NHS
Derbyshire Healthcare
NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – THURDAY 27 JULY 2017
TO COMMENCE AT 1.00 PM IN CONFERENCE ROOMS A&B
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOMENT, KINGSWAY HOSPITAL

	TIME	AGENDA	ENC	LED BY
1.	1:00	Chair's welcome, opening remarks, apologies for absence and Declarations of Interest Register	**A**	Caroline Maley
2.	1:05	Service Receiver Story	**-**	Carolyn Green
3.	1:30	Minutes of Board of Directors meeting held on 28 June 2017	**B**	Caroline Maley
4.	1:35	Matters arising – Actions Matrix	**C**	Caroline Maley
5.	1:40	Questions from governors or members of the public	**-**	Caroline Maley
6.	1:45	Acting Chair's Update	**-**	Caroline Maley
7.	1:50	Acting Chief Executive's Update	**D**	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY				
8.	2:00	Integrated Performance and Activity Report	**E**	Mark Powell/Claire Wright/Amanda Rawlings/Carolyn Green
9.	2:30	Position Statement on Quality	**F**	Carolyn Green
10.	2:40	Board Committee Assurance Summaries and Escalations: Quality Committee 15 June, Audit & Risk Committee 11 July, People & Culture Committee 20 July *(minutes of these meetings are available upon request)*	**G**	Committee Chairs
11.	2:45	Business Plan 2017-18 Monitoring	**H**	Lynn Wilmott-Shepherd
3:00 B R E A K				
12.	3:15	Deep Dive – Crisis and Home Treatment Service	**I**	Mark Powell
13.	3:45	Board Assurance Framework (BAF) 2017/18 Second issue	**J**	Sam Harrison
14.	3:55	Workforce Race Equality Standard (WRES) 2017/18 Submission	**K**	Amanda Rawlings
CLOSING MATTERS				
15.	4:05	Any Other Business	**-**	Caroline Maley
16.	4:10	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	**L**	Caroline Maley
FOR INFORMATION				
Report from Council of Governors Meeting held 17 July 2017			**M**	-
2017/18 Board Forward Plan			**N**	-

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

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

There will be no Board meeting in August. The next meeting will be held at 1.00 pm on 27 September 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 Chair's discretion

Declaration of Interests Register 2017-18

NAME	INTEREST DISCLOSED	TYPE
Margaret Gildea Non-Executive Director	Director, Organisation Change Solutions Limited Non-Executive Director, Derwent Living	(a, b)
Ifti Majid Acting Chief Executive	Board member, North East Midlands Leadership Academy Board Kate Majid (spouse) Assistant Chief Commissioning Officer, NHS North Derbyshire CCG	(a, d)
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)
Lynn Wilmott-Shepherd Interim Director of Strategic Development	Substantive post – Director of Commissioning and Delivery, NHS Erewash CCG	(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 share holdings 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

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Wednesday 28 June 2017

MEETING HELD IN PUBLIC

Commenced: 1pm Closed: 4.35pm

PRESENT:	Caroline Maley	Acting Trust Chair
	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director
	Barry Mellor	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Acting Chief Executive
	Claire Wright	Director of Finance & Deputy Chief Executive
	Carolyn Green	Director of Nursing & Patient Experience
	Dr John Sykes	Medical Director
	Samantha Harrison	Director of Corporate Affairs & Trust Secretary
	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
	Julie Carvin	Infection Control Support Nurse (shadowing Carolyn Green)
For DHCFT 2017/095	Scott	Service User
For DHCFT 2017/095	Alice Smallwood	Team Manager - Substance Misuse Services
For DHCFT 2017/095	Nicola Fletcher	Acting Assistant Director of Clinical Professional Practice
For DHCFT 2017/103	David Hurn	Service Line Manager - Substance Misuse Services
For DHCFT 2017/103	Dr Senthil Mahalingam	Consultant Psychiatrist - Substance Misuse Services
For DHCFT 2017/104	Harinder Dhaliwal	Assistant Director for Engagement and Inclusion
VISITORS:	John Morrissey	Lead Governor, Public Governor, Amber Valley South
	Carole Riley	Deputy Lead Governor, Public Governor, Derby City East
	Lynda Langley	Public Governor, Chesterfield North
	Mark McKeown	Derbyshire Mental Health Alliance

DHCFT 2017/094	**ACTING CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** Acting Trust Chair, Caroline Maley, opened the meeting and welcomed everyone. No apologies for absence or declarations of interests were received.
DHCFT 2017/095	**SERVICE RECEIVER STORY** Nicola Fletcher introduced service receiver Scott who talked about how he successfully

	completed his treatment for opiate addiction with the Substance Misuse Service through their rapid recovery process in June 2016. Towards the end of his treatment Scott developed his role as service user representative, supporting others in treatment. Since leaving treatment Scott has continued to support the service as a peer mentor and has now applied to volunteer at the Ilkeston substance misuse facility. Ifti Majid asked Scott if the Trust's substance misuse service had made him want to recover from his addiction. Scott replied that he had reached a point where he definitively wanted to recover and the Trust's service had given him the help and support to enable him to learn how to cope with stressful situations without using drugs. Substance Misuse Team Leader, Alice Smallwood accompanied Scott and described how other service users were being motivated by Scott's enthusiasm and were inspired by his noticeable healthy appearance since he completed his recovery process. The Board heard how Scott was helping people learn to deal with situations that led to their drug use by encouraging them to build structure into their life through physical activities such as boxercise and using gym programmes developed by Phoenix Futures who work in partnership with the Trust. Scott and Alice also described how the Recovery Through Nature programme worked as well as walking groups, allotment work and projects being run by the service in partnership with the National Trust and how these structured activities within the community play a major part in teaching people about the importance of personal motivation in their recovery. The Board found Scott's story truly inspiring and understood how structured activities and intervention had a positive impact on his life and looked forward to the Deep Dive into the Substance Misuse Service taking place later in today's meeting. **RESOLVED: The Board of Directors expressed thanks to Scott for sharing his inspiring story and appreciated the opportunity to hear at first hand the service the Trust had provided.**
DHCFT 2017/96	**<u>MINUTES OF THE MEETING DATED 24 MAY 2017</u>** The minutes of the previous meeting, held on 24 May were agreed and accepted subject to the following amendments: DHCFT2017/076 – Questions from Public Governors – a written statement responding to these questions would be included as an appendix to the minutes. DHCFT2017/079 Integrated Performance Report (IPR) – the third paragraph of this item would be corrected to read *'With regards to financial performance, Claire Wright reported that at month one the Trust is ahead of plan and the forecast assumes full delivery of CIP (Cost Improvement Programme). Although a full set of plans to achieve the Trust's CIP of £3.85m are not yet finalised she is forecasting that the Trust will achieve its control total at the end of the year. In response to a question from Caroline Maley she clarified that there is an overspend on pay and employee expenses which is offset by over-recovery of income, both due to QIPP (Quality Improvement Prevention and Productivity) contract and service changes not yet being enacted'.* The final paragraph of the IPR (Integrated Performance Report) would also be corrected to read '*Concern was raised with regard to safe staffing levels in the Hartington and Radbourne Unit. Carolyn Green assured the Board that emergency planning measures were not required at this time although intensive actions were required over the summer to maintain stability. She referred to bed occupancy and pointed out that occupancy is currently quite low on the Cubley Wards and as a result some staff were transferred to other areas or skill mix reduced as bed occupancy was less than 50%. The Board requested that future IPR reports include a short summary on safer staffing, and that a report be received by the Quality Committee on safer staffing mitigation plans'.*

DHCFT 2017/097	**MATTERS ARISING AND ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and were noted on the actions matrix.
DHCFT 2017/098	**ACTING CHAIR'S VERBAL REPORT** Caroline Maley reported that the beginning of the month was dominated by the Board's decision to withdraw from the acquisition transaction with Derbyshire Community Health Services (DCHS) and was taken up with discussions and meetings with the Council of Governors, NHS Improvement (NHSI) and key stakeholders. This decision was taken extremely carefully in light of a number of factors across the environment including the pressure on staff to maintain quality, safety and financial stability throughout the transaction process. Caroline Maley thanked everyone who was party to this decision. During the last month Caroline Maley attended various meetings including the meeting of the Mental Health Act Committee when it was agreed to set up a sub-group to support the duties of this Committee. Caroline Maley and Ifti Majid attended the NHS Confederation Annual Conference in Liverpool where Jeremy Hunt was present and she described how this was a meeting that was symptomatic of our political time. She also had the opportunity to discuss the role of women on trust boards and the joining up with FTSE companies and having representatives from the BME network and LGBT joining different trust boards. During a quality visit to Ward 34 at the Radbourne Unit Caroline had met with medical staff governor, Jason Holdcroft and found it valuable hearing how we are supporting people through challenging times. It was the hottest day of the year and concerns were raised by staff regarding the heat and the effect this had on service users and staff. In response Carolyn Green explained that air conditioning is only installed in patient areas and not in staff areas. Legislation prohibits the use of portable units and although there is a cost issue in installing fixed air conditioning, the Trust is exploring extending air conditioning to staff areas and also looking at ways staff can wear lighter uniforms. Caroline Maley concluded that June was a busy month that focussed on strategic issues and our destination as a Trust. **RESOLVED: The Board of Directors noted the activities of the Acting Chair throughout the month of June.**
DHCFT 2017/099	**CORPORATE GOVERNANCE STATEMENT** Samantha Harrison noted that following written confirmation (received on 25 May) of a decision made by NHS Improvement (NHSI), the Trust had complied with all its enforcement undertakings. This compliance has now been incorporated into the Corporate Governance Statement (FT4) annual declaration which was reviewed and approved by the Board at the 24 May meeting. The additional text to be incorporated is as follows: *Following a decision made by NHS Improvement the Trust was informed that the Trust had complied with all enforcement undertakings and a compliance certificate was issued on 24 May 2017.* The revised document will be signed by Ifti Majid and Caroline Maley and published on the Trust's website by Friday, 30 June. **RESOLVED: The Board of Directors noted the Trust's compliance with all its**

	enforcement undertakings which will be incorporated into the Corporate Governance Statement declaration
DHCFT 2017/100	**ACTING CHIEF EXECUTIVE'S REPORT** The Acting Chief Executive's report provided the Board of Directors with feedback and an update on developments occurring within the local Derbyshire health and social care community. Ifti Majid referred to the Board's decision to withdraw from the acquisition by DCHS and reported that the Board had received strong support from the Council of Governors, Staff Side colleagues and staff. He outlined discussions he had with various members of staff regarding continuing to work with DCHS on back office functions and he reported that this was also discussed at the Joint Negotiating Consultation Committee. The Trust will continue to work closely with DCHS to build on the work carried out as part of the transaction programme. The Board heard how some administrative staff had talked to Ifti about their career progression and were concerned that the Trust was seen as 'Derbycentric'. Ifti Majid and the Executive Leadership Team (ELT) had considered this staff concern and as a result senior staff will now be working around the county to demonstrate that the Trust is not a wholly Derby focussed organisation. Ifti had also listened to staff who had asked if some of the senior appointed posts could be more focussed on the BME network. He was pleased to report that this initiative is being developed through the reverse mentoring project and is incorporated into our inclusion and diversity programme which is covered in the Equality and Diversity brief featured later at today's meeting. Ifti Majid referred to the Deloitte report on the Well-led review conducted in February 2016 which reflected significant progress in all areas. He was extremely proud of the improvements made over the last year and thanked his team and all staff across the organisation for bringing about a significant shift in the Trust's performance. This report has already been shared with Clinical Commissioning Groups (CCGs) and now that the report is in the public domain it will be forwarded to the CQC (Care Quality Commission). Following review by NHSI of the Trust's position including the assurances as presented in the Deloitte report, the Trust received official notification from NHSI that the Trust is now free of all former licence breaches and this was included as an appendix to Ifti's report. Samantha Harrison made Board colleagues aware that actions resulting from the Well-led review and the Governance Improvement Action Plan (GIAP) are progressing through the Board's Committees. As previously agreed an update report on progress and embeddedness of GIAP actions will be brought to the Board in October 2017. It is anticipated that this work will align with the Trust's work on the Well-led framework as recently launched by NHSI. **RESOLVED: The Board of Directors noted the Acting Chief Executive's update**
DHCFT 2017/101	**INTEGRATED PERFORMANCE AND ACTIVITY REPORT (IPR)** The IPR provided the Trust Board with an integrated overview of performance as at the end of May 2017. The focus of the report is on workforce, finance, operational delivery and quality performance. The Trust continued to perform well against many of its key indicators during May despite staffing levels and activity pressures. The Board noted that community caseloads remain challengingly high and that waiting time for care co-ordination remains long because of the lack of care co-ordination to enable shorter wait times. It was recognised that some progress has been made with risk mitigation plans and Mark Powell assured the Board that this will continue to be revised and he hoped that work with the STP (Derbyshire Sustainability Transformation

	Programme) will address some of these challenges. The Board discussed the high bed occupancy across all wards which had resulted in a substantial number of patients placed out of area. This was recognised as an indication of the staffing challenges currently being faced and Mark Powell assured the Board of the work taking place to reduce patients being placed out of area and reported that as of today's date there were four patients placed out of area. The report indicated that staffing remains an ongoing challenge for many services. Through various engagement events Carolyn Green and Mark Powell have recognised where further support is required and assured the Board that safe and effective operational management will provide the correct level of staffing against planned standards. The Board discussed quality and operational performance and was informed that there are no nursing vacancies or challenges within CAMHS services. Carolyn Green would like to reduce the vacancy rate and trajectory to between 6 – 8% and she and Amanda Rawlings intend to progress this through the Executive Leadership Team (ELT) to drive the vacancy rate down. The Board heard how investment has been made in the supervision initiative which has shown signs of improvement. Quality indicators have shown we are under performing in safer staffing although performance is expected to be more stable in the autumn. The IPR showed that the number of inpatients with VTE (Venous Thromboembolism) assessment is increasing. In response to Ifti Majid inquiring if this result was sporadic across the Trust, John Sykes advised that this increase was sporadic. Performance and IT measures have now been brought in to ensure more reliable recording and assessment takes place which will be monitored through the Quality Committee. In the drive to improve patient safety the Quality Committee will escalate any concerns to the Board after the next meeting in July. In addition to this, month on month VTE targets will be included in next month's IPR report which, as advised by Lynn-Wilmott Shepherd is in line with our contractual requirement. Ifti Majid referred to the increase of incidents of violence involving patient to patient and patient to staff. Carolyn Green responded that she had seen an increase in incident recording in the neighbourhood. She did not think that these were necessarily related to an increase in people being released from prison but she had noticed an increase in incidents involving violence from women. Carolyn Green assured the Board that she and heads of nursing are working to address these incidents on a week by week basis. Anne Wright raised concern with the number of cancelled outpatient appointments. John Sykes explained that this situation has been caused by the short notice termination of agency doctors creating gaps in the rota where doctors were required to volunteer to fill in these gaps. The Board was assured that patients were located to another appointment as a matter of priority and it is expected that this situation will improve by the beginning of August. Julia Tabreham was concerned about adherence to CPA (Care Programme Approach) and the overwhelming pressure this placed on staff. Mark Powell replied that the Trust is firmly committed to CPA and staff are following the component parts of the CPA policy. He assured the Board that CPA is at the centre of everyone's focus and he is working with commissioners to ensure we have the resource to deliver service centred care. Caroline Maley asked how the non-smoking policy was progressing. Carolyn Green informed her that the Trust is partially compliant with this policy and care plans are being developed with individual patients. We are in the process of re-energising smoking cessation across the organisation. Discussions are taking place with other trusts to establish ways of complying with the smoke free policy and this is being monitored by the

