inspection comprehensive review detailed a number of gaps in assurance (21013). Clinical audits identifying gaps due to inconsistent application of process i.e. capacity and consent, nutritional screening, DNAR, DEWS scoring, recording of allergies. Re-audits of rapid tranquilisation and seclusion identifying gaps in adherence to policy remain. Supporting staff retention through practice development and embedding uptake of clinical supervision and appraisal rates. HealthWatch survey report re delayed complaint response times and impact on patient experience.	Further engage clinical leadership (though QLT's in particular) in the review and implementation of NICE guidelines.	Carried forward to 17/18	Paper to TMT Feb 2017 identifying options required to fully support and report on implementation of NICE guidance. Task and finish group identified to pursue solution. (Action rolled over to 17/18)	20830
											Embedding of actions resulting from incidents and complaints into the medium to long term through Quality Leadership Teams. Improve systems and processes to identify links between incidents and learn lessons, including embedded learning from Serious Care Reviews and Homicide Reviews.	Completed	Nursing and Patient Experience Directorate visiting clinical services i.e. CAMHS, children's, to raise awareness and transfer of learning	
											Implement improvement plan for medicines management, as highlighted in Board deep dive into medicines management (Sept 2015) and hence to commissioners. Implement measures to ensure medicines are being stored at the correct temperatures.	Completed Completed	Medicines management groups have significantly improved performance and assurance in this area. Medicines management position statement and assurance provided to Quality Committee. Report to Quality Committee Feb 17 demonstrates significant improvement. The capital investment plan for reducing temperatures in rooms used for the storage of medicines (through the installation of portable air conditioning units) has been delivered.	
											Raise risks with commissioners regarding community team capacity and forensic community offer. Recruit to new investment and action planning around 12 hour A&E breaches.	Completed	The risk / concerns log and register of issues is reviewed, each QAG group. STP plans to mitigate. Further A&E breaches. Meeting with NHSE resulted in position statement and development of detailed multi system actions	
											Implementation of clinical dashboards to monitor early warning signs of service failure	Completed	Routine reporting to Board and Quality Committee as of Nov 16.	
											Implementation of action plans resulting from gaps identified through clinical audit projects	Completed	The clinical audit team are working with QLT's to address the issues raised and to ensure there is swift and effective feedback on the audit process. Now part of business as usual.	
											Increase uptake of clinical and managerial supervision and level 3 safeguarding training	Completed	Compliance achieved Jan 2017	
											Reinstate practice development groups	Completed	Confirmation of practice groups at Kingsway and Hartington. additional evidence of embeddedness at Radbourne and neighbourhood teams is required	
											PICU bed manager being appointed to review pathway. Cluster analysis of incidents requested via CCG through STEIS incident reporting.	Completed	Post has been appointed to and PICU access has reduced.	
											Implement emergency planning measures re staffing on inpatient wards at Radbourne and Hartington.	Completed	Emergency planning successfully completed and mitigated	
											Improve compliance with fire warden training	Completed	Completed plan and delivered. Compliance monitoring through monthly Integrated Performance Report to Board in place.	
											Security and safety action plan to be implemented	Carried forward to 17/18	Action underway led by Safeguarding Committee, supported by Health and Safety Committee. (Action rolled over to 17/18)	
1b	There is a risk that the Trust does not operate inclusivity and may be unable to deliver equity of outcomes for staff and service users.	Interim Director of People and Organisational Effectiveness People and Culture Committee (Audit Committee)	MODERATE	4	2	1) Full time expertise in post 2) Launch of a new Equalities Forum 3) Additional resource to support development of the equalities agenda 4) Reporting of approach and progress reported to Board and the People and Culture Committee 5) Urgent non compliance addressed and reported to the People and Culture Committee	Embedded focus on equalities across all trust committees Embedded focus on equalities across all directorates				External verification on EDS 2 planned for the 23/3/17	Completed	EDS2 external validation took place on 23/03/2017 at Postmill Centre. HealthWatch Derby, Mental Health carers and other stakeholders externally graded the evidence presented. EDS2 report to be tabled in board meeting April 17	20936