	Trust Management Team (TMT). The Board discussed incidents relating to absconding and was assured that the Quality Committee will be carrying out a Deep Dive on Datix (patient safety software) checking and any escalations will be made to the Board through the Quality Committee Assurance Summary. Claire Wright summarised the financial position for month two and confirmed that delivering the financial plan is a key priority. Cost Improvement Planning (CIP) is continuing to achieve the 2017/18 control total financial plan. A full set of plans is not yet in place to address the Trust CIP cost reduction of £3.85m and work is continuing to close the gap. Agency spend is scoring well on the rating although workforce risks will have a financial impact on the plan. With regards to the STP, the QIPP (Quality, Innovation, Productivity and Prevention) programme is not yet resolved. STP is requesting a higher CIP from all providers and although this is not currently in our plans the Trust will work with commissioners to understand what is acceptable to change. However, it has been confirmed that the Trust will receive its QIPP income which is good assurance for the Board and the regulator. Carolyn Green informed the Board that new clinical priorities will be applied to fire standards and will be reprioritised accordingly. In light of the Grenfell Tower tragedy work has taken place quickly with the fire prevention team. Ward checks have been completed for all services which resulted in minor rated issues around door stops. Carolyn Green was pleased to confirm that none of the Trust's buildings contain any form of cladding. Challenges around staffing were discussed by the Board. Amanda Rawlings reported that the biggest challenge currently is staff retention and is covered extensively in the Workforce Plan being reviewed later in today's meeting. The Board understood that the main priority is to build on the recent success in recruitment by improving staff retention as turnover is being affected by new staff recruited to inpatient areas then moving on to roles in specialised areas. The Board considered this to be a comprehensive IPR report and was pleased to see that it included a good focus on neighbourhood issues and was assured by the performance shown in month two. **ACTION: VTE targets will be included in forthcoming IPR reports** **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 2017/102	**<u>CYBER ATTACK AND LESSON LEARNED REPORT</u>** Mark Powell's report informed the Board of the impact, response and actions arising from the Wanna Decryptor Ransomware attack that caused a disruption to DHcFT business continuity and provided assurances regarding the Trust's cyber security. The report set out the key issues arising from the attack; lessons learned and associated actions that will be taken forward as a result of the attack. The report also set out the Trust's position on the controls in place to limit the potential impact of any future cyber-attack. The Board noted the controlled response that brought IT systems back online in stages which avoided computers being infected and how risks were professionally managed which meant patients were not affected. Significant lessons were learned in how to resolve the situation in the event of a further cyber-attack happening again. The lessons learned action plan will be overseen by the Trust Management Team with assurance reporting made to the Quality Committee to ensure a response is developed through

	major incidents activity. The Board felt assured that the response in managing the cyber-attack was proportionate and controlled. Assurance was also obtained through the Ten Steps to Cyber Security which will be reinforced and taken forward through the Information Governance Committee and through business continuity. **RESOLVED: The Board of Directors obtained significant assurance in the response to the cyber-attack, the subsequent action plan and cyber essentials.**
DHCFT 2017/103	**<u>DEEP DIVE – SUBSTANCE MISUSE SERVICE</u>** David Hurn and Dr Senthil Mahalingam from the Substance Misuse Service joined the meeting and provided the Board with a presentation that gave an insight into some of the key challenges and achievements experienced by the team. For the first time the Trust is providing a range of drug and alcohol services offering support for adults of all ages in the local Derby community providing a complete service from a single point of access. The service also works in partnership with Phoenix Futures who provide a one to one assessment service with no appointment required. The service's biggest achievement was implementing the Derbyshire Recovery Partnership which is a new service for the county focussing on improvements in physical health which also works in partnership with Intuitive Thinking Skills (intuitive recovery process) to meet the needs of people with a drug and/or alcohol problem offering them different levels of support from advice and harm reduction to prescribing and structured one to one or group work. The Board was pleased to hear that this service resulted in the successful transfer of specialist nurses being brought back into the service and that staff engagement had been very good throughout this process. The Board heard how the ECG (electrocardiogram) pilot project started in December 2016 in conjunction with the steroid outreach project that took place within local gyms. This initiative has been a very successful project that engaged a number of service users who have been very interested in working with the team and has had a significant impact on patients overall. The contract for Substance Misuse Services will be put out to tender shortly and this is proving quite challenging for the team who are committed to preparing the tender for submission by September 2017. The Board was made aware of the progression of preparedness meetings that are taking place leading up to the tendering process and how innovations borne from experience are enabling the team to write their own service specification. It was recognised that today's Deep Dive was scheduled because a targeted CQC inspection will be taking place in the Substance Misuse Service during the next few weeks. The Board was assured that the team has a lot of strengths that will be recognised by the CQC and a great deal of work is taking place to prepare for the CQC's visit. The Board was impressed with the positive impact that the Substance Misuse Service has on people's lives which was observed during the service receiver story heard earlier at today's meeting. It is clear that the team instilled hope into their patients and are leading the way in systems and processes and are able to be more creative and proactive in their approach to treating patients. The staff engagement team had drawn attention to the way the team had worked and it was proposed that the team would be invited to the People & Culture Committee to tell their story so lessons could be learned from the innovative way they have adapted their service. **ACTION: Substance Misuse Service to be scheduled into the programme of staff stories heard by the People & Culture Committee**

	RESOLVED: The Board of Directors considered and noted the presentation made by the Substance Misuse service team
DHCFT 2017/104	**EQUALITY, DIVERSITY AND INCLUSION UPDATE** This report provided the Board with an update relating to equality, diversity and inclusion (ED & I). Harinder Dhaliwal joined the meeting to present this paper. She outlined the key messages and assured the Board that the Trust is on track to complete goals one and two by 23 November 2017. Reference was made to the positive feedback received from Board members when they attended the Equality, Diversity and Inclusion Board Development Session on 12 April. Claire Wright wished it to be noted that although she was unable to take part in this event, this was no reflection of her commitment to ED & I. It was confirmed that the event will be repeated later in the year to ensure all Board members have participated in the session. Attention was drawn to the priorities contained in the Draft Board Equality Action Plan 2017-2020 (top six priorities) and these were duly approved by the Board. It was noted that Board and Board Committee papers are to be audited in February, 2018, as set out in EDS2 Implementation Plan 2017/18. The Board recognised that reverse mentoring is a component part of a suite measures the Trust is undertaking. Reverse mentoring will be taken forward and as a learning organisation we will show best practice in this area. Harinder Dhaliwal drew attention to the forward planning of the Workforce Race Equality Standard (WRES) 2017/18. It was understood that the WRES action plan is to be developed and submitted to key committees as part of the reporting schedule, including the Board meeting on 27 September. It was recommended that the Board considers the WRES submission and findings at the July Board meeting. Board members were aware that the Trust's Board of Directors does not contain a strong BME mix. Margaret Gildea referred to the conversations Caroline Maley had when she had attended the recent NHS Confederation Annual Conference with regard to representatives from the BME network joining trust boards and she asked Harinder Dhaliwal to explore this initiative. **ACTION: Board to consider the WRES submission and findings at the July Board meeting for sign off along with the Board statement.** **ACTION: Harinder Dhaliwal to develop the initiative of representatives from the BME network joining trust boards** **RESOLVED: The Board of Directors:** **1) Approved the Draft Public Sector Equality Duties & EDS2 Implementation Plan 2017/18 setting out the Trust's plans for annual grading process** **2) Noted EDS2 Outcome 4:2 10 Board/key committee papers to be audited in February, 2017, as set out in EDS2 implementation, 2017/18** **3) Approved the Draft Board Equality Action Plan 2017-2020 (top six priorities)** **4) Noted the Board's ED& I Development Session held on 12 April, 2017 Evaluation Report and considered an additional session to achieve full attendance** **5) Noted and supported Reverse Mentoring for Diversity and Inclusion (ReMeDy) pilot in partnership with the University of Nottingham. The initial pilot will include Executive mentees paired with BME staff (Mentors)**

	6) **Considered scheduling WRES 2017/18 submission and findings, including Board statement at July 2017 Board meeting prior to submission to NHS England National WRES team by 1 August 2017 (in line with WRES technical guidance)**
DHCFT 2017/105	**QUALITY POSITION STATEMENT** Carolyn Green provided the Board of Directors with an update on the organisation's continuing work to improve the quality of services that are provided in line with the Trust Strategy, Quality Strategy and Framework and strategic objectives. Reference was made to systems leadership in physical health and mental health with regard to eating disorders. Julia Tabreham asked what was being done to improve the extreme vulnerabilities of this psychiatric disorder, especially with regard to the quality of life of sufferers and those that care for them. Carolyn Green responded that carers work is included in our family practice work for children and adults and she is currently working with commissioners to make sure this service is addressed through a BMI (Body Mass Index) approach. The Trust has also entered a partnership with the Royal Derby Hospital to improve this clinical pathway. Eating disorders is also embedded in the Derbyshire STP community pathway. **RESOLVED: The Board of Directors received and noted the Quality Position Statement**
DHCFT 2017/106	**BOARD ASSURANCE SUMMARIES & ESCALATIONS** Assurance summaries were received from the meetings of the Audit & Risk Committee held on 25 May and the Mental Health Act Committee of 9 June. Committee Chairs summarised the escalations that had been raised and these were noted by the Board. Particular note was made to development of a sub-group of the Mental Health Act Committee which will enable this Committee to operate more effectively. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries and Escalations**
DHCFT 2017/107	**WORKFORCE STRATEGY AND PLAN 2017 - 2022** Amanda Rawlings's report provided the Board with the Trust's Workforce Strategy for 2017 – 2022 and a first year costed implementation plan to enable the Trust to proactively mitigate its workforce supply challenges, reduce reliance on agency and locum staff and retain staff by providing enhanced career pathways. Amanda Rawlings explained how we have captured our five-year plan in line with the Health Education England (HEE) Mental Health Workforce Strategy (2017). Prioritisation for affordability and implementation has been given to Year 1 of the Plan. A review of costs for implementation and affordability will need to take place year on year in line with local and national developments. Although we have highlighted numbers for recruitment plans in mental health nursing, we will over-recruit in readiness for staff who may retire. It was recognised that the Workforce Plan is a live document and will be amended in line with local and national developments and will regularly be reviewed by the People & Culture Committee. The next stage will be to bring the Year 2 implementation plan to ELT, the People & Culture Committee and then the Board. The report demonstrates how the organisation is to use its workforce. Apprenticeships will form a key part of the workforce development plan. However, both Richard Wright and Barry Mellor queried the amount of nursing apprenticeships the Trust would engage

	given the workforce's changing profile and felt that five apprentices would not be enough. Amanda Rawlings responded that the apprenticeship model has been established so that the number of apprentices can be increased year on year. The Board recognised that this strategy is an important step forward and is a credit to the work of the People & Culture Committee. The Workforce Plan is a long term plan and the Board acknowledged the need to fund its implementation and noted that as each local development is phased into the plan this could be aligned with the national mental health workforce strategy. **RESOLVED: The Board of Directors:** **1. Approved this document as the DHCFT WorkForce Strategy and Plan** **2. Acknowledged that this Strategy and Plan will remain a live document and will be amended in line with local and national developments.** **3. Acknowledged the need to fund the developments identified in this document and acknowledged the cost pressure identified in year 1.**
DHCFT 2017/108	**PROGRESS ON THE STAFF SURVEY** Amanda Rawlings' report provided the Board with an overview of the 2016 staff survey and quarter 1 pulse check results and the approach and actions that are being taken to improve staff engagement and involvement across the Trust. It was noted that four areas from the Staff Survey are being focused on for improvement and are being tracked for progress through the People & Culture Committee. In addition to this all leaders have been asked to develop their action plans with three key focus areas that they will work on with their teams and TMT will track progress of the local development work. Amanda Rawlings pointed out that since completing the two recent surveys the Trust has undertaken a cultural survey with EY and once these results have been received the Trust will look to combine the findings and areas of focus into its improvement plan. The Board agreed that the report provided assurance on how the staff survey process will improve staff engagement across the Trust and that it illustrated how this will progress throughout the year. The paper also allowed the Board to see signs of improved engagement and feedback which was encouraging. **RESOLVED: The Board of Directors acknowledged the staff survey and pulse check results and the approach being taken to improve staff engagement, involvement and advocacy for the Trust.**
DHCFT 2017/108	**REPORT FROM THE CONFIDENTIAL COUNCIL OF GOVERNORS MEETING** This report was provided for information and was noted by the Board. **RESOLVED: The Board of Directors noted the report from the Confidential Council of Governors meeting held on 6 June 2017.**
DHCFT 2017/111	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK** BAF risk 1d 'Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident'. The Board discussed how this risk's initial rating was moderate and is difficult to mitigate. There are good mitigation plans in place but the risk of further attack is potentially likely to occur. Following discussions held during this morning's Remuneration & Appointments

	Committee the additional risk of potential instability of the Board arising from the proposed appointments processes to acting roles was agreed to be added as an additional risk to the BAF and will be included in the BAF update for the July Board meeting. **ACTION: Revised and elevated risk rating relating to business continuity BAF risk 1d arising from likelihood of future cyber-attacks to be included in BAF update to July Board** **ACTION: Additional risk of potential instability of the Board arising from the proposed appointments processes to be included in the BAF update to the July Board**
DHCFT 2017/112	**2017/18 BOARD FORWARD PLAN** The forward plan was noted by the Board. **RESOLVED: The Board of Directors noted the forward plan for 2017/18.**
DHCFT 2017/113	**MEETING EFFECTIVENESS** The Board agreed that discussion will continue to take place to ensure agenda items keep to time and that discussion is appropriately focussed. Quality of discussion has been effective and good enquiry was made across the Board.

The next meeting of the Board held in Public Session will take place at 1pm on Thursday, 27 June 2017.

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

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - JULY 2017			Enc C
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
24.5.17	DHCFT 2017/073	Service Receiver Story	Carolyn Green	**ACTION TRANSFERRED TO THE QUALITY COMMITTEE** Carolyn Green will work with the Nursing and Quality team specifically Allied Health professionals to develop a recovery and enablement strategy that will be submitted to the Quality Committee to focus upon employment and a positive approach to recovery	29.11.2017	The recovery and enablement strategy is currently in development and will be submitted to the October Quality Committee.	Yellow
26.6.17	DHCFT 2017/101	IPR	Mark Powell	VTE targets will be included in forthcoming IPR reports	27.7.2017	VTE targets now inlcuded in IPR ACTION COMPLETE	Green
26.6.17	DHCFT 2017/103	Deep Dive - Substance Misuse Service	Amanda Rawlings	Substance Misuse Service to be scheduled into the programme of staff stories heard by the People & Culture Committee	27.7.2017	Substance Misuse Team staff story is being scheduled into the People & Culture Committee's autumn programme ACTION COMPLETE	Green
26.6.17	DHCFT 2017/104	Equality, Diversity and Inclusion Update	Sam Harrison Harinder Dhaliwal	Board to consider the WRES submission and findings at the July Board meeting for approval along with the Board statement	27.7.2017	WRES submission received for July Board meeting ACTION COMPLETE	Green
26.6.17	DHCFT 2017/104	Equality, Diversity and Inclusion Update	Harinder Dhaliwal	Harinder Dhaliwal to develop the initiative of representatives from the BME network joining trust boards	27.7.2017	Meeting is being arranged for Harinder Dhaliwal to discuss this initiative with Chair and Senior Independent Director	Amber
26.6.17	DHCFT 2017/111	Issues arising for inclusion / updating in BAF	Sam Harrison	Revised and elevated risk rating relating to business continuity BAF risk 1d arising from likelihood of future cyber-attacks to be included in BAF update to July Board	27.7.2017	BAF risk 1d revised and included in updated version of the BAF submitted to July Board. ACTION COMPLETE	Green
26.6.17	DHCFT 2017/111	Issues arising for inclusion / updating in BAF	Sam Harrison	Additional risk of potential instability of the Board arising from the proposed appointments processes to be included in the BAF update to the July Board	27.7.2017	This risk is now identified in the BAF as risk 3e ACTION COMPLETE	Green

Resolved	**GREEN**	5	72%
Action Ongoing/Update Required	**AMBER**	1	14%
Action Overdue	**RED**	0	0%
Agenda item for future meeting	**YELLOW**	1	14%
		7	100%

Derbyshire Healthcare NHS Foundation Trust
Report to Public Board of Directors 27 July 2017

Acting Chief Executive's Report to the Public Board of Directors

Purpose of Report:

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

National Context

1. In June 2017 the CQC released a very helpful publication called *'Driving Improvement'*. This report is of particular importance for us as a Trust as it details 8 case studies of Organisations that have gone from requires improvement to good in their ratings. The report suggests 9 key areas that should be the focus of energy and resources:

    - Reaction to the initial rating – ensuring the initial report was seen as a catalyst for change, the areas for improvement being recognised and owned by the organisation

    - Leadership – visible and approachable leadership not just from the Board but from middle layers of managers. The report comments on the importance of building a strong Executive Team.

    - Cultural Change – engaging and motivating staff to support the improvements because it is the right thing to do not because they are told to do it. Moving from blame to celebrating success and recognising commonality in purpose. In addition clear recognition Trusts must tackle equality and diversity issues openly and robustly

    - Having a shared and simple vision, understanding the golden thread that connects all staff in the Organisation, recognising the work done in Leeds that Directors will be familiar with following our recent Board development session

    - Improving governance both clinically and organisationally, having an equal symbiotic relationship between quality and finance

    - Improving safety through clear quality improvement cycles empowering staff and teams to make changes that improve outcomes.

    - Having clear mechanisms to hear the voice of people who use services and those who care for them and evidence of how that feedback has been acted upon

- Developing strong relationships with stakeholders in the wider health and social care economy

- Putting time and effort into developing a good relationship with the CQC local officers to ensure the specific issues and complexities of our Trust are known to them

As we prepare for our next CQC visit these insights are vital in ensuring that our scarce resources are focussed on the right areas and we look to the quality committee and the Trust Management Team to optimise outcomes in these areas.

2. In the month that the Executive Leadership Team reviewed our internal leadership strategy, NHS Improvement have released a helpful prompt for Trusts around supporting and developing medical leaders, *A Guide to the Medical Director's Role*. The medical director's role has been a statutory trust board position for 30 years. It is fundamental to any organisation that has high value, high quality patient care at its heart. Yet preparation for the role is often minimal. Those taking on this role are highly engaged, dedicated and passionate leaders and this guide starts to help aspiring senior medical leaders prepare and develop towards this vital role. As a Board of Directors we are committed to developing sustainable succession plans and we want the next generation of medical directors through our current senior medical staff to feel supported, to have access to appropriate development, mentoring and peer support opportunities, so they are prepared and have the very best chance of being successful in the role should that be the direction of choice for them.

3. This month has seen the release of NHS providers 'State of the Provider Sector, a key document detailing the current performance, challenges and opportunities the sector is facing. What I found refreshing is that there is a specific focus on the mental health sector and this is what I have focussed on here. Some key facts about how busy our sector has been:

    - In February 2017 over 1.2 million people accessed NHS mental health services:
        - 86% accessed adult mental health services
        - 12% children and young people's mental health services
        - 6% accessed learning disabilities and autism services, some of whom will have also accessed adult or children's mental health services

    These figures include:
        - 114,000 new referrals to talking and psychological therapies
        - over 13,000 open ward stays in adult acute and specialised services
        - over 314,000 active referrals for under 19s, including 42,000 new referrals

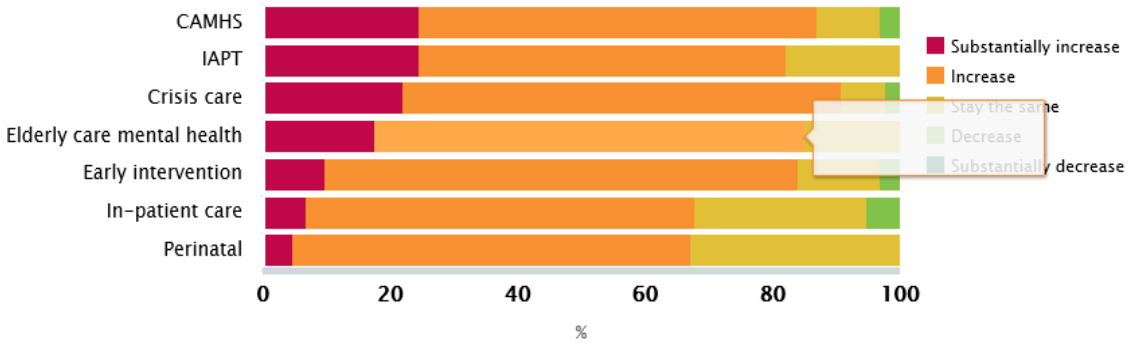
    And in the first three months of this year:
        - nearly 3,000 referrals with suspected first episode psychosis started treatment
        - 1,600 new referrals for people aged under 19 with eating disorders
        - over 16,000 admissions to crisis resolution home treatment team adult wards

NHS Providers carried out a survey of all mental health providers and I felt it important to share the results with the Board:

- demand for service is rising rapidly
- the extra financial investment is not running to the NHS mental health frontline
- workforce challenges are increasing
- taken together, these are impacting adversely on access to and quality of service delivery
- commissioning is fractured
- support between different parts of the NHS, as embodied by liaison psychiatry, still needs to be improved
- the new sustainability and transformation partnerships (STPs) are not giving sufficient priority to improving mental health provision.

Two key areas worth dwelling on a little more include the anticipated increase in demand for mental health services and confidence in new investment being passed to providers by CCGs. The two graphs below demonstrate the level of concern within the sector:

Mental health services providers: Based on current trends, how do you think demand will change for the following mental health services in 2017/18?



(n=40-41)

Mental health services providers: How confident are you that national commitment to increase investment in mental health and transparency on CCG spending will result in adequate investment to meet mandate ambitions in 2017/18?

This national picture is clearly replicated in Derbyshire and in the pressure that we see in our Trust day in day out. We continue to develop our approach to mental health transformation through the STP and continue to press commissioners to demonstrate the clear need for investment to follow clearly increasing demand – in the current austere climate this is a challenging ask.

Local Context

4. 29 June was the first County Health and Wellbeing Board following the change in Council control with Carol Hart in the Chair. It was great to receive a document pulled together by the voluntary and non-statutory sector that was referred to as the shadow STP. The purpose of the document was to augment the submitted STP with areas where the voluntary and community sectors could get involved, particularly around supporting self-help and community resilience. In addition we received a revised falls pathway for the whole of Derbyshire and with respect to the health protection agenda heard about how Derbyshire is currently breaching response times following cervical smear tests with currently in excess of 50% of results taking 28 days to return – the standard is 21 days for return.

   The Fire and Rescue Service reported the Derbyshire response to the Grenfell Tower disaster in London.

   - There is only 1 high rise residential building in Derbyshire, this has been assessed and residents reassured
   - Fire and Rescue service have assessed Derbyshire in-patient health provision and have found no serious issues
   - No Derbyshire properties contain the same cladding as at Grenfell
   - There are 28 building across Derbyshire with more than 6 floors and they have been prioritised for assessment
   - Requests have now been received to assess all schools, universities and adult education establishments

5. Our work in developing the mental health system delivery plan continues. It is essential that we work with clinicians from our own Trust and partners in the system to develop our plans, specifically seeking advice and guidance around the how we can deliver these requirements. The mental health workstream leadership are absolutely committed to an inclusive approach to ensure sustainable, safe service delivery. To this end we have arranged an initial launch event on 1 August. This event has been advertised widely in organisations however we also recognise that we need to use multiple opportunities for engaging clinicians and we will continue to hold similar events as well as engaging with clinicians in routine meetings such as practice development forums. The four key areas our workstream focuses on are:

Mental Health Primary Care Support **What we want to achieve:** • Increased primary care capacity to recognise and effectively manage people with mental health needs in their community • Easier movement between primary care and secondary services • Equity of physical and mental health by ensuring people with a severe mental illness get an annual health check • People with long-term conditions get to access psychological help	**MH Delirium and Dementia** **What we want to achieve:** • Consistent community based memory assessment services across Derbyshire to maintain the rate of diagnosis above two thirds • Improved post diagnostic treatment and support to people • Support for people to live in their own homes and 'live well' with dementia • Improved specialist mental health support in care homes across Derbyshire • Consistent training within care homes to help prevent delirium, in dementia
Mental Health Responsive Community Services **What we want to achieve:** • Increased availability of clinical time in community teams so that more people with specialist needs can be supported in their community • Increased access to specialist group treatment in a person's local community i.e. day support • Development of a 'mental health' urgent care pathway that allows more people to get timely advice and support and where necessary, treatment • Availability of a mental health bed is available in Derbyshire when it is needed	**MH Rehabilitation and Forensic Pathways** **What we want to achieve:** • Reduction in the number of people in an inpatient rehabilitation facility • Better use of the inpatient facilities we have in Derbyshire for people who need it • Help in the community for people who have a forensic history • Help for people who have complex needs • More people being offered a personal health budget

I will update the Board on progress on a monthly basis and include updates from the other three main work streams impacting our services, Children's and Maternity, Urgent Care and Learning Disability.

Within our Trust

6. Following improvements made around CQC compliance that the Board are aware of and the conformation that all breach requirements have been met I have received a letter from NHS England as part of the normal quarterly Nottinghamshire and Derbyshire Quality Surveillance Group (QSG). QSG is a forum which systematically brings together the different parts of the system to share information and intelligence relating to provider organisations. Partners will share a view of risks to quality across NHS commissioned services. I am delighted that our rating has now returned to green – routine monitoring which is the highest possible rating that can be achieved.

7. On 13 July Caroline Maley and I visited Lincolnshire Partnership Trust, a small specialist provider of mental health and learning disability services to understand what their key focus had been in securing an improvement in CQC ratings from requires improvement to good. It was a detailed discussion with many points corresponding to the CQC report I mentioned earlier, however a few highlights included

    - Strong Board level oversight of the CQC actions, their action plan had 1000 lines of actions all owned and reviewed by the Board such was the priority given to it

    - Clarity from the Board of those areas the 'CQC shouldn't have found', what should the Board have known about and systems fixed in advance

    - Massive focus on a cultural shift:

        - Going out to find estates issues and other 'hygiene issues' that make it hard for staff to do their job. Not passively waiting for staff to report issues
        - Significantly increasing visibility of senior and Board staff
        - Clarity about the quality improvement programme, enabling staff to showcase things they are proud of to the CQC, confident to take control of the visits

    - Back to basics around areas such as ligature risks – files with ligature risk heat maps in every area with mitigation plans associated with patient group

    - Leadership programme

    - Focus on recruitment and filling vacancies

    - Creating a simple hook that links vision and values and is meaningful for staff

    - Completion of NHSI cultural diagnostic

    - Significantly invested in relationship with governors.

    My thanks to the Chief Executive and Chair for their open approach, sharing of materials and invitation for our staff to join some of their sessions. These insights will be a significant support to us as we prepare for our next visit from the CQC.

8. Monday 12 July was the first time we took our Executive Leadership Team meeting 'on the road'. Thanks to all at the Ritz in Matlock for making us so welcome. The purpose of doing this is to create an opportunity for staff to meet with team members in their local area and for team members to see the executive in a 'working' situation rather a 'royal visit' situation. Our first experience was very successful with a number of staff calling in to share their experiences and seek help around improving their working life. Over the rest of this year Executive Meetings are all out in team bases, the next few being in Chesterfield, Swadlincote and Derby, St Andrews.

9. During July we had the follow up meeting of the Trust BME Network to develop our innovative and exciting project around BME reverse mentoring. The group discussed and took decisions around the cohort we would use for mentors and protégées and agreed the timeline through getting research approval, training our mentors with an aimed start date of November. I view this as a vital component of developing our inclusive culture and I know the Board will be keen to receive updates as we progress with this exciting work.

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

Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people).

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

Actions to Mitigate/Minimise Identified Risks

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

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

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

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

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

- Identifying barriers and removing them before they create a problem
- Increasing the opportunities for positive outcomes for all groups, and
- Using and making opportunities to bring different communities and groups together in positive ways

Transformation done well has the potential to *improve* our delivery of equality, by for example, increasing the opportunity for communities to come together in more positive ways than those that exist in the way we currently deliver services

The Reverse Mentoring training is a specific example where the outcomes will positively impact on all three aims of the Equality Act for groups of staff, i.e. the BME staff community, in helping the executive to identify barriers and remove them, increase the opportunities for positive outcomes for BME groups, and support the creation of opportunities to bring communities and groups together in positive ways.

I believe the integrated approach we are taking to delivering the mental health transformation programme as part of the STP supports our need to focus through individual clinical pathways on protected groups to ensure that in each clinical pathway area we have a clear understanding of the barriers to engagement and outcomes for those groups within our communities.

The Board should recognise that at a population health level the data contained about the mental health sector does give rise to risks for all Regards groups due to the pressures being experienced. The mitigation of this risk is reliant on the development and delivery of effective working as a system recognising and mitigating risks based on impact to the population not impact on providers.

Recommendations

The Board of Directors is requested to:

1) Scrutinise the report, noting the risks and actions being taken
2) Challenge myself or the Executive on the content therein.

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

Derbyshire Healthcare NHS Foundation Trust

Derbyshire Community Health Services NHS Foundation Trust

Derbyshire Community Health Services NHSFT and Derbyshire Healthcare NHSFT 'Towards more integrated working'

Programme Closure Report

Version: V0.5 FINAL
Date: 18 July 2017

Purpose of this document

Purpose

Following notification on 6 June 2017 of the Derbyshire Healthcare NHSFT Board decision not to proceed with the transaction process, this document is intended to provide Trust Boards with assurance that any associated tasks have now drawn to a close.
The report identifies:

- A reminder of the context in which the proposals and considerations came about
- A summary of the decision to stop the transaction process
- A final summary position for each of the workstreams
- A final expenditure position against the £650k joint programme budget
- A summary of the developments in relation to the case for change
- The next steps with regards to taking the pathway areas forward in the context of the system wide partnership approach

Background: How did these proposals come about? What was the rationale for closer collaboration?

It is important to remind ourselves of the context in which these considerations came about. This will be particularly important to build upon the work undertaken to date and aim to deliver as many benefits as possible from the clinical case for change, in the context of the Sustainability and Transformation Partnership between all providers and commissioners in Derbyshire.

The foundations were set out in the Strategic Options Case (SOC), which were based on the context of the Derbyshire wide Sustainability and Transformation Plan, now the Sustainability and Transformation Partnership (STP) and both Trust's objectives which are in response to the challenges the Derbyshire health and care system is facing. There are three 'gaps' identified in the STP (the health and wellbeing gap, the care quality gap, and the finance and efficiency gap) which are the result of national influences such as NHS funding, rising demand and expectations, and local factors such as marked health inequalities across the county and city, regional workforce shortages and the historical pattern of NHS provision in the patch. These challenges affect us all and therefore the framework for our considerations was based upon addressing these gaps, as both Derbyshire Community Health Services NHSFT (DCHS) and Derbyshire Healthcare NHSFT (DHcFT) recognised that we could not focus on an approach which was 'best for self' if we were to achieve the sustainability required and maximise benefits for our local population. These foundations have continued as the basis throughout the subsequent developments of the Outline Business Case (OBC).

As a result of the Derbyshire STP developments and the need to create more person centred Place Based Care, the Boards of both organisations began initial discussions together to consider how the system and organisational objectives could be met by working more closely together. A Pre-SOC proposal was approved by the respective Boards in June 2016; resulting in agreement to consider the collaboration options further.

This was followed by the joint development of the SOC. The SOC identified a preferred option for a 'merger by acquisition', with DCHS as the acquiring organisation. In October 2016, both Boards approved the preferred option and confirmed on-going commitment to progress to the next, more detailed stages; the Outline Business Case (OBC) and Full Business Case (FBC) and subsequent implementation.

A compelling case for change was presented in the SOC. The hypothesis being tested was that closer collaboration between DCHS and DHcFT would enable genuine integration of services through Place Based Care by overcoming traditional organisational boundaries and obstacles such as uncoordinated workforce and lack of shared information. This would also provide opportunities to bring together physical and mental health so that both are treated equally; the importance of which was emphasised throughout the SOC. (summary slides from the SOC can be found at Appendices 1 and 2).

It is important to note that although this would technically have been an acquisition, both organisations made a commitment through the SOC to change which would be reflective of community physical and mental health services delivered by both organisations. Furthermore, to the creation of a new organisation which would have strong leadership and governance, so the constitution would be reconfigured with Executive Directors, Non-Executive Directors and Council of Governors balanced to reflect the scope and expertise in the services provided.

Feedback from our strategic advisors was that the case for change presented in the SOC was already more comprehensive than would be anticipated at the SOC stage. As this provided the overarching position it was developed further to make it specific to the areas prioritised for development during the OBC stage, and although the transaction process has come to a close , both organisations remain committed to driving forward the service level benefits (this is set out further later in this document).

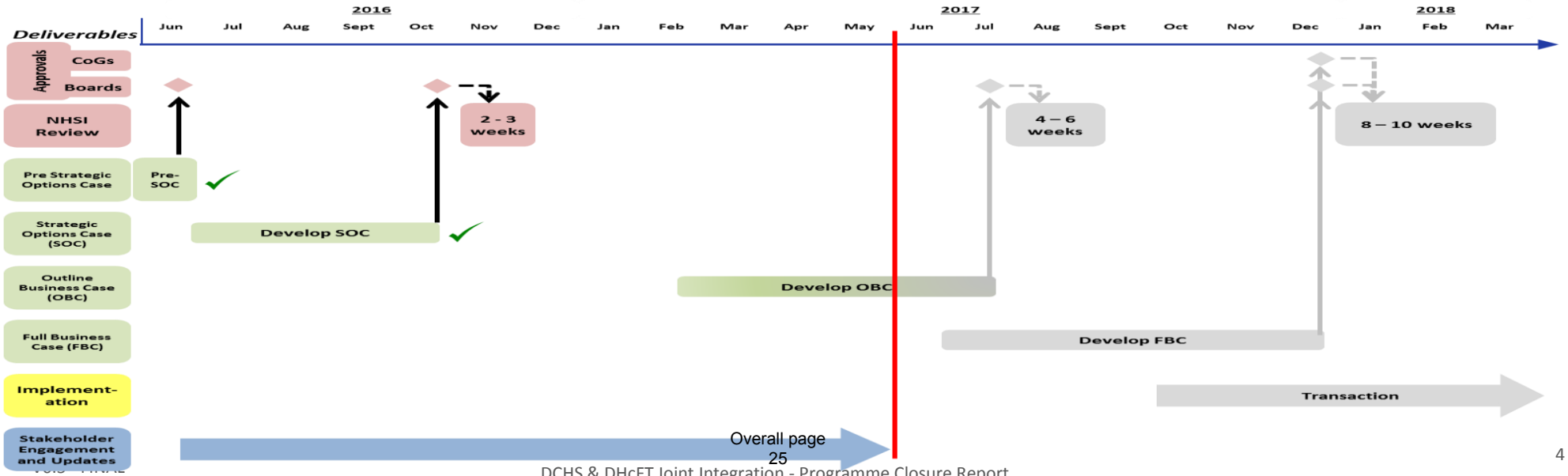
Programme Close: Decision

On 6 June 207 the Board of DHcFT notified DCHS that the decision had been taken not to pursue the proposed formal integration of the two Trusts. In summary, the rationale for the DHcFT Board decision was based on:

- The changed environment of the STP that will potentially achieve greater benefits of partnership working across the whole system than a bilateral merger alone could achieve, which fundamentally changes the counterfactual by undermining the ability to prove merger-specific benefits
- Changes to some of the core rationale for acquisition contained within the SOC
- Staff capacity constraints to support the intensity of the transaction's programme of work, the wider STP work and business as usual such that it was disrupting DHcFT business as usual and creating unacceptable quality and operational risks that could not be mitigated. Maintaining and improving the CQC quality rating was vital and serious concerns of the achievability of this were emerging requiring rapid action
- Improved governance position of the Trust that the Trust wishes to further embed and consolidate
- Significant lack of internal stakeholder support for the transaction (Staff, Governors, Board members) associated with 'programme heavy 'approach

The Board of DCHS were disappointed by this decision, as they still believed there was a compelling case for change; however, the decision of the DHcFT Board was respected. This resulted in communications being issued by both organisations to notify staff of the decision on 6 June 2017 (see appendices 3 and 4).

The timeline below summarises the stages which would have been required to complete this transaction and the point at which the developments ceased.