1c	Risk to delivery of safe, effective and person centred care due to the Trust being unable to source sufficient permanent and temporary clinical staff	Interim Director of People and Organisational Effectiveness People and Culture Committee (Audit and Risk Committee)	HIGH	4	4	1) Recruitment policies and processes 2) Recruitment campaigns 3) Reporting of numbers of vacancies and time to recruit to People and Culture Committee 4) Weekly senior management review of agency spend 5) Overarching framework developed to offer incentivisation to fill very hard to fill posts 6) Revised recruitment process including approval to appoint, TRAC and EDBS to speed up the recruitment process	System wide recruitment tracker Detailed recruitment plan for professional groups. Staffing risks identified in operational risks: (3386) (3410) (2801) (3262) (20857) 20819) (20867) (3385) (20988) and consultant agency spend risks (20916) Sufficiently well stocked bank and adequate resource to manage bank office function			2016/17 Consultant job planning (high risk)	Embed the revised recruitment process to increase the speed of recruitment	Carried forward to 17/18	Work commenced to align the current recruitment with DCHS, eDBS, TRAC (electronic approval to appoint process) partnership working with DCHS. The existing approval to appoint process being streamlined. Ready to launch end March 2017. (Action rolled over to 17/18)	20976
											Recruitment plan by post developed	31/03/2017	Developed overseas and UK recruitment campaign for both medical and nursing staff. (Action rolled over to 17/18)	
1d	The Trust does not fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA) which has resulted in a 'requires improvement' action from the CQC and an impact on person centred care.	Medical Director Mental Health Act (MHA) Committee	HIGH	4	4	1) MHA and MCA policies and procedures 2) MHA Committee oversight of dynamic application of MHA/MCA 3) MHA Committee oversight of workplan of compliance checks, clinical audits and training 4) Lead director accountability and designated MCA medical lead	Training plan trajectory and consistent recording on ESR Assurance of junior doctor supervision taking place, which includes focus on MHA/MCA compliance Monitoring of application of MHA against equality standards Consistent application of seclusion and segregation Delays by local authorities in undertaking DoLS assessments Reporting of hospital managers duties and decisions of panels	Range of compliance checks and supporting clinical audit programme: - Consent to admission - Section 17 leave - Use of Section 5(2) - S58 (T2/T3) and SOAD requests - Community Treatment Orders and S132 - DoLS applications, assessments and outstanding waits		Findings from CQC comprehensive identifying significant lack of knowledge by staff in recording of capacity and consent. 2016/17 Mental Capacity Act - review of patient notes (medium risk) 2016/17 Section 132 Rights (medium risk)	Quarterly reports from MCA medical lead and Mental Health Act Manager to MHA Committee to demonstrate level of adherence to compliance checks and findings from supporting clinical audit programme	Carried forward to 17/18	Range of compliance checks and audits agreed in MHA Committee forward plan and clinical audit programme (Action rolled over to 17/18)	21039
											Ensure all doctor appraisals include focus on MHA/MCA compliance and improve recording of supervision for junior doctors.	Carried forward to 17/18	All doctors appraisals from 16/17 onwards now include the requirement for evidence of compliance with the MHA/MCA. Plan underway to improve recording of junior doctor supervision, key requirement to support MHA/MCA compliance (Action rolled over to 17/18)	
											Compare ethnicity data of people who have been held under a section of the MHA against background population in line with equality standards	Carried forward to 17/18	Overall cohort is too small in comparison to general population statistics to complete in year, so year end analysis to be completed and presented to MHA Committee May 2017. (Action rolled over to 17/18)	
											Develop prompts to local authorities with outstanding DoLS applications. Continue to monitor and report compliance to the MHA Committee	Completed	Now routinely reported as part of the MHA Managers report to the MHA Committee	
											Medical Director to review Seclusion and Long Term Segregation policy with Director of Nursing to ensure consistent understanding in application of seclusion and segregation	Completed	Review undertaken, policy amended. FAQ issued Feb 2017.	
											Commence Hospital Manager reporting to MHA Committee	Completed	Regular verbal updates to commence as standing agenda item from March 2017	
1e	Lack of compliance with the Civil Contingencies Act as a category 2 responder. Risk identified through 2016/17 EPRR Assurance Process	Acting Chief Operating Officer Quality Committee Risk rating reduced (impact of 3) due to mitigation in place and CCG formal notification of compliance	MODERATE	3	3	1) Emergency Plan, published under own section on Trust intranet 2) Designated EPRR lead 3) Action plan agreed with NHS England 4) Quality Committee oversight and escalation, on behalf of Board.	Capacity of EPRR lead to deliver full requirements of the EPRR Assurance Process				Challenge from Southern Derbyshire CCG re non compliance with EPRR core standards compliance framework	Capacity support to be provided by DCHS and NHS England	Completed	DCHS have agreed to provide a member of their team 1 day per week to support the delivery of the Trust's plan Resources provided by NHSE for Hazmat training	21036
												Hardwick CCG and DHCFT to respond to Southern Derbyshire CCG's challenge re non compliance	Completed Completed	
												Develop and deliver action plan to close gap/risk	Completed	Comprehensive action plan developed and being implemented. Director led oversight group in place to oversee and manage action plan, 1st EPPR steering group held on 10/01/17. EPRR Strategy, Incident Response Plan and Core standards action plan all discussed, with actions agreed ahead of the next meeting.