Workstream status at programme close

Workstream	Summary
Transaction	• Dedicated planning and programming activities to ensure delivery now ceased • OBC Framework refined based on feedback and work to begin populating sections had commenced. • Due Diligence – any work underway to commence the exercise has ceased, with notification sent to respective leads to delete any information received as the 'recipients' in line with the joint Non-Disclosure Agreement. The only exceptions being the HR and Estates elements as it has been agreed that these will still be required for the purpose of the back office work.
Strategy	• Competition and Choice – The initial view from NHSI based on preliminary discussions with CMA was that the transaction would not be reviewable as deemed to be low risk. A formal note was submitted to CMA by NHSI. This resulted in some queries for follow up (usual practice). An independent competition expert also reviewed all material and confirmed it was unlikely that a formal CMA review would be warranted. As the transaction is no longer progressing, no further follow up will be undertaken. • Organisational strategies mapped to identify initial synergies, gaps and opportunities.
Clinical Pathways	• 'Triple Aim' confirmed through CQRG as the basis to develop a future joint clinical strategy and to provide the foundations for the organisational culture work and further development of the case for change • Prioritisation of services undertaken to confirm initial service development areas (LD, OPMH, Children's and PLACE) for work up at OBC stage (steps 1 and 2 as set out in SOC) • Framework and specification used as basis for joint discussions by pathway groups (initial work undertaken jointly across both organisations for each area followed up by two facilitated workshops). The outputs of these sessions were intended to be confirmed through further follow up discussion with the service leads (including clinical staff)
People & Culture	• Vision and values approach agreed and sessions planned. Due to poor uptake of initial sessions in May further sessions were planned throughout June and July. These sessions have now all been cancelled. • Wider stakeholder session and future joint leadership sessions also cancelled. • EY Cultural Due Diligence work completed (desktop review, online survey, leadership interviews and focus groups) and report prepared. • E-Bulletin drafted which would have been issued this month
Finance	• Individual 'do nothing' LTFMs complete, based on historic performance and consistent forward looking assumptions • Early draft narrative structure for finance section of OBC prepared
Corporate Governance	• Approach to constitution development (relevant aspects) and engagement with governors agreed and 3 meetings with core group of governors held (external facilitator for the latter two sessions). Some progress made with governors in terms of amendments to the relevant sections of the constitution, however these were intended to be worked through in the follow up session planned for 21 June and are therefore not confirmed. • Wider joint governor engagement commenced, with a focus on the case for change. There was an initial meeting in May and a follow up was planned for 15 June. • Due diligence shared folder created (initial issues due to IT problems following Cyber attack) and information uploaded as per agreed lists, mapping of areas and cross over undertaken to minimise multiple information requests and manage the process more effectively
Infrastructure	• Estates - Draft combined strategy paper developed setting out synergies, areas of risk and opportunities, with first draft combined strategy in development. • IMT – All aspects reviewed to identify processes, similarities and differences with some opportunities for early harmonisation identified.. Also looking at policy harmonisation. • Workforce – Initial baselines and KPI information collated. • All of the above would have been aligned to the outcomes of the clinical pathways discussions to enable early consideration of any potential implications which would need to be worked through as part of the FBC.

Programme Budget – Closing Position

	YTD Budget 30-Jun-17 £000s	YTD Actual 30-Jun-17 £000s	YTD Variance 30-Jun-17 £000s	OBC Plan 30-Jun-17 £000s	FBC Plan 31-Dec-17 £000s	Post FBC Plan 31-Mar-18 £000s	Total Plan 31-Mar-18 £000s
Staffing							
Programme Manager	58	59	1	58	53	26	137
Non Pay	5	1	-4	5	5	5	15
Consultancy							
Strategic Advice	167	101.8	-65.2	167	147	153	467
Legal Costs	15	19.1	4.1	15	30	15	60
Total Costs	245	180.9	-64.1	**245**	**235**	**199**	**679**

With the decision made not to proceed during the OBC stage, a significant proportion of the planned work with strategic advisors was not required. This has enabled an underspend on the planned budget to OBC stage of £64,100.

The costs of the project will be funded by both organisations on a 60:40 proportion, based upon organisation turnover. The shares are therefore £108,500 for Derbyshire Community Health Services NHS Foundation Trust, and £72,400 f or Derbyshire Healthcare NHS Foundation Trust

Case for Change: Key Messages

Whilst some pathway areas already work together (for instance through the STP) there was a consensus view that this programme of work took things further and gave individuals greater scope and opportunity to genuinely come together to think about things differently. As a result the clinical pathways workshops had begun to stimulate constructive and enthusiastic discussions in each of the four priority areas.
In addition to some of the emerging benefits, the discussions reinforced the overarching comprehensive case change detailed in the SOC.
As these considerations were based upon the premise of the proposed integration in the SOC, the discussions were focused on identifying those things which would make a genuine difference as one organisation versus those that could be done as separate organisations. There were clear generic aspects identified which were thought to provide greater opportunities as a single organisation, though some may still be achievable through close partnership working. These were consistent across all workshops and include:

- Shared patient records through single IT systems
- Single governance structures, procedures and policies (there were examples where various governance challenges have precluded services from working effectively)
- Genuine shared responsibility and accountability
- Single set of outcomes
- Co-location; 'conversations not referrals'
- Consistent development agenda
- Ability to improve clinical research (e.g. easier to recruit top academics and for trials)
- Opportunity to reduce overhead costs to remain competitive
- Greater transformation and leadership capacity to deliver scale of change
- Improvements would be quicker and easier to implement
- Quality and clinical sustainability – ability to afford governance and senior clinicians to drive improvements
- Workforce - attracting and retaining staff with right skills
- Shared identify, creating genuine teams

These improvements identified through the clinical pathways workshops are also consistent with those identified *'Making Mergers Work – Improvements NHS providers have achieved through mergers, NHSI, May 2016'* (see appendix 5).

One of the key messages that came out consistently in the workshops was that the challenges and obstacles faced to date would continue to slow down progression. This was because staff felt, that in theory some things could be done in partnership but in reality the obstacles of working across organisational boundaries would continue to get in the way. This would result in increased risks within the process as ultimately everyone aims to work towards common goals however these would always come secondary to the respective organisational priorities and drivers and staff would revert to 'what my organisation wants'.

Overall, whilst the development of the detailed case for change for each of the four areas made significant progress, there was further work required to confirm buy-in and clearly identify benefits. The outputs were also to be developed in the context of the transaction itself to ensure there were no negative implications as a result of the proposals (e.g. in terms of due diligence, finance and infrastructure). The decision was taken to cease the programme prior to this work being undertaken. As a result the case for change developments have not been finalised with respective clinical/ managerial leads.

Furthermore the discussions were in the context of a single organisation and the outcomes will now need to be considered and refined on the premise of our two organisations working as part of a system wide approach.

Conclusions and Next Steps

The overarching case change remains compelling and it is important to remember this was the driver for the transaction rather than organisational specific challenges (e.g. finance, governance or service sustainability) which are usually the reasons for other NHS transactions. Both organisations have stated continued commitment to taking forward the case for change and make improvements in patient care; however, this will now be done through the Derbyshire STP and the development of Accountable Care Systems rather than formal integration of the two Trusts.

In the STP there are opportunities which will progress and it will be important to harness the enthusiasm witnessed through the clinical pathways discussions. It is necessary to recognise that as this work progresses through the STP there will need to be successful engagement of clinical and other staff to support the developments, and dedicated capacity and commitment to deliver the changes.

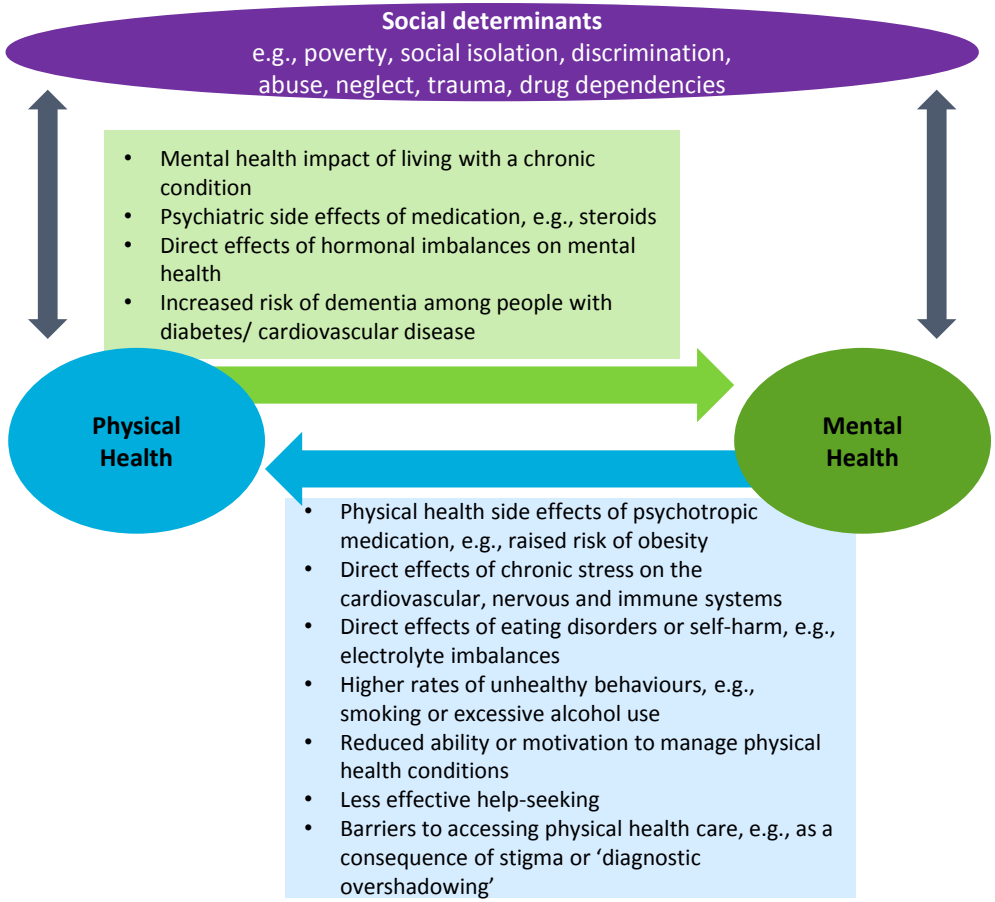
Placed Based Care will be one of the key areas where the greatest improvements can be made by DCHS and DHcFT as the two community providers in the STP; . Successful transformation through the Derbyshire STP will be predicated on clinical engagement and both organisations will need to ensure this is prioritised to actually make the changes happen.

DHCS and DHcFT's work together on back office functions collaboration will continue, distinct from the discontinued merger process.

There is now a need to overlay the learning from clinical pathways discussions with the STP plans to ensure the two aspects mesh together and support delivery. This will be taken forward through the STP accountable groups so the progress made through the transaction process is not lost.

Strategic Case: Overview

Nationally and locally the importance of bringing together physical and mental health is recognised; along with new approaches to integrate care. However, there remains a view that '*integrated care initiatives in England and elsewhere have paid insufficient attention to the relationship between physical and mental health' (Kings Fund 2016).* Furthermore *'physical and mental health are closely interconnected and affect each other through a number of pathways' (Kings Fund 2016)* as demonstrated in the diagram below.



Bringing together physical and mental health - A new frontier for integrated care, Kings Fund, March 2016.

We recognise that there are various factors which have created obstacles in our local response to physical and mental health needs in an integrated way, such as institutional and cultural barriers. This is also true for people with solely physical needs (e.g. people with long term conditions). This results in our patients receiving care in a disconnected way; which is further compounded where they have both physical and mental health needs. Separate clinical systems, governance arrangements and organisational cultures do not currently facilitate a consistent response to meet these needs.

The Dalton review (Dalton 2014), set out a range of ways in which provider organisations might work together in future to address the challenges facing the NHS. Whilst this supports our considerations and the case for change it is important to note that successful delivery of place based care will need to facilitate opportunities for *'providers in the same area being supported to collaborate. This is based on a conviction that, for the most part, health care provision is essentially local and the opportunities to develop systems of care are therefore best pursued among those serving the same or similar populations' (Place-based systems of care; A way forward for the NHS in England; Kings Fund, November 2015).*

There is a risk that even by developing and delivering place based care to ensure services are more joined up and coordinated, the step change required to genuinely integrate our services will not come to fruition; particularly given the interconnection between physical and mental health and wellbeing.

As described earlier in this SOC, the Derbyshire STP aims to address the three gaps which have been identified (Health and Wellbeing, Care Quality, Finance and Efficiency) a key component of which will be the establishment of place based care. Both DCHS and DHcFT fully recognise that addressing the system challenges requires a coordinated response with each other and our partner organisations. We cannot focus on an approach which is 'best for self' and continues to reinforce organisational boundaries if we are to ensure the best possible outcomes for our patients and the populations we serve. This therefore provides a compelling case as to why we need to change.

The considerations set out in this SOC are therefore structured around addressing the three STP gaps and are reflected in the case for change which follows.

Case for Change: Why do we need to change?

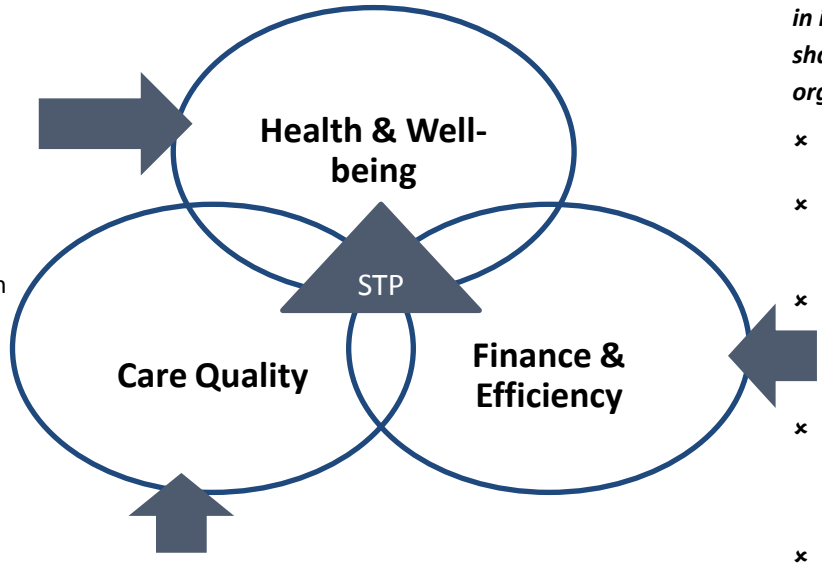
APPENDIX 2

As well as the need to integrate physical and mental health overall, both organisations face challenges in supporting the system to address the STP gaps. These are summarised below. The detailed case for change can be found at Appendix 3.

The case has been developed primarily by the Clinical Quality Reference Group with additional input by Finance leads and the Core Group; this is described in the approach section of this SOC.

People living longer in ill health, significant inequalities in outcomes and healthy life expectancy; geographically and across certain key groups of the population

- Current models of care do not maximise the opportunities to impact on Public Health issues
- Supporting self-help and self-directed care to enable more effective prevention
- Current access to universal Children's services is complex and inconsistent
- Differentiated care impacting on equality & diversity affecting both physical and mental health
- Ageing population with increased dependency on services for both physical and mental health



Service pressures caused by rising demand, lack of integrated and proactive care and infrastructure challenges including shortages in key professional groups, an underutilisation of estate, challenges in integrating clinical information systems and sharing information within and across organisations

- Workforce pressures and challenges
- Working practices are not optimised and may not add value
- Lack of leadership (clinical and non-clinical) and culture to support the transition to place based care
- Patient care is too often characterised by organisational and role boundaries rather than centred on people and communities
- Inefficient maintenance and use of estate owned by both organisations
- Future financial unsustainability and the lack of system wide productivity
- Inefficient use of existing resources

The local system is not as joined up as it should be; is overly reliant on bed based care and we do not always provide care in the right settings

- Clear pathways from point of referral from primary care onwards do not always exist
- Variation in access to services for both physical and mental health
- Complexity in navigation through the system results in duplication and people not being treated holistically
- Current models do not fully support connectivity to place based care

APPENDIX 3

DHcFT STAFF COMMUNICATION
6 June 2017

Dear colleague

This afternoon, the Trust's Board of Directors reached a decision not to proceed with the proposed merger of our organisation with Derbyshire Community Health Services NHS Foundation Trust (DCHS) at this time. We have informed DCHS of this decision.

There are several reasons why we have made this decision:
As directors of the Trust, we are keenly aware of our duty to provide high-quality care and support to the people we serve. We are very proud of the services you and your teams provide, and believe it is our duty to ensure those services are maintained – both now and in the future.

- We know that services across our Trust are currently under a lot of pressure. Demand is very high, and resources are stretched. We feel that the Trust as a whole needs to focus on maintaining our day-to-day quality of care, backed up by good governance and strong financial management. Developing the business case for a potential merger with DCHS has put additional pressure on a wide range of staff, and we feel we must take that pressure off staff with immediate effect.

The clinical case for change was the driving force behind the proposed merger. There has been a lot of important and beneficial work done through clinical workshops to explore the potential benefits for patients, and it seems that some of our services may be able to see benefits from working more closely with teams at DCHS. We will continue to pursue those benefits and to encourage more joint working between teams here and at DCHS. However we no longer believe that a merger of the two organisations is the best way to achieve these benefits.

- The landscape in which we are operating has changed since we began our work with DCHS last year. Health and care organisations across Derbyshire have strengthened their commitment to working more closely together. The Sustainability and Transformation Plan (STP) has now developed into a Sustainability and Transformation Partnership, which is gaining momentum. Meanwhile there is a new national direction of travel towards the development of Accountable Care Systems (ACS) that will seek to establish new models of care, meaning that services previously provided separately will be more integrated. We feel that we should focus our attention on the development of an Accountable Care System for the whole of Derbyshire, as we believe that this could bring even greater benefits for our population – not least in ensuring that mental health is valued equally with physical health.

Thank you to everyone who has contributed to the discussions to date on the potential merger. We have received some really valuable feedback and can assure you that this work will not be lost. Over the coming months, we will be working closely with colleagues at DCHS to build on the work done so far and to understand where opportunities for closer integration might lie. We are anticipating that these will be presented to both our Boards over the summer.

We will also continue to work with our colleagues at DCHS to integrate some of our support services, such as our Workforce & Organisational Development and Estates services. This is part of a wider NHS efficiency programme associated with Lord Carter's work on NHS efficiency.
We are in a strong position as a Trust, thanks to your efforts. Thank you, as always, for your ongoing support and commitment.

Caroline Maley
Acting Chair

Ifti Majid
Acting Chief Executive

APPENDIX 4

DCHS STAFF COMMUNICATION
6 June 2017

Dear all,

DCHS NHS FT has been informed by the Board of DHcFT that they no longer want to pursue the merger that we have been working together on. You can read about their decision and the reasons behind it in the attached statement.

We respect this decision which has obviously been taken after much deliberation but are very disappointed by it. The vision we jointly set out in the Strategic Outline Case for integration last year remains compelling and has, in our view, been strengthened and supported by the clinical case for change that many colleagues across the two organisations have been developing over the last few months.

We will be working closely with DHcFT trust colleagues to see how we can deliver as many benefits as possible from the clinical case for change without an organisational transaction in the context of the emerging Sustainability and Transformation Partnership between all the providers in Derbyshire.

Our work together on streamlining and integrating 'back office' functions, driven by the national Carter review, will continue with an immediate focus on People, Organisational Effectiveness and Estates.

We would like to thank everyone who has been involved in the work to develop the Outline Business Case for the time and energy they have devoted to the process and assure you of our commitment to building on it through a more informal alliance with our partners at DHcFT.

Tracy Allen
Chief Executive

Prem Singh
Chair

Making Mergers Work – Improvements NHS providers have achieved through mergers, NHSI, May 2016

Figure 1 Improvements that can be achieved through a merger

Improvement	
Improvement in clinical service delivery	• Relocating, consolidating and introducing new services • Implementing best practice clinical processes and models • Standardising clinical practice and processes • Improving and rationalising estate • Improving clinical research (eg easier to recruit top academics and for trials)
Corporate overhead savings	• Consolidating hospital boards and senior management • Integrating back-office functions (eg finance, HR, IT, legal and estate management)
Clinical savings	• Integrating clinical support services and management • Centralising the procurement function
Workforce improvements	• Aligning roles and pay grades • Increased ability to recruit and retain clinical and non-clinical staff

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 27 July 2017

Integrated Performance Report Month 3

Purpose of Report

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

Executive Summary

The Trust continued to perform well against many of its key indicators during June This Executive Summary draws out a number of key issues for discussion by the Board of Directors.

The main key theme for month's 3, 4 and 5 is the escalation in staffing issues across the acute inpatient wards.

Despite the delivery of recruitment activities, staffing remains a constant challenge for many Trust services both in the community and ward areas. As requested by the Board of Directors, the Director of Nursing has reviewed the safer staffing report.

The Trust wide vacancy rate is 8% below the Trust target of 10%. This is well below the national and regional average. It was discussed last month the need to reduce this trajectory down to drive performance improvement so we focus on service areas which are significant outliers against the trust average.

There is a high level of RMN (Registered Mental Health Nurse) / RNLD (Registered Nurse Learning Difficulties) in the Trust's workforce. In addition, campus skill mix is set at five staff on shift which is set at three registered professionals. This is above the national average.

Acute areas have had very traditional skill mix models, over 2016/ 17, pilots of occupational therapists working day shifts at the Hartington unit have been undertaken and in design at the Radbourne unit. These posts are out to advert and we are using our expanded OT (Occupational Therapy) and AHP (Allied Health Professionals) leads to attract, recruit and retain this workforce.

The Director of Nursing has partial assurance on staffing levels, against planned standards, however, is assured that safe and effective operational management is in place to mitigate all risks, however our performance in filling ward staffing is fluctuating significantly.

Nursing and Quality staff, as well as other staff, are being deployed to support campus services over the summer period to maintain safety and also to support our staff in this time of transition until our new staff commence.

Last month the team discussed the need to have a continued focus over the summer to restabilising key campus sites and ensure proactive operational management and planning. To mitigate this in particular at the Hartington unit, additional senior

management support will be meeting with the Hartington campus team to ensure full mitigating actions are put in place to maintain safe services over this period.

Bed occupancy is lower at this time and this is creating a balancing situation of risk which is being monitored closely by the leadership team.

If operational vacancies and mitigating plans are not fully realised, the Director of Nursing's opinion is there is still a risk to patient experience and to the quality of the service which we provide. Further mitigation and deployment of our resources and additional resources are still required to maintain the quality of our services.

Additional recruitment programmes to drive forward some recruitment diversification from RGN's, (Registered Nurses) social workers and occupational therapists are being additionally supported and have had external support in social media of staff taking an interest in positions.

Quality and Operational Performance

There is substantial improvement in the uptake of supervision in some service areas. However, there remains a concerted effort to create sufficient time to enable supervision to be undertaken in Campus.

Following a reported increase in May across a number of indicators, during June;

- The number of incidents of prone restraint has decreased compared with the previous month (from 13 to 9)
- The number of incidents of absconsion has reduced
- The number of patients with a Safety Plan is continuing to increase. A trajectory is in design by the medical Director and is considering the monthly activity and the need to focus upon the individuals with the greatest needs.
- The number of inpatients with a VTE (Venous Thromboembolism) assessment is increasing and this is showing a more firm improvement
- The forensic risks assessment and risk profile HCR20 assessments have been completed for relevant patients
- The percentage of in-patients with a recorded capacity assessment has neared the target at 94.49%; we continue to invest the time of our clinical skills tutor and staff to work on improving the quality. We will roll out further initiatives over the summer to ensure layering of knowledge and skills in this area.
- In our patient experience reports the number of compliments has increased

Also of note is the number of outstanding actions following serious incident investigations has reduced. We have scheduled a number of learning events over the summer period for our children's, substance misuse and county wide services to address the improvement required in safeguarding training.

The number of outstanding actions following the CQC (Care Quality Commission) comprehensive review has reduced, we continue to have focused meetings to drive continual service improvement and ensure our learning is embedded.

There remain a number of challenges. This report includes quarterly data and raises issues with respect to an overall increase against quarterly targets in serious incidents, duty of candour, seclusion, physical assault on staff and patients, due to the increases previously reported during May. Some further equalisation of trend will be required over a twelve month period rather than a quarterly or monthly observation in these areas.

There is an increase in the number of concerns raised, this service feedback is critical to enabling our service to learn and improve.

Continued focus is required to improve compliance with; safety plans, VTE assessment, response to complaints, completing actions resulting from complaints and serious incidents. As previously highlighted the impact will not be experienced until September 2017.

Issues with systems to accurately identify LD (Learning Difficulties) Care and Treatment Review are in progress and we endeavour to see improvements in this area again in September.

The Quality Committee has reviewed longitudinal data on the positive and safe strategy considering the use of restraint and seclusion. Over time this continues on a downward trajectory and performance this month with the number of episodes of patients held in seclusion has increased needs to be reviewed in this context.

The number of inpatients with a VTE assessment is increasing, although compliance remains low and has limited improvement. It has been recommended that this continues to be a main focus for the Executive Director for physical health and campus ACDs (Associate Clinical Directors) with their wider teams to significantly improve this trajectory. This is a key indicator for our emerging Physical Healthcare Strategy which is in design and will be completed in September 2017.

Linked to the above, there has been increase in the number of serious incidents reported to the CCG (Clinical Commissioning Group) and an increase in the number of incidents meeting the duty of candour requirements. This shows good governance of our model of operations in this area. The quality committee will assess and benchmark whether there is a trend over one quarter.

The number of falls on inpatient wards has increased, however initial base analysis demonstrates this is related to good reporting and less actual harm. The Director of Nursing has reviewed an analysis and the full analysis will be included in the Quality Committee report in September.

Operational performance remains relatively stable with the vast majority of KPI’s being achieved.

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

People Performance

Staff attendance remains a significant challenge to the Trust with an annual sickness absence rate of 5.53%. In June the sickness absence rate for the month was 5.49% which is lower than the annual rate and 0.79% lower than in the same period last year (June 2016).

Compulsory training compliance remains high at 86.96% which is below our 90% target but above our main contract non CQUIN (Commissioning for Quality and Innovation) target of 85%. There has been an increase in overall appraisal completion at 75.22% against a target of 90%, however medical staff appraisal completion has decreased by 1.13% but remains high at 84.16%.

The budgeted full time equivalent vacancy rate for June was 8.32%, a decrease of 0.11% compared to the previous month. During June 21 employees left the Trust and 23 people joined the Trust as new starters. Over the previous six months 118 employees have left the Trust and 154 people joined the Trust.

Work continues on the recruitment action plan which covers how we plan to tackle each vacancy and includes campaigns and open days across the UK, incentives where necessary and overseas recruitment for hard to fill posts.

Financial Performance

In surplus terms, the Trust is slightly ahead of plan in the month by £5k and is ahead of plan by £22k year to date. The forecast is to achieve the control total at the end of the financial year.

With regard to other financial performance factors, the Use of Resources (UoR) metrics is a 2 year to date and is forecast to be a 2 at the end of the financial year. Current performance is strong in all measures. Forecast-wise four of the five metrics remain strong at 2, 1, 1 and 2, but there is deterioration in agency spend against ceiling, which is forecast at a 3 by year end. This is, however, still better than last year and would meet our objective of being less than 50% above the ceiling. Currently the forecast for agency medical expenditure is above the required reduction by £190k. However it is important to note that the forecast includes a contingency for unforeseen agency requirements. If this was not included in the forecast then the required reduction would be achieved.

Planning continues for cost improvement action required to achieve 2017/18 control total financial plan. The forecast assumptions for the year-end financial plan delivery now requires an over-achievement against the cost reduction target, so there is now even greater urgency required in finalising the CIP (Cost Improvement Programme) plans. The Commissioner-driven QIPP (Quality, Innovation, Productivity and Prevention) disinvestment schemes that require £3.05m income and cost reduction are not yet agreed. These are incorporated into the Mental Health STP (Sustainability Transformation Programme) work stream planning.

The numbers reported in the IPR are consistent with the numbers reported in the monthly finance return to NHS Improvement.

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

Assurances

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

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

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

Consultation

This paper has not been considered elsewhere however 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

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks
This report reflects performance related to our whole staff and service receiver population and therefore includes members of those populations with protected characteristics in the REGARDS groups. Any specific impact on members of the REGARDS groups is described in the report itself.

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

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

- Surplus slightly ahead of plan year to date
- Forecast achievement of control total
- Cash better than plan
- All UoR ratings strong YTD
- Cost Improvement Programme forecast to over deliver

Challenges

- Delivery of Cost Improvement Programme
- Containment of expenditure in order to deliver the control total
- Containment of agency expenditure within ceiling set by NHSI

Operational Perspective

Highlights

- Outpatient letters compliance has improved

Challenges

- Achieving priority metric compliance
- Clustering
- Outpatient cancellation compliance
- Discharge fax sent in 2 working days
- Delayed transfers of care

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

- No of incidents of prone restraint has decreased compared with the previous month (from 13 to 9)
- No of incidents of absconsion has reduced
- No of patients with a Safety Plan is continuing to increase
- No of inpatients with a VTE assessment is increasing
- All HCR20 assessments have been completed for relevant patients
- No of compliments has increased
- % of in-patients with a recorded capacity assessment has neared the target at 94.49%
- No of outstanding actions following serious incident investigations has reduced
- No of outstanding actions following the CQC comprehensive review has reduced

Challenges

- This report includes quarterly comparison data for Q2 17/18. It raising challenges with respect to an increase in serious incidents, duty of candour, seclusion, physical assault on staff and patients, overall during the last quarter due to the increases previously reported during May
- An increase in the number of concerns raised
- Continued focus required to improve compliance with; safety plans, VTE assessment, response to complaints, completing actions resulting from complaints and serious incidents
- Issues with systems to accurately identify LD Care and Treatment Review and seclusion episodes to be resolved

FINANCIAL OVERVIEW – June 2017

Category	Sub-set	Metric	Period	Plan	Actual	Rating	Trend	Key Points
Governance	Use of Resources (UoR) Metric	**Overall Use of Resources Metric**	YTD	1	2	Y	↓	At the end of June the Use of Resources Rating is an overall '2'. Forecast is a rating of '2' which is slightly worse than the plan of '1'. This is mainly driven by the agency metric which is forecast at a '3' for the end of the financial year. The downward trend in the overall metric, moving from '1' last month to '2' this month is due to the Income and Expenditure variance to plan metric. As previously forecast this metric has moved to '2' due to a lower forecast surplus and income being forecast higher than the plan.
			Forecast	1	2	Y	→	
		Capital Service Cover	YTD	2	2	Y	→	
			Forecast	2	2	Y	→	
		Liquidity	YTD	1	1	G	→	
			Forecast	1	1	G	→	
		Income and Expenditure Margin	YTD	1	1	G	→	
			Forecast	1	1	G	→	
		Income and Expenditure variance to plan	YTD	1	2	Y	↓	
			Forecast	1	2	Y	→	
		Agency variance to ceiling	YTD	1	2	Y	↓	
			Forecast	1	3	A	→	
	Single Oversight Framework	NHS I Segment	YTD		2	n/a	n/a	

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
I&E and profitability	Income and Expenditure	Control Total position £'000	In-Month	339	345	G	↑	At the end of June the surplus is slightly ahead of plan by £22k and is forecast to achieve the control total at the end of the financial year. EBITDA is slightly behind plan at the end of June by £36k and forecast £1m behind plan. This is offset by below the line items such as profit on disposal, small underspends on depreciation and Public Dividend Capital payments.
			YTD	803	825	G	↑	
			Forecast	2,765	2,765	G	→	
		Underlying Income and Expenditure position £'000	In-Month	300	305	G	↑	
			YTD	684	706	G	↑	
			Forecast	1,971	1,971	G	→	
		Normalised Income and Expenditure position £'000	In-Month	300	340	G	↑	
			YTD	684	820	G	↑	
			Forecast	1,971	2,161	G	→	
	Profitability	Profitability - EBITDA £'000	In-Month	952	948	R	↑	
			YTD	2,681	2,645	R	↑	
			Forecast	10,159	9,137	R	↓	
		Profitability - EBITDA %	In-Month	8.5%	8.2%	R	↗	
			YTD	8.0%	7.7%	R	↗	
			Forecast	7.6%	6.6%	R	↘	

Liquidity	Cash	Cash £m	YTD	13.424	14.917	G	↗	Cash is ahead of plan year to date. The forecast includes additional STF income from 2016/17 that will be received during 2017/18 along with cash receipts from asset disposals. Net Current Assets are less than plan due to the removal of an Asset Held for Sale. Capital expenditure is behind plan year to date but is forecast to achieve full spend.
			Forecast	12.193	15.835	G	↑	
	Net Current Assets	Net Current Assets £m	YTD	7.742	4.930	R	↑	
			Forecast	8.345	7.161	R	↑	
	Capex	Capital expenditure £m	YTD	0.468	0.224	R	↓	
			Forecast	3.338	3.338	G	→	

Efficiency	CIP	CIP achievement £m	In-Month	0.321	0.380	G	↑	CIP is currently behind plan. The forecast assumes an overachievement of £853k by the end of the financial year.
			YTD	0.962	0.829	R	↑	
			Forecast	3.850	4.703	G	↑	
			Recurrent	3.850	1.170	R	→	

Key:

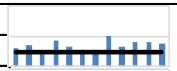
Period In-Month = Current Month
YTD = Year to Date
Forecast = Year end out-turn

Plan In-month or Year end Trust plan

Achieving plan
Not achieving plan

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

OPERATIONAL OVERVIEW – JUNE 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	Key Points
Performance Dashboard	NHSI	CPA 7 Day Follow-up (M)	Month	95.00%	97.73%	G	→		All NHSi metrics are all compliant except "Priority Metrics" which is a new indicator since April 2017. Plans are being formulated to address the under-performance. For each metric we have indicated if it is monitored by NHSi Quarterly (Q) or Monthly (M).
			Quarter	95.00%	97.93%	G	→		
		Data completeness - Identifiers (M)	Month	95.00%	99.39%	G	→		
			Quarter	95.00%	99.39%	G	→		
		Data completeness - Priority Metrics (M)	Month	85.00%	71.12%	R	↓		
			Quarter	85.00%	69.49%	R	↓		
		Crisis Gatekeeping (Q)	Month	95.00%	100.00%	G	→		
			Quarter	95.00%	100.00%	G	↑		
		IAPT RTT within 18 weeks (Q)	Month	95.00%	100.00%	G	→		
			Quarter	95.00%	99.90%	G	→		
		IAPT RTT within 6 weeks (Q)	Month	75.00%	96.50%	G	↑		
			Quarter	75.00%	94.63%	G	↑		
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Month	50.00%	83.33%	G	↓		
			Quarter	50.00%	85.71%	G	↓		
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Month	50.00%	77.78%	G	↑		
			Quarter	50.00%	74.42%	G	↑		
		Patients Open to Trust In Employment (M)	Month	N/A	8.98%		→		
			Quarter	N/A	8.75%		→		
		Patients Open to Trust In Settled Accommodation (M)	Month	N/A	59.15%		↓		
			Quarter	N/A	56.97%		↓		
		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%	52.85%	G	→		
			Quarter	50.00%	53.48%	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