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

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
2a	Risk to delivery of national and local system wide change. If not delivered this could cause the Trusts financial position to deteriorate resulting in regulatory action	Interim Director of Strategic Development Finance and Performance Committee (Audit and Risk Committee)	16 HIGH	4	4	1) Programme of public consultation to support system wide changes 2) Stakeholder and relationship management in order to develop and maintain partnerships 3) Continued discussions with commissioners re work within mental health STP whilst awaiting further guidance 4) Trust involvement with Outline Business Case (OBC)/Full Business Case (FBC) for merger with DCHS 5) Executive to executive and Board to Board discussion with DCHS on opportunities for collaboration in line with national guidance re reviews of 'back office' functions 6) Governance structure with DCHS to programme manage potential merger	Unclear system wide governance to oversee delivery of national priorities Lack of clarity around collaboration and competition Issues of communication owing to NHSE directives Long term local strategic partnerships to deliver quality, sustainable services (21002)	National agreement of Derbyshire's STP		2017/19 contract round not completed in line with agreed system wide principles with reversion to bilateral contracts	Delivery of NHSI operational plan	Completed	NHSI Operational Plan for 2017/19 approved by Trust Board and sent to NHSI within the agree timeframe.	20832
											Agree system wide Sustainability and Transformation Plan (STP)	Completed	STP plan for Derbyshire was submitted on the30/6/16 in line with national expectations.	
											Implementation of Sustainability and Transformation Plan (STP)	Carried forward to 17/18	Whilst revising a system wide approach to delivery of the STP, commissioners and DHCFT continue to look at ways that mental health elements can continue for the benefit of the population	
											Engagement with STP business case workstreams to ensure local ownership of DHCFT specific plans	Completed	All STP business cases were completed in time for the submission date. Further work to develop full business cases for March 2017	
											Delivery of DHCFT and DCHS strategic options case to confidential Board Oct 2016	Completed	Approved at extraordinary Confidential Board October 2016	
											Phase 1 (back office functions) business case to be developed	Completed	Phase 1 business case was developed. Further work on implementation is in place	

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

	Principal Risk	Director Lead and named responsible Committee	Rating	5)	d (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
3a	There is a risk that the NHSI enforcement actions and CQC requirement notice, coupled with adverse media attention may lead to significant loss of public confidence in our services and in the trust of staff as a place to work. Furthermore, failure to deliver the governance improvement action plan could lead to a risk of further breaches in licence regulations with Monitor and the CQC and further regulatory action	Acting Chief Executive Audit and Risk Committee	12 MODERATE	4	3	1) Governance committees and structures, with clear responsibility to lead on specific GIAP actions 2) People and Culture Committee, with clear responsibility to lead on specific GIAP actions, including full review of progress Nov 16 3) Governance processes to deliver the governance improvement action plan including reporting to ELT and monthly reporting to Board 4) Engagement and communication with workforce 5) Formal reporting to regulators on a monthly basis. 6) Ongoing engagement with regulators 7) CQC assurance reporting to the Quality Committee 8) 'Blue Form' final sign off of GIAP actions to Board	Identified in the governance improvement action plan. Deloitte well led report, CQC reports, Yates report	Well led self assessment Reporting through CQC portal providing live assurances against actual performance. Scrutiny by Board of 'blue forms' detailing assurances on completed GIAP actions. Media monitoring report provided monthly to Board	NHSI agreement of governance improvement action plan DHCFT Quality Summit, +ve feedback Deloitte and CQC reports 2016/17 Governance and improvement action plan//well led review (planned) 2016/17 Performance Management Framework (planned) 2016/17 CQC action plan (planned) 2016/17 Compliance with HR policies and procedures (medium) 2016/17 BAF and Risk Management (planned)	Initial outcomes from Deloitte and CQC reviews Fully delivered GIAP and CQC improvement plans	Implement actions from Governance Improvement Action Plan. To be undertaken via weekly review of the GIAP at the ELT, robust monitoring of progress through identified board committees, monthly monitoring reports to Board, monthly reporting to NHSI and the CQC.	Monthly	Number of 'off track actions' significantly reduced. Last planned 'blue form' to Board due May 2017	20834
											Internal audits to be undertaken on key areas identified in the governance improvement action plan, i.e. compliance with policies and procedures	Completed	Audit focusing on specific HR policies in line with GIAP actions completed. Agreed report and associated management actions in place.	
											Fully deliver GIAP and CQC improvement plans	Carried forward to 17/18	Ongoing improvement work monitored on a monthly basis by Board Committees, Board and externally by the PRM process with NHSI/CQC. Last 'blue form' on GIAP action planned for May 2017. CQC feedback re warning notice planned end Jan/Feb 17.Ratings reviewed by CQC for service areas rated as inadequate. Have improved. (Action rolled over to 17/18)	
											Agree framework with Deloitte over remaining quarters of the year to undertake a full well led review	Carried forward to 17/18	The GIAP and CQC improvement plans have not yet fully delivered and hence we are not ready to have external assurance from Deloitte/CQC that gaps have been closed. Planned for Q4 16/17 and now underway. (Action rolled over to 17/18)	
											NHSI to undertake licence review Q4 16/17	Carried forward to 17/18	Working with Deloitte and NHSI on revised plan for further review. Expected Q1 17/18. (Action rolled over to 17/18)	
3b	Risk of a loss of confidence by staff in the leadership of the organisation at all levels	Interim Director of People and Organisational Effectiveness People and Culture Committee (Audit and Risk Committee) Risk rating reduced (impact of 4) due to stability in senior leadership team and increased confidence of regulators	12 MODERATE	4	3	1) Director of People and Organisational Effectiveness in post to deliver on the people agenda and strengthen the HR function and organisational culture going forward 2) Roll out of the leadership development programme 3) Engagement Group 4) Increased focus on vacancy management 5) Increased focus on vacancy management 6) Implementation of the People Plan 7) Living the trust values	Robust approach to delivery of the People Plan and GIAP action plan Strong partnership working with staff side New board members familiarisation with the trust	Executive and board visits to staff Launch of the pulse check Staff survey action plan Closure of actions from 2016/17 audits on grievance and disciplinary processes	HEE annual quality visit Final closure in CQC/NHSI governance standards (as identified in GIAP action plan). 19 'blue forms' for HR actions completed to date 2016/17 Compliance with HR policies and procedures (medium). Actions completed	Safer staffing data identified in Staff survey results	Implement actions from Governance Improvement Action Plan To be undertaken via weekly review of the GIAP at the ELT, robust monitoring of progress through identified board committees, monthly monitoring reports to Board, monthly reporting to NHS Improvement and the CQC.	Monthly	Performance Review Meeting with NHSI 2/9/16 noted progress made on GIAP and plans in place to mitigate actions 'off track'. (Action rolled over to 17/18)	20835
											Implement actions from internal audit report (2015/16 HR Processes: Recruitment) in relation to safer staffing reports.	Completed	Reported to P&CC and Audit and Risk Committee	
											Proactive management and delivery of the staff survey actions	Carried forward to 17/18	Tracked through People and Culture Committee. (Action rolled over to 17/18)	
											Complete the leadership development training to ensure consistent approach to delivering on HR policies and processes	Completed	First wave to be completed March 2017, second wave to begin April 2017	
											Implement Pulse Checks across the trust to provide rapid feedback on the climate across teams	Completed	Go live planned for Feb 2017	