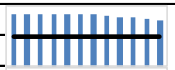
Quarter Current Quarter

Achieving target

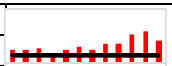
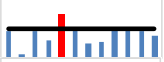
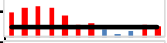
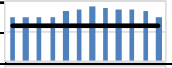
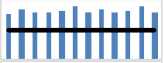
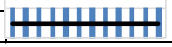
Not achieving target

Trend compared to previous month/quarter

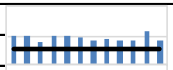
OPERATIONAL OVERVIEW – JUNE 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	Key Points
Performance Dashboard	Locally Agreed	CPA Settled Accommodation	Month	90.00%	95.12%	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%	95.12%	G	↓		
		CPA Employment Status	Month	90.00%	96.27%	G	→		
			Quarter	90.00%	96.27%	G	→		
		Data completeness - Identifiers	Month	99.00%	99.39%	G	→		
			Quarter	99.00%	99.39%	G	→		
		Data completeness - Outcomes	Month	90.00%	93.51%	G	→		
			Quarter	90.00%	93.51%	G	→		
		Patients Clustered not Breaching Today	Month	80.00%	77.52%	R	→		
			Quarter	80.00%	77.91%	R	→		
		Patients Clustered regardless of review dates	Month	96.00%	93.89%	R	→		
			Quarter	96.00%	94.08%	R	→		
		7 Day Follow-up - all inpatients	Month	95.00%	97.85%	G	↑		
			Quarter	95.00%	96.27%	G	↓		
		Ethnicity coding	Month	90.00%	91.56%	G	↓		
			Quarter	90.00%	91.56%	G	↓		
		NHS Number	Month	99.00%	100.00%	G	→		
			Quarter	99.00%	100.00%	G	→		
		CPA Review in last 12 Months (on CPA > 12 Months)	Month	95.00%	95.12%	G	→		
			Quarter	95.00%	95.12%	G	↓		
		Community Care Data - Activity Information Completeness	Month	50.00%	94.32%	G	→		
			Quarter	50.00%	94.24%	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%	73.74%	G	→		
			Quarter	50.00%	74.63%	G	↓		
		Early Interventions New Caseloads	Month	95.00%	100.00%	G	↓		
			Quarter	95.00%	100.00%	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 – JUNE 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	Key Points
Performance Dashboard	Schedule 6	Consultant Outpatient Trust Cancellations	Month	5.00%	9.31%	R	↑		The most common reason was clinician absent from work.
			Quarter	5.00%	11.22%	R	↓		
		Consultant Outpatient DNAs	Month	15.00%	16.05%	R	→		
			Quarter	15.00%	15.70%	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%	90.08%	G	↑		
			Quarter	90.00%	88.71%	R	↑		
		Outpatient letters sent in 15 working days	Month	95.00%	96.89%	G	↑		
			Quarter	95.00%	95.00%	G	↑		
		Inpatient 28 day readmissions	Month	10.00%	7.34%	G	↑		
			Quarter	10.00%	8.79%	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%	85.23%	R	↓		13 discharge faxes were sent outside the target 2 patients on Ward 34 are causing the target to be breached
			Quarter	98.00%	91.09%	R	↓		
		Delayed Transfers of Care	Month	0.80%	0.88%	R	→		
			Quarter	0.80%	0.79%	G	→		
		18 Week RTT Less Than 18 Weeks - Incomplete	Month	92.00%	94.74%	G	↓		
			Quarter	92.00%	95.92%	G	↓		
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%	94.40%	G	↓		
			Quarter	92.00%	95.64%	G	→		
		Mixed Sex accommodation breaches	Month	0	0	G	→		
			Quarter	0	0	G	→		
		Completion of IAPT Data Outcomes	Month	90.00%	95.73%	G	↓		
			Quarter	90.00%	96.39%	G	→		
		Ethnicity coding	Month	90.00%	99.86%	G	↑		
			Quarter	90.00%	95.15%	G	↑		
		NHS Number	Month	99.00%	99.99%	G	→		
			Quarter	99.00%	99.99%	G	→		

OPERATIONAL OVERVIEW – JUNE 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	Key Points
Other Dashboards	Health Visiting	% 10-14 Day Breastfeeding coverage	Month	98.00%	99.28%	G	↓		Compliant with Health Visiting Targets
			Quarter	98.00%	99.73%	G	→		
		% 6-8 Week Breastfeeding coverage	Month	98.00%	99.56%	G	→		
			Quarter	98.00%	99.72%	G	→		
	IAPT	Recovery Rates	Month	50.00%	52.92%	G	→		Compliant with IAPT Targets
			Quarter	50.00%	53.48%	G	→		
		Reliable Improvement Rates	Month	65.00%	69.00%	G	→		
			Quarter	65.00%	70.17%	G	↑		
	Safer Staffing	Inpatient Safer Staffing Fill Rates	Month	100.00%	97.4%	G	↑		Detailed ward level information shows specific variances
			Quarter	100.00%	98.7%	G	↑		

WORKFORCE OVERVIEW – June 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance		Trend	Key Points
Workforce Dashboard	NHSI Key Performance Indicator (KPI)	**Turnover** (annual)	**Jun-17**	10%	**10.49%**	↘	G	↑	Annual turnover remains within the Trust target parameters and is below the regional Mental Health & Learning Disability average of 12.49% (as at April 2017 latest available data). The monthly sickness absence rate is 0.19% higher than the previous month, however compared to the same period last year (June 2016) it is 0.79% lower. The annual sickness absence rate is running at 5.53% (as at May 2017 latest available data). The regional average annual sickness absence rate for Mental Health & Learning Disability Trusts is 5.18% (as at March 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 33.47% of all sickness absence, followed by surgery at 18.32% and other musculoskeletal problems at 8.08%. The Funded Fte vacancy rate has decreased by 0.11% to 8.32%. The number of employees who have received an appraisal within the last 12 months has increased by 0.60% to 75.22%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £232k. Compulsory training compliance has decreased by 0.77% to 86.96% but remains above the 85% main contract non CQUIN.
			May-17		10.59%		G		
		Sickness Absence (monthly)	**Jun-17**	5.04%	**5.49%**	↗	R	↓	
			May-17		5.30%		R		
		Sickness Absence (annual)	**May-17**	5.04%	**5.53%**	→	R	↓	
			Apr-17		5.53%		R		
		Vacancies (including funded fte flexibility / cover)	**Jun-17**		**8.32%**	↘		↓	
			May-17		8.43%				
		Appraisals (**all staff** - number of employees who have received an appraisal in the previous 12 months)	**Jun-17**	90%	**75.22%**	↗	R	↑	
			May-17		74.62%		R		
		Appraisals (**agenda for change staff only** - number of employees who have received an appraisal in the previous 12 months)	**Jun-17**	90%	**74.83%**	↗	R	↑	
			May-17		74.13%		R		
		Appraisals (**medical staff only** - number of employees who have received an appraisal in the previous 12 months)	**Jun-17**	90%	**84.16%**	↘	A	↓	
			May-17		85.29%		A		
		Agency Usage (£ year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Jun-17**	£0	**£1.122m**	↗	R	↑	
			May-17		£0.707m		R		
		Agency Usage (% year to date level of agency expenditure exceeding the ceiling set by NHSI)	**Jun-17**	0%	**26.04%**	↗	R	↑	
			May-17		8.83%		R		
	Other KPI	**Compulsory Training** (staff in-date)	**Jun-17**	90%	**86.96%**	↘	A	↓	
			May-17		87.73%		A		

Key:

Period Current month and previous month

Plan Trust target

↗ Variance to previous month

Achieving target/within target parameters

Approaching target/approaching target parameters

Not achieving target/outside target parameters

Trend based on previous 4 months Turnover parameters (8% to 12%)

QUALITY OVERVIEW – JUNE 2017

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Key Points
Quality	Safe	No of incidents of moderate to catastrophic actual harm	Month	29	32			Plan: average last fin yr 2016/17 (month).
			Quarter	88	98			Plan: average last fin yr (Qtr) 2016/17. Actual: 2017/18 Q1 data
		No of deaths of patients who have died within 12 months of their last contact with DHcFT	Month	104	115			Note, data as at 05/07/2017
			Quarter	312	382			Plan: average last fin yr (Qtr).Actual: 2017/18 Q1 data Note, data as at 05/07/2016
		No of serious incidents reported to the CCG	Month	5	5			Plan - average last fin yr (month)
			Quarter	16	22			Plan: average last fin yr (Qtr). Actual: 2017/18 Q1 data
		No of episodes of patients held in seclusion	Month	10	11			Note, 1 incident did not have the patients details.
			Quarter	30	33			Plan: average last fin yr (Qtr). Actual: 2017/18 Q1 data Note, 1 incident form did not have the patients details.
		No of incidents involving patients held in seclusion	Month	16	12			
			Quarter	47	50			Plan: average last fin yr (Qtr). Actual: 2017/18 Q1 data
		No of incidents involving physical restraint	Month	48	40			
			Quarter	143	126			Plan: average last fin yr (Qtr). Actual: 2017/18 Q1 data
		No of incidents involving prone restraint	Month	10	9			Month plan based on average from 1/7/16 when prone restraint collected on Datix as defined field
			Quarter	29	32			Qtr plan based on average for Q2/Q3/Q4. Actual 2017/18 Q1 data
		No of incidents of physical assault - patient on patient	Month	12	15			
			Quarter	37	37			Actual: 2017/18 Q1 data
		No of incidents of physical assault - patient on staff	Month	19	27			
			Quarter	56	61			Actual: 2017/18 Q1 data

QUALITY OVERVIEW – JUNE 2017

Quality	**Safe**	No of falls on in-patient wards	Month	32	28			
			Quarter	96	83			Actual: 2017/18 Q1 data
		No of incidents of absconsion	Month	33	24			
			Quarter	99	90			Actual: 2017/18 Q1 data
		No of patients with a clinical risk plan (FACE or Safety Plan)	Month	100%	76.14%			
			Quarter	100%	75.39%			
		Of above, no of patients with a Safety Plan	Month	90%	27.23%			Safety Plan replaced FACE from 1/4/2017
			Quarter	90%	27.64%			
		% of staff compliant with Level 3 Safeguarding Children training	Month	85%	78.93%			
			Quarter	85%	NA			Qtr comparison not available
		% of staff compliant with Think Family training	Month	85%	82.56%			
			Quarter	85%	NA			Qtr comparison not available
		% of staff compliant with Clinical Safety Planning eLearning	Month	95%	95.12%			
			Quarter	95%	NA			Qtr comparison not available
		No of people with LD or Autism admitted without a CTR (Care & Treatment Review)	Month	NA	NA			Concern re data quality remains . More robust systems to ensure data quality being worked up imminently with Commissioners.
			Quarter	NA	NA			
		% of compliance with inpatients VTE assessment	Month	95%	15.98%			
			Quarter	95%	NA			
		HCR20 assessment completed, Low Secure	Month	100%	12.5%			Indicator relates to no of patients with HCR20 assessment completed in time. All assessments now completed, but these were not within the timescale. Variance shown as amber, if a breach occurs going forward, the variance will return to red.
			Quarter	100%	NA			

QUALITY OVERVIEW – JUNE 2017

Quality	**Caring**	No of complaints opened for investigation	Month	12	14			
			Quarter	37	47			Actual: 2017/18 Q1 data
		No of concerns received	Month	35	40			
			Quarter	104	106			
		No of compliments received	Month	100	99			
			Quarter	300	266			
		No of investigations by the Parliamentary Ombudsman	2016/17	NA	6			Data is provided cumulatively from 1st April each year
			2017/18	NA	1			
		% of complaints upheld (full or in part) by the Parliamentary Ombudsman	2016/17	2	0			1 ongoing and 5 no further action
			2017/18	0	0			
		% of responded to (orange) complaint investigations completed within 40 working days, opened after 01/04/2016	Year	100%	19%			As at 06/07/2017, 189 (orange) complaints. 91 not responded to within 40 working days. 62 ongoing
			Year	100%	0%			As at 06/07/2017, 7 (red) complaints. 4 not responded to within 60 working days. 3 ongoing.
		No of incidents requiring Duty of Candour	Month	1	1			These figures will fluctuate based on the outcome of investigations.
			Quarter	2	7			Due to increase in major incidents in May 2017
	Effective	% of in-patients with a recorded capacity assessment	Month	100%	94.49%			
			Quarter	100%	93.21%			
		% of patients who have had their care plan reviewed and have been on CPA > 12months	Month	90%	94.85%			
			Quarter	90%	95.30%			
		No of seclusion forms not received by MHA Office	Month	0	NA			Seclusion pathway being moved to PARIS. Being tested on Radbourne Unit from May 2017. Notifications not yet automating. Urgent solution being developed to resolve.
			Quarter	0	NA			
		% of CTO rights forms received by MHA Office	Month	100%	96.0%			
			Quarter	NA	NA	NA	NA	
		% of in patient older adults rights forms received by MHA Office	Month	100%	89.0%			
			Quarter	NA	NA	NA	NA	

QUALITY OVERVIEW – JUNE 2017

Quality	**Responsive**	% of staff uptake of Flu Jabs	Month	45%	NA			Data to end of 30/11/16
			Year	45%	38.40%			Relates to 2016 campaign. Final data as shown in 16/17 Quality Account
		% of policies in date	Month	95%	97.24%			As at 06/07/2017
			Quarter	NA	NA	NA	NA	
	Well Led	% of staff who have received Clinical Supervision, within defined timescales	Month	100%	58.64%			% target increased to 100% to be in line with overall reporting
			Quarter	100%	NA	NA	NA	
		% of staff who have received Management Supervision, within defined timescales	Month	100%	69.10%			% target increased to 100% to be in line with overall reporting
			Quarter	100%	NA	NA	NA	
		No of outstanding actions following serious incident investigations	Month	0	24			Total overdue actions as at 30/06/2017
			Quarter	0	NA		NA	
		No of outstanding actions following complaint investigations	Month	0	56			Total overdue actions as at 30/06/2017
			Quarter	0	NA	NA	NA	
		No of outstanding actions following CQC comprehensive review report (2016)	Month	0	57			

Financial Section

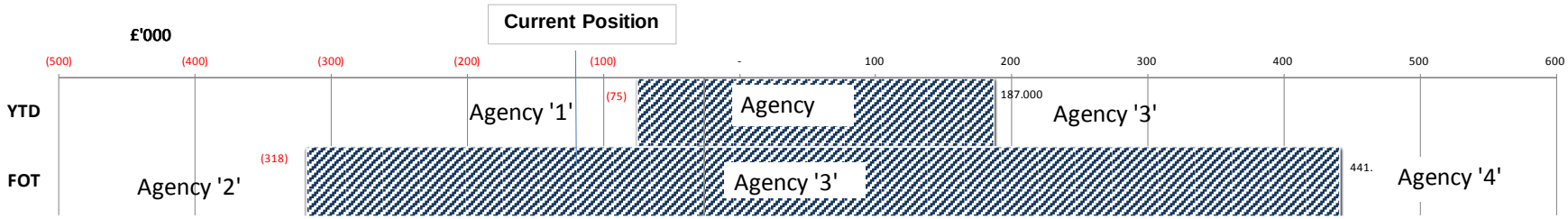
Governance – Use of Resources (UoR) Rating

The Use of Resources rating at the end of June is a '2', with the Liquidity rating and I&E Margin metrics being at a '1' and all other metrics at a '2'. The ratings for each quarter are forecast to be a '2' which is mainly driven by the agency metric moving to a 3 by the end of quarter 2'.

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

As most of the metrics are in a healthy position and it is the agency metric that is driving the lower rating in the forecast, this is the area of focus from a headroom perspective.

The agency metric is currently forecast at a '3' for the end of the financial year. In order to reduce that metric down to a '2' by the end of March then we need to reduce agency expenditure by £318k. However if we spend an additional £441k above the current forecasted levels then this would move the metric to a 4 and trigger an override.