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

	Principal Risk	Director Lead and named responsible Committee	Risk Rating	Impact (1-5)	Likelihood (1-5)	Key Controls	Gaps in control	Assurances on Controls (Internal)	Positive Assurances	Gaps in Assurance	Action plan: To increase effective controls. To gain assurance.	Action: due/review date	Progress on action	Risk Register ID
4a	Failure to deliver short term and long term financial plans could adversely affect the financial viability and sustainability of the organisation	Executive Director of Finance Finance and Performance Committee (Audit and Risk Committee) Risk rating reduced (likelihood to 2) due to confidence in year end forecast	10 MODERATE	5	2	1) Monthly Financial Performance Reporting to Public Trust Board meetings providing assurance on financial performance, including integrated performance reporting to enhance triangulation when assessing finance, quality, workforce and operational performance 2) Reporting to Finance and Performance Committee to gain assurance on all aspects of financial (and other resources) management on behalf of the Board, including oversight of CIP delivery and contractual performance 3) Project Assurance processes and systems for in-year monitoring of CIP delivery and escalation procedures 4) System of delegated budgetary responsibility - in line with standing financial instructions and scheme of delegation 5) F&P and PCOG meeting monitoring of contractual performance that impacts on contractual payments including activity levels, CQUIN and contract levers/penalties. 6) Service Line Reporting and other financial reporting systems and action planning at Finance & Performance, Performance and Contracts Overview Group (PCOG), Divisional meetings -and other groups	Control Totals for required surplus imposed by Regulator do require stretch levels of CIP delivery Additional regulatory reporting and controls having negative impact on capacity and flexibility in financial planning Outcome of contract negotiations for 17/18 and 18/19 requires provider CIP and commissioner disinvestment through QIPP - schemes not yet defined As yet unknown financial impact of transaction with Derbyshire Community Health Services FT (LTFM as part of business cases will be developed)	Monthly financial reporting systems on current and forecast performance include "challenge and review" each month before reporting Pre-submission scrutiny of annual operational financial plan prepared and submitted to NHSI Pre-submission scrutiny of health system Sustainability and Transformation Plan (STP) (5 year plan) Budget-setting operational requirements are signed-off by those responsible for their delivery (and the Trust Board) In-year financial forecasts are co-owned by finance and the individuals responsible for their delivery Existence of contingency reserve and the contingency reserve access request process Large proportion of income guaranteed through block contract for 1617 . Block contract secured for 17/18 and 18/19	External Audit: the Audit Findings for DHCFT (year ended 31 March 2016) . Issued with Unqualified Opinion Confirmed NB - VFM assessment and governance (see gap in assurance) External Audit: Bespoke Key Financial Indicators 2015 report show that aside from the gap in assurance for liquidity (as the only red indicator) - the other indicators are amber or green (benchmarked against MH FT peers) . Strongest indicator is EBITDA. Generally improving position on metrics or benchmarked position 2016/17 Key Financial Systems - Data Analysis (low risk)	Re: External Audit benchmarking for Financial KPIs and resilience: Main area to improve is liquidity ET/Governance reviews/investigations and subsequent regulatory impact created negative external assurance (e.g. need to develop integrated reporting and update F&P TOR and had negative impact on External Audit VFM Assessment for 1516 annual accounts and report) and likely same impact on 1617 accounts Residual gaps in assurance related to exceeding agency controls on: % cost ceilings, pay rate caps, use of approved frameworks and high cost off payroll compliance SoF Use of Resources Rating overall metric score capped at 3 because of agency metric of 4 (worst) Number of high risk audits (16/17 Agency Controls and 16/17 Consultant Job Planning) and worsened HOIA opinion for part year 16/17	To minimise control gap around future payment systems: Attendance at events, keeping up to date with current thinking from Regulator, discussions with commissioners (joint exec ownership between DoF and Director of Strategic Development)	Completed	Discussions with Commissioners for the next two year contracts as part of STP planning are to keep block contracts	20833
											To minimise gap in control re control total required by NHSI - continue financial planning and financial control and ensure CIP delivery. Due the worsened level of assurance over CIP delivery as at mid May there have been additional CIP emergency meetings and action planning meetings. Progress is reported to ELT every meeting, and to F&P May and Board. 6. Extraordinary F&P meeting took place in June 2016 to focus on CIP.	Completed	CIP gap is fully mitigated as at month 9	
											To minimise control gap for regulatory capacity and inflexibility in planning - ensure long term financial plans are deliverable and effectively monitored, continue to improve liquidity.	Completed	Long term STP submission being developed. STP submitted and operational plan for 1718 and 1819 submitted	
											To improve assurance gap on External Audit benchmarking indicators: continue to improve liquidity and build cash reserves (e.g. through retention of disposal proceeds), maintain tight financial control	Carried forward to 17/18	(Action rolled over to 17/18)	
											To improve assurance gap related to financial components of governance gaps: achieve delivery of the relevant governance improvement actions and compliance with findings recommendations from Deloitte et al	Completed	Papers provided to F&P and Board during the year are being amended as required. E.g. Enhanced financial dashboard reporting actioned from Feb 16 board onwards. Also from March board 16 onwards Trust Board receive a new integrated performance report. PCOG and F&P reports from Feb/March 16 included additional content on forward financial risks and trends.	
											To improve assurance related to agency usage: Internally monitor and manage reduction in use of agency staffing and monitor the delivery of improvement trajectories and also report progress on trends to relevant committees and Trust Board. (Action owner = Ops director) Also achieve further evidence of assurance on rostering and longer term workforce planning to reduce reliance on agency (reported through People committee) (Action owner= Workforce Director)	Carried forward to 17/18	The increased scrutiny and oversight continues - however agency usage is still in excess of NHSI ceiling Additional operational processes and procedures continue. Progress is reported as part of regular performance reporting to both Trust Board, F&P Committee and People committee. Recruitment incentives and streamlining of processes is taking place. Review again at end of year. At the end of the year many actions are in place to increase the scrutiny. There is ongoing scrutiny to maintain oversight into 1718 (Action rolled over to 17/18)	
4b	Failure to deliver the agreed transformational change, at the required pace could result in reduced outcomes for service users, failure to deliver financial requirements and negative reputational risk	Interim Director of Strategic Development Finance and Performance Committee (Audit and Risk Committee)	15 HIGH	5	3	1) New 5 year Strategy 2016 - 2021 outlining strategic direction for Trust 2) Tight plans for implementing transformational change , with clear objectives and metrics for internal and external reporting. 3) Programme of engagement events with staff and stakeholders to consult with and agree the programme for implementing transformational change 4) Commissioner involvement and support of transformational process	Embedded coaching culture to deliver empowered leadership and accountability Capacity to deliver transformational plan, exacerbated by regulatory actions, alongside other project demands.(21030) Plans to realise high proportion of CIP, however high risk elements remain	Board reporting on strategy implementation with associated board discussion and challenge		Gaps in assurance on CIP schemes 2016/17 Data Security and Handling (medium risk).	Develop transformational project plans submitted for current and future years with assurance on cost out in line with Trust strategy and national policy.	Carried forward to 17/18	System wide plans assume a 3.17% efficiency within provider Trusts. Efficiencies to be realised from back office efficiencies, agency spend, rotas, estates etc. and other internal CIP plans. (Action rolled over to 17/18)	20831
											Develop a performance framework to support empowered leadership and accountability to ensure decision making is undertaken at the right level.	Completed	A new Trust wide accountability framework agreed by Trust Board. Further detailed work on how it will work in practice is being undertaken by ELT and SLT. The development of a Trust wide management team (TMT) agreed, to commence Jan 2017 as planned.	
											Review capacity to deliver transformational agenda	Carried forward to 17/18	Wider transformation change is linked to systematic change. Ongoing discussion with commissioners re sharing capacity. Capacity remains an issue. Still discussions with the wider system although other issues are impacting. The MH STP Steering Group has been reformed and will be asked to provide greater clarity and facilitate the release of capacity (Action rolled over to 17/18)	
											Progress implementation plans via agreed business planning process	Carried forward to 17/18	Business planning process underway with read across to STP outline cases. Capacity remains an issue. Work undertaken to triangulate internal business plans, STP and NHSI, and annual plan with aim of providing a single 'plan on a page' per area which can be performance managed. 'Plan on a Page' identifies the key objectives for operational and corporate areas. This pulls together year 2 of the Trust Strategy, the NHSI plan and elements of the STP. Due for Board approval in April 2017 (Action rolled over to 17/18)	