Income and Expenditure

Statement of Comprehensive Income — June 2017

	Current Month			Year to Date			Forecast		
	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)	Plan	Actual	Variance Fav (+) / Adv (-)
	£000	0	£000	£000	£000	£000	£000	£000	£000
Clinical Income	10,297	10,698	401	31,136	31,912	776	124,378	127,846	3,468
Non Clinical Income	874	797	(77)	2,376	2,559	183	9,822	9,975	153
Employee Expenses	(7,914)	(8,205)	(291)	(23,829)	(24,571)	(742)	(95,932)	(99,877)	(3,945)
Non Pay	(2,305)	(2,342)	(37)	(7,003)	(7,255)	(253)	(28,108)	(28,807)	(699)
EBITDA	**952**	**948**	**(4)**	**2,681**	**2,645**	**(35)**	**10,159**	**9,137**	**(1,022)**
Depreciation	(278)	(272)	6	(835)	(815)	20	(3,338)	(3,319)	20
Impairment	0	0	0	0	0	0	(300)	(605)	(305)
Profit (loss) on asset disposals	0	0	0	0	0	0	0	950	950
Interest/Financing	(176)	(174)	2	(566)	(535)	31	(2,146)	(2,120)	26
Dividend	(159)	(157)	2	(478)	(471)	6	(1,910)	(1,884)	26
Net Surplus / (Deficit)	**339**	**345**	**5**	**803**	**825**	**22**	**2,465**	**2,160**	**(305)**
Technical adjustment - Impairment	0	0	0	0	0	0	(300)	(605)	(305)
Control Total Surplus / (Deficit)	**339**	**345**	**5**	**803**	**825**	**22**	**2,765**	**2,765**	**0**
Technical adjustment - STF Allocation	40	40	0	119	119	0	794	794	0
Underlying Net Surplus / (Deficit)	**300**	**305**	**5**	**684**	**706**	**22**	**1,971**	**1,971**	**0**

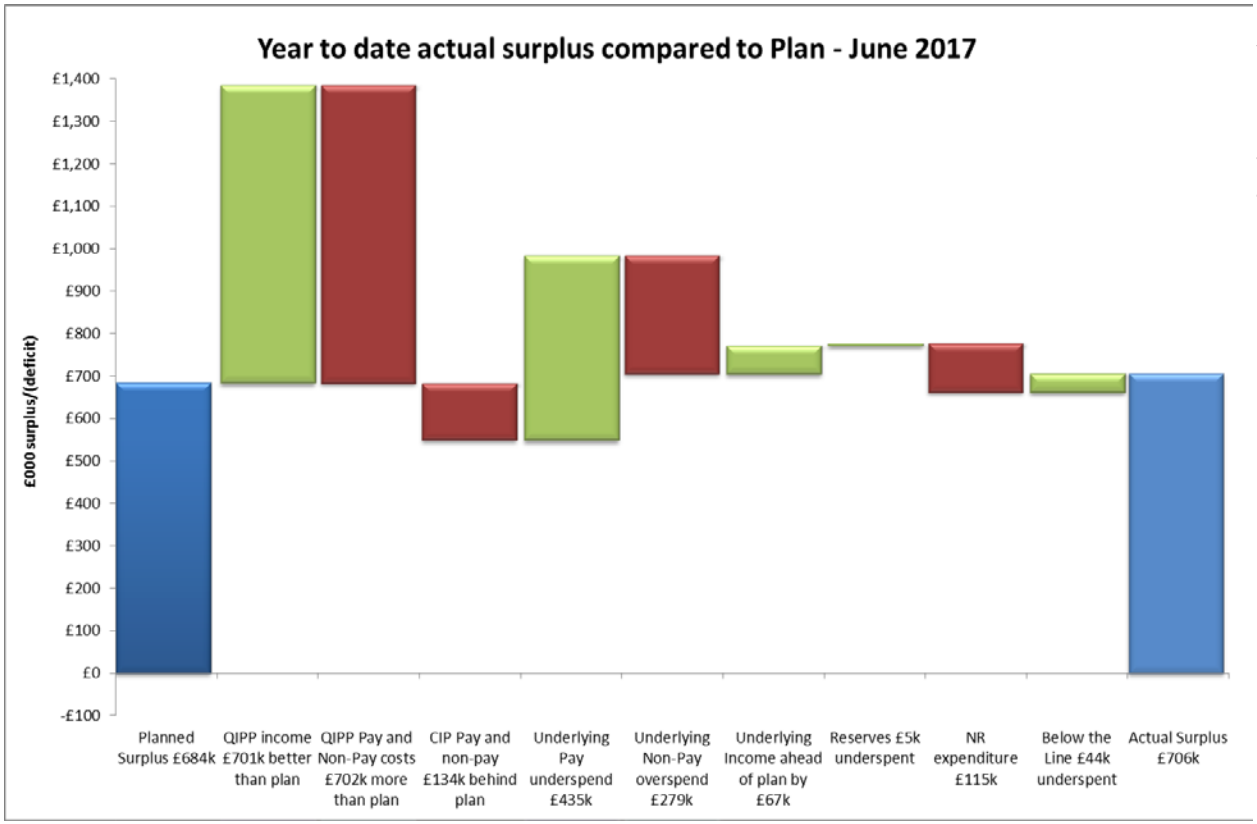
The Statement of Comprehensive Income shows both the control total surplus of £2.77m which includes the Sustainability Transformation Fund (STF) income and the underlying surplus / (deficit) against the underlying plan with the STF income excluded £1.97m.

Clinical Income is £776k more than plan year to date and at the end of the year is forecast to be £3.47m ahead of plan. This is mainly due to the income related to QIPP disinvestments not being removed from the contract as currently no further disinvestments have been identified (offsetting expenditure).

Non Clinical income is ahead of plan year to date by £183k and has a forecast outturn of £153k ahead of plan. This mainly relates to secondments (with corresponding expenditure) along with Education and Training income being higher than planned.

Pay expenditure is £742k more than the plan at the end of June and forecast £3.9m more than plan. This relates to costs not yet being released relating to QIPP disinvestments (offsetting income) and CIP forecast to be delivered in a different way to the plan.

Non Pay is overspent year to date by £253k and is forecast to be £699k more than plan at the end of the year which mainly relates to the overspend on the Acute Out of Area budget partly offset by other underspends.



Summary of key points for YTD variances

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

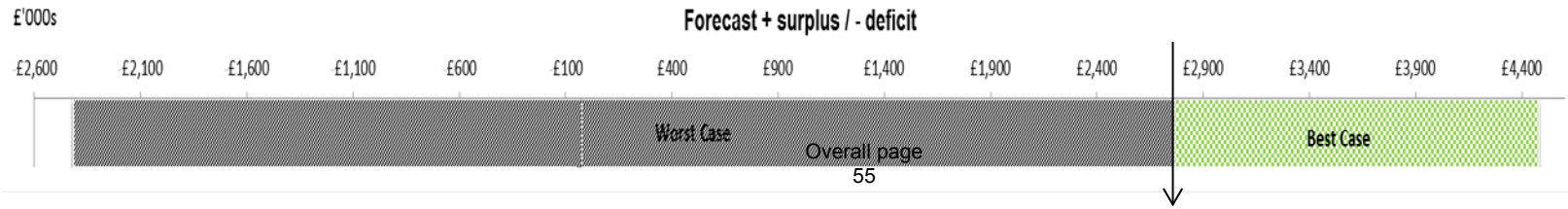
- QIPP income is more than plan which is equally offset by pay and non-pay expenditure being more than plan . This is due to the disinvestment not yet being fully agreed with Commissioners.
- CIP is currently behind plan in the month.
- Underlying pay underspends (exc. QIPP/CIP) due to various vacancies across the Trust, partially offset by bank and agency expenditure.
- Underlying non-pay overspend (exc. QIPP/CIP) driven by out of area expenditure higher than plan.
- Non-recurrent expenditure related to some temporary posts along with non-recurrent transaction costs.

Forecast Range

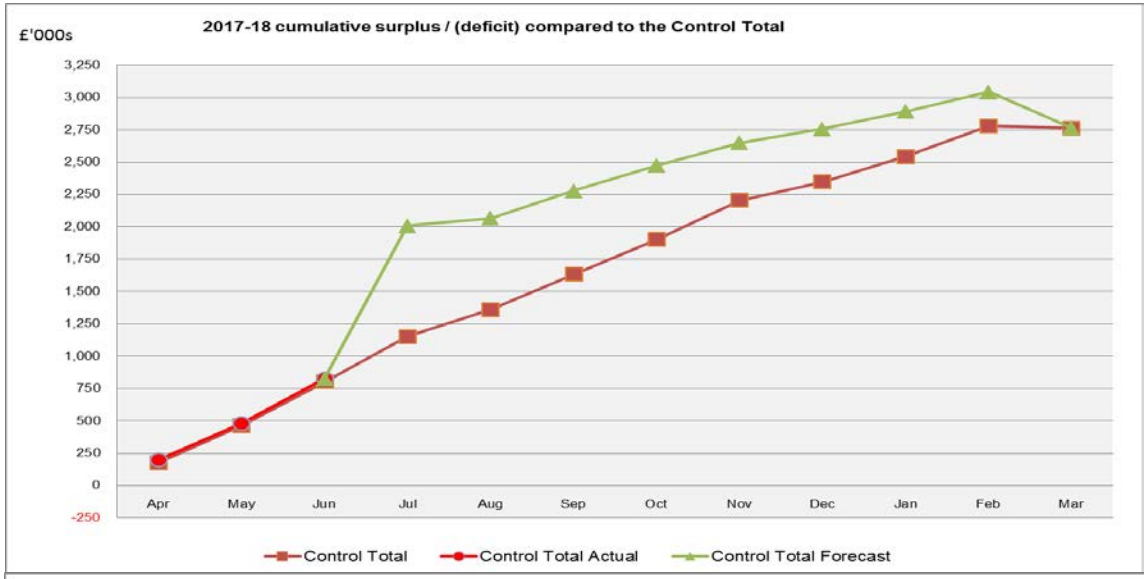
Best Case	Likely Case	Worst Case
£4.5m surplus	£2.8m surplus	£2.4m deficit

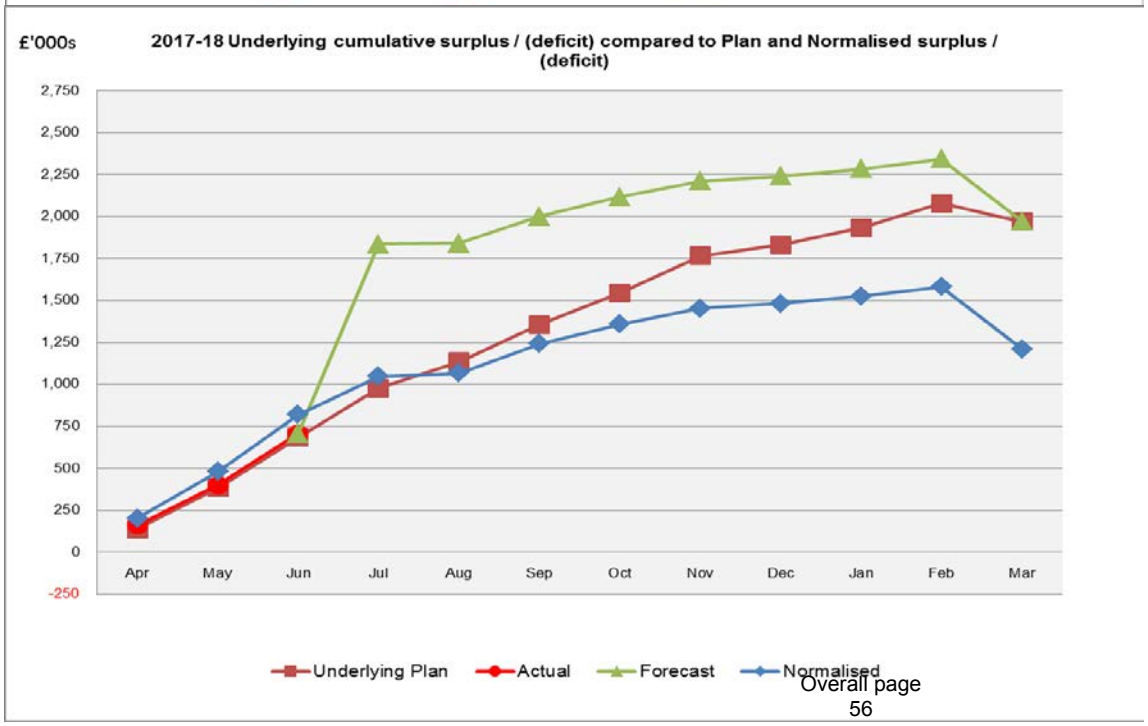
Forecast Range

The main variables in the forecast range are: STF income loss, CIP not fully achieved, agency expenditure, CPC income and other unexpected pay and non-pay costs.



Normalised Income and Expenditure position





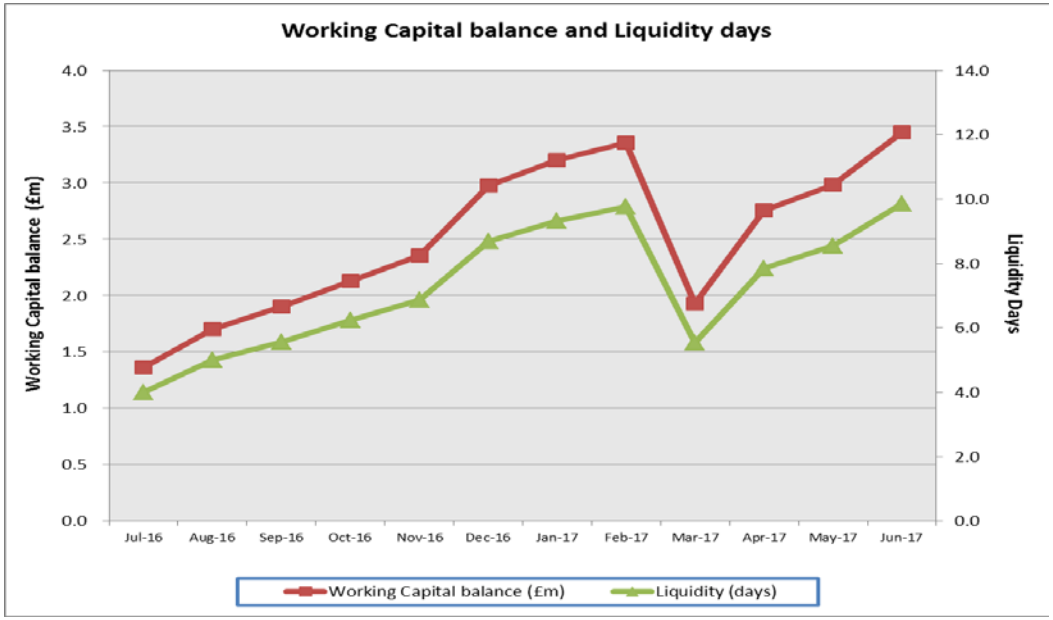
The first graph shows the actual cumulative surplus against the control total (including the Sustainability Transformation Fund (STF).

The peak in the forecast for July (on both graphs) relates to some additional overage income from a previous asset disposal.

This second 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 expenditure in the position related to temporary staff posts for part of the financial year and non-recurrent transaction costs. There is also some non-recurrent income from the overage related to a previous asset disposal. In the normalised position these have been removed.
As shown in the graph if these non-recurrent items were not incurred then the forecast outturn would be below the plan and would require additional management action to achieve the control total.

Liquidity



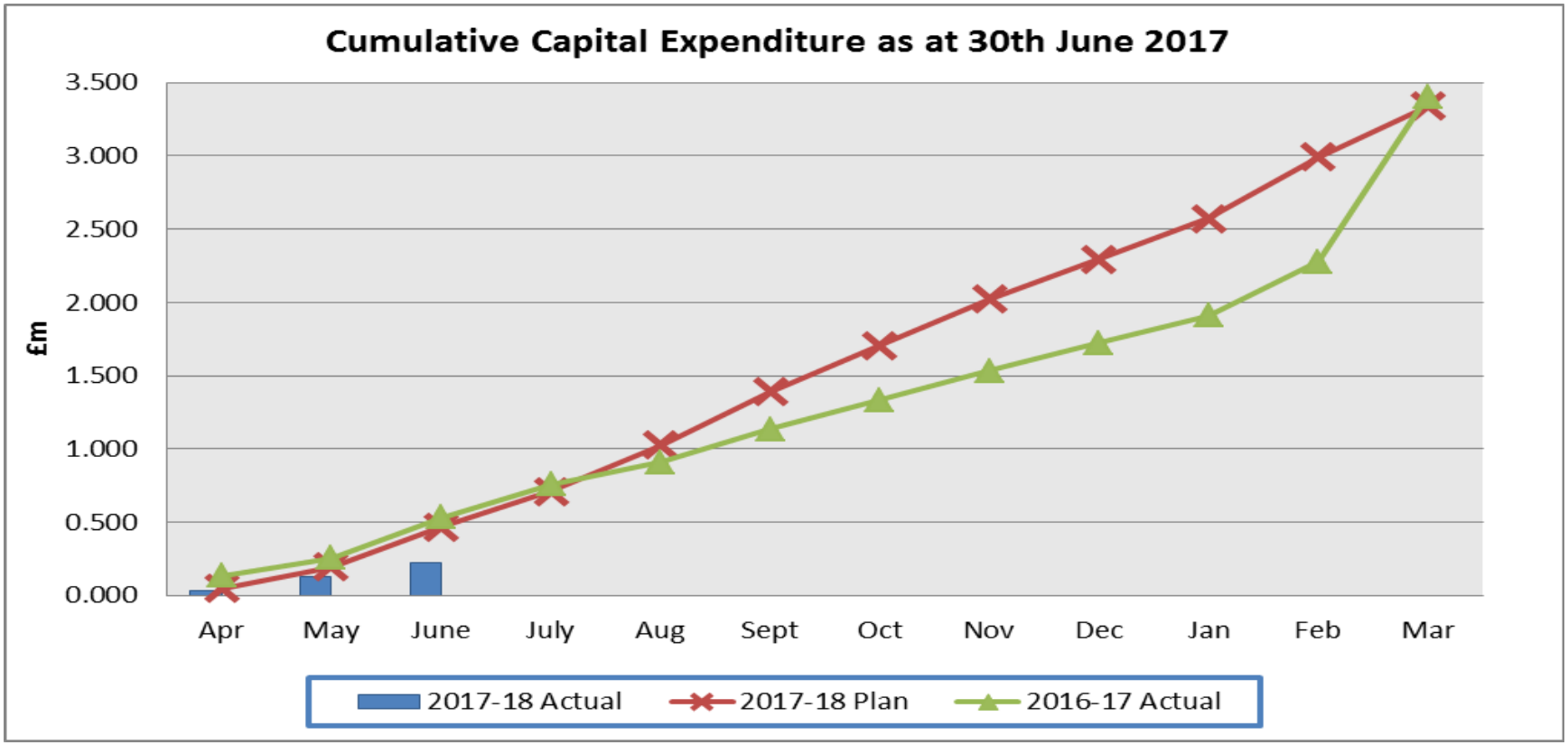
The first graph shows the working capital balance for the last 12 months (net current assets less net current liabilities adjusted for assets held for sale and inventories) and how many days of operating expenses that balance provides.