Abbreviations

ACAS	Advisory, Conciliation and Arbitration Services
CEO	Chief Executive Officer
CIP	Cost Improvement Programme
COSRR	Continuity of Services Risk Rating
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment
CRG	Clinical Reference Group (accountable to QLT's)
DEWS	Derbyshire Early Warning System - tool to identify sharp physical health decline
DCHS	Derbyshire Community Healthcare Services
DNAR	Do Not Attempt Resuscitation order

Cross reference to ID of related operational high/extreme risk

ID	Directorate	Date of next review	Risk Subtype	Title	Risk level (current)	BAF risk
2801	Campus - Radbourne Unit	18/12/2016	H&S - Fire Safety	Increase risks of fire related to smoking ban_Ward 34	High Risk	1a 1c
3260	Neighbourhood Services	31/07/2016	Commissioning Risk	Lack of ADHD service for adults	High Risk	1a
3262	Community Paediatrics	31/01/2017	Clinical - Staffing levels	Long waiting lists following reduction in staffing levels	High Risk	1a 1c
3314	Neighbourhood Services - City	31/12/2016	Commissioning Risk	Lack of pathway for patients discharged from prisons	High Risk	1a
3385	Neighbourhood Services - City	31/12/2016	Clinical risk - Other	Waiting Times for Psychological Assessment and Intervention	High Risk	1a 1c
3386	Campus - Radbourne Unit	31/12/2016	Clinical - Staffing levels	Vacancies, reduced leadership, capacity for succession planning	High Risk	1a 1c
3410	Campus - Radbourne Unit	11/01/2017	Clinical - Staffing levels	Vacancy levels above 30%	High Risk	1a 1c

DoLS	Deprivation of Liberty Standards
DoF	Director of Finance
EBITDA	Earnings before interest, taxes, depreciation and amortization
ELT	Executive Leadership Team
ESR	Electronic Staff Record
EPRR	Emergency Preparedness, Resilience and Response
F&P	Finance and Performance Committee
FRR	Financial Risk Rating
FSRR	Financial Sustainability Risk Rating
GIAP	Governance Improvement Action Plan
HR	Human Resources
IAPT	Improving Access to Psychological Therapies
NICE	National Institute for Health and Care Excellence
NHSI	NHS Improvement (formally Monitor)
PARIS	Electronic Patient Record solution provided by Civica
PCOG	Performance and Contracts Overview Group
PICU	Psychiatric Intensive Care Unit
POMH-UK	Prescribing Observatory for Mental Health
PYE	Part Year Effect
QAG	Quality Assurance Group (led by Commissioners)
QC	Quality Committee
QIA	Quality Impact Assessment
QLT	Quality Leadership Teams (accountable to Quality Committee)
SOAD	Second Opinion Appointed Doctor
SLA	Service Level Agreement
STP	Sustainability and Transformation Plan
TOMM	Trust Operational Management Meeting
VFM	Value for Money

20819	Neighbourhood Services - City	31/01/2017	Operational - Business Continuity	Waiting lists for assessment and interventions	High Risk	1a 1c
20857	Neighbourhood Services - North	27/01/2017	Clinical risk - Other	Transfer of patients through the change in neighbourhood boundaries	High Risk	1a 1c
20867	Learning Disabilities Services	01/06/2017	Clinical - Therapeutic activity	Lengthy waiting times for psychological involvement	High Risk	1a 1c
20908	Substance Misuse Services	06/10/2016	Clinical risk - Other	Communication of information regarding patients on discharge from Royal Derby Hospital	High Risk	1a 1c
20928	Neighbourhood Services - North	31/10/2016	Clinical - Staffing levels	Long waiting times for MAS Diagnosis	High Risk	1a
20988	Neighbourhood Services - City	30/12/2016	Clinical - Staffing levels	Not enough nurses to manage the initial assessments, waiting list for community intervention and to cover long term sickness	High Risk	1a 1c
21002	Campus - Admin & Management Team	03/12/2016	Commissioning Risk	Patient transport	High Risk	2a
21013	Campus - Radbourne Unit	31/01/2017	H&S - Violence and Aggression	Sec 136 suite	High Risk	1a
20120	Children in Care	30/01/2017	Clinical - Staffing levels	Staffing Levels	High Risk	1a 1c
21031	Neighbourhood Services - City	13/01/2016	Clinical risk - Other	Non-Adherence to Waiting List Management Policy and Procedure	High Risk	4b
21044	Neighbourhood Services - North	01/03/2017	Clinical - Staffing levels	reduction in medical support	High Risk	1a 1c
21049	Campus - Radbourne Unit	23/02/2017	Clinical risk - Other	Limited access to safe and secure transport	High Risk	1a 1c
21050	Neighbourhood Services - North	24/03/2017	Clinical - Staffing levels	low staffing levels	High Risk	1a 1c
21055	Neighbourhood Services	31/03/2017	Operational risk - Other	Waiting for care coordination	High Risk	1a 1c
21068	Pharmacy	28/04/2017	Clinical - Medication/ Pharmaceutical	Medicines Management - providing effective care for patients	High Risk	1a 1c
21070	Neighbourhood Services - North	12/04/2017	Clinical - Staffing levels	Extreme Pressures in team	High Risk	1a 1c
21071	IM & T	16/06/2017	Operational risk - Other	SystmOne prescribing: financial, governance, clinical and reputational risks	High Risk	1a 1c

2017-18 Board Annual Forward Plan

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

2017-18 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
SH	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			X							
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance - Confidential - Mental Health Act Committee - Quality Committee - Safeguarding Committee - People & Culture Committee	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X
SH	Governance Improvement Action Plan	Licence Condition FT4	X	X	X	X	X	X	X	X	X	X
SH	Fit and Proper Person Declaration	Licence Condition FT4		X								X
MP	Emergency Planning Report (EPPR)								X			
SH	Board Effectiveness Survey			X								
SH	Report from Council of Governors Meeting		X	X		X		X		X	X	X
SH	Review of Policy for Engagement between the Board & COG								AR			
SH	Board Development Programme										X	
LWS	Measuring the Trust Strategy		X									
OPERATIONAL PERFORMANCE												
CG, CW, AR, MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	Licence Condition FT 4 Strategic outcome 1 Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X
QUALITY GOVERNANCE												
CG	Position Statement on Quality (Incorporates Strategy and assurance aspects of Quality management) Includes Annual Review of Recovery Outcomes in October and Annual Looked After Children Report in December	Strategic Outcome 1 CQC and Monitor	X	X	X	X	X	X	X	X	X	X

2017-18 Board Annual Forward Plan

Exec Lead	Item	Purpose of Item - Statutory or Compliance Requirement Alignment to FT Strategic Objectives	26 Apr 17	24 May 17	28 Jun 17	26 Jul 17	27 Sep 17	1 Nov 17	29 Nov 17	27 Jan 18	28 Feb 18	28 Mar 18
CG/JS	Safeguarding Children Annual Report	Children Act Mental Health Standard Contract							AR			
CG/JS	Safeguarding Adults Annual Report	CQC Mental Health Standard Contract								AR		
CG	Control of Infection Report	Health Act Hygiene Code		AR								
CG/JS	Integrated Clinical Governance Annual Report including MHA/Governance/Complaints and Compliments/SIRIs/Patient Safety/NHS Protect (LSMS) and Emergency Preparedness/H&S (including H&S and Fire Compliance and Associated Training)	CQC and H&S Act							AR			
CG	Annual Community Patient Survey	Clinical Practice CQC							AR			
JS	Re-validation of Doctors	Strategic Outcome 3			AR							
CG	Annual Review of Recovery Outcomes *							AR				
CG	Annual Looked After Children Report *									AR		

* Incorporated in Quality Position Statement