During the last 12 months working capital and liquidity continues to improve due to higher cash levels. The downturn in 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 June is just under 10 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 £14.9m which is £1.5m better than the plan at the end of June and is forecast to be above plan by £3.6m. This is mainly due to sale proceeds and additional STF income related to 2016/17.

Capital Expenditure

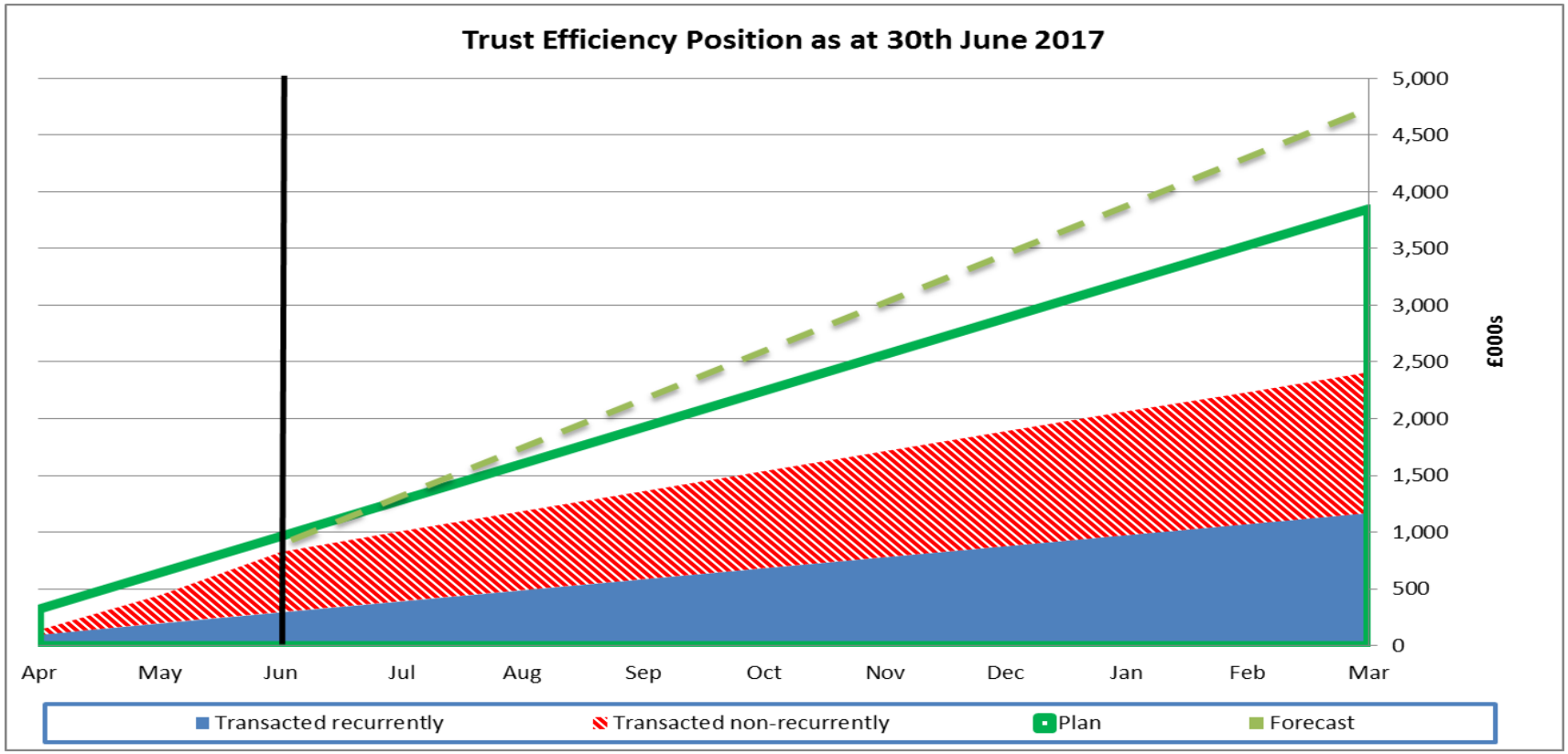


Capital Expenditure is behind plan by £244k at the end of June. There is a fully committed plan which may need to be re-prioritised in year to take into account any urgent bids that arise, which will be monitored by the Capital Action Team.

Additional STF income which was notified to us in 2016/17 and will be paid in this financial year is expected to be added to the capital plan. This could be invested in schemes that will drive further efficiencies across the Trust. This is currently not included in the forecast.

Efficiency

Cost Improvement Programme (CIP)



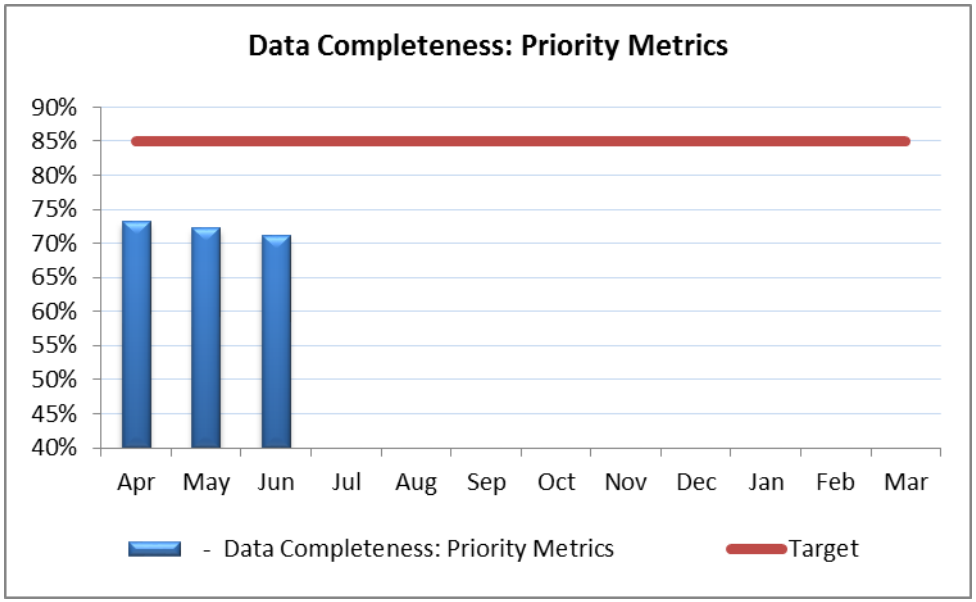
At the end of June there was £2.4m of assured CIP against a plan of £3.8m, which left a gap of £1.4m. Of the £2.4m assured, £1.2m was assured non-recurrently.

The forecast assumes a further delivery of £2.3m of which £1.8m is non-recurrent. The total CIP forecast to be delivered is £4.7m which is an overachievement of £853k against the target of £3.8m. Of the £4.7m £3.0m is non-recurrent in nature.

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.

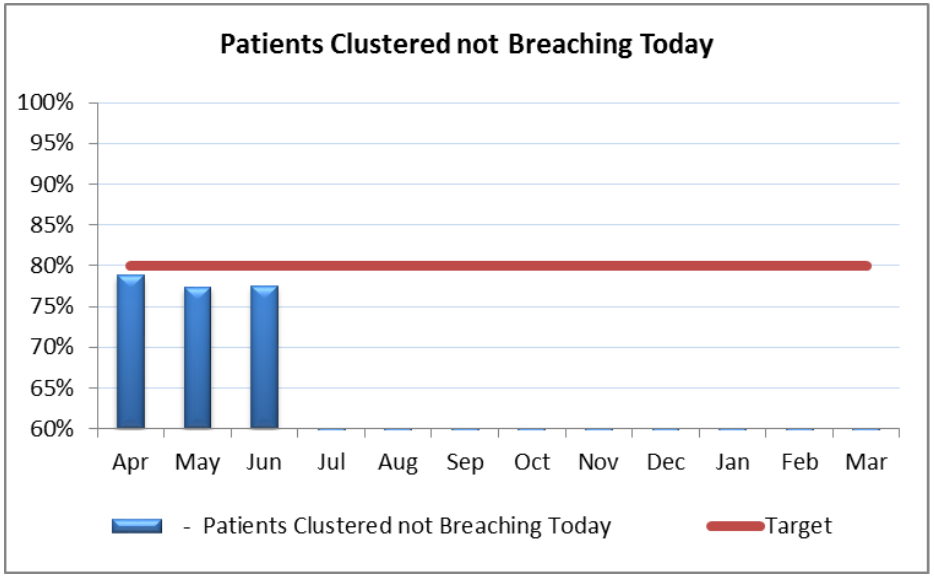
Operational Section

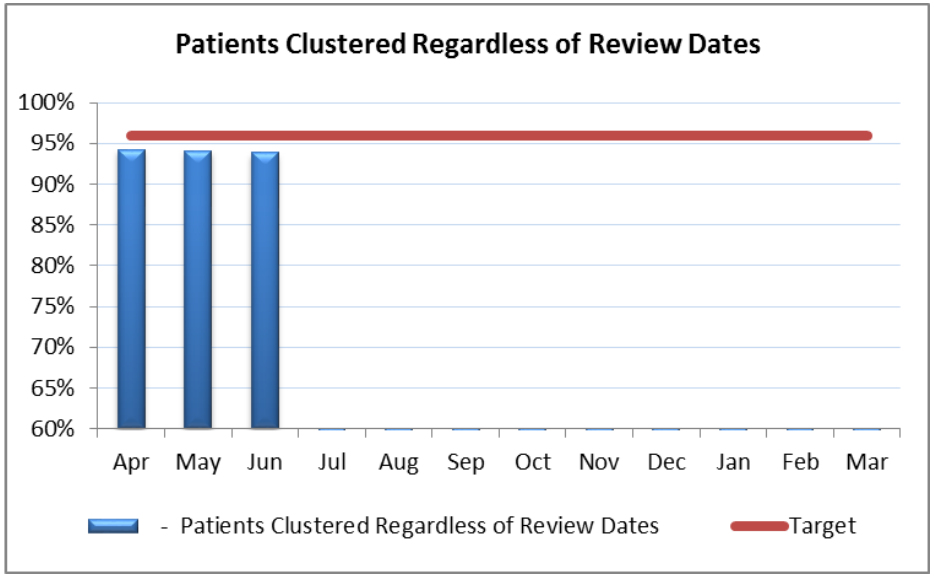
Data Completeness: Priority Metrics



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%. Achieving this target will be extremely challenging without additional resource. There are currently 15,339 patient information gaps that need sourcing and inputting into the patient records concerned, which is a further increase of 680 since last month. It is acknowledged there are capacity issues.

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

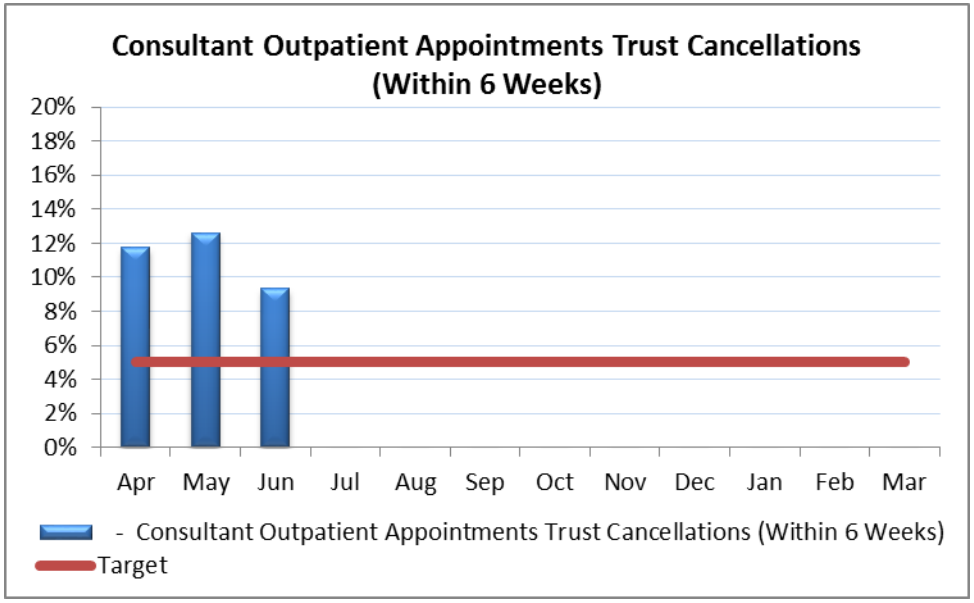




A paper was presented to the Finance and Performance Committee on 22nd May 2017. The Committee stated that it was important to achieve the identified performance standards and commissioned an action plan to address the requirements:

- The 2 performance targets should be complemented by the approved quality indicators not replaced by them
- Clusters to be used to help analyse caseloads and case flow.
- Audit to understand why there is a discrepancy with the red rule adherence.
- Multi-disciplinary reference group to be established.
- Target teams or individuals where clustering seems out of kilter with the performance and red rules

Consultant Outpatient Appointments Trust Cancellations (within 6 weeks)

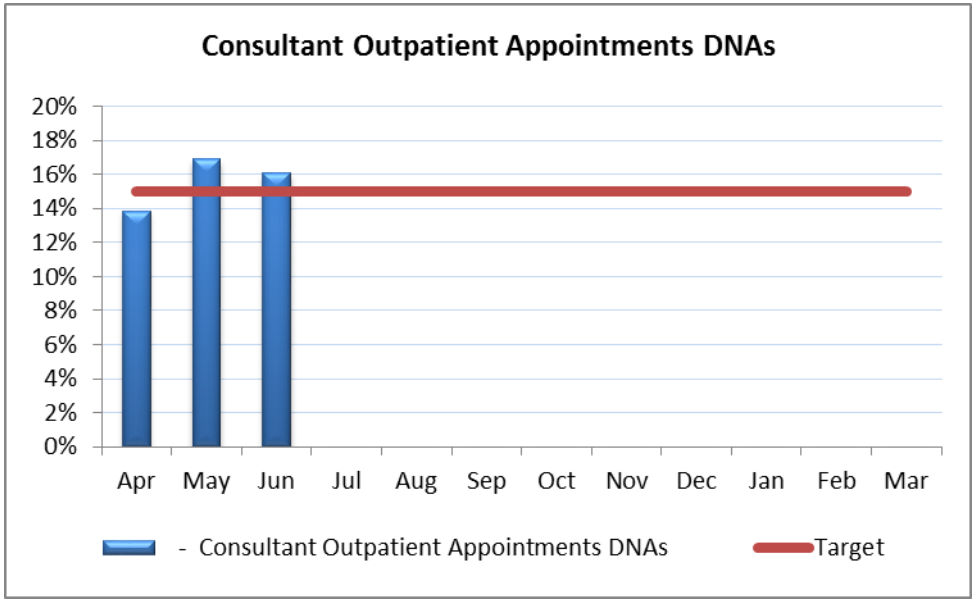


The majority of cancellations were owing to clinician absence, appointments needing to be moved to accommodate more urgent cases, or there being no consultant.

Action: recruitment to vacant consultant posts is progressing slowly. Absence is being managed in line with trust policies.

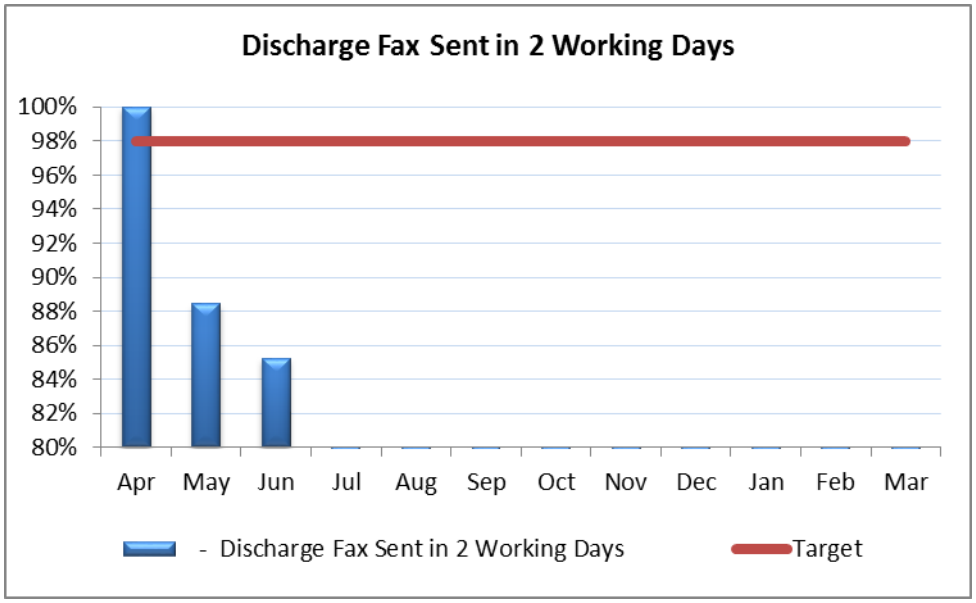
Reason	n	%
Clinician Absent From Work	175	42%
Moved - Trust Rescheduled	51	12%
Moved - Clinic Cancelled	46	11%
No Consultant	40	10%
Moved - Staff Issue	31	7%
Clinic Booked In Error	21	5%
Clinician On Annual Leave	13	3%
Clinician Must Attend Tribunal	8	2%
Clinician Must Attend Meeting	7	2%
Moved - Location Issue	6	1%
Clinician on annual leave	5	1%
Junior doctor clinic no consultant	4	1%
Paris System Issue	4	1%
Clinician Must Attend Training	4	1%
Grand Total	**415**	**100%**

Consultant Outpatient DNAs



Despite the trust sending text message appointment reminders, the number of patients who did not attend scheduled outpatient appointments in June was high.

Discharge Fax sent in 2 working days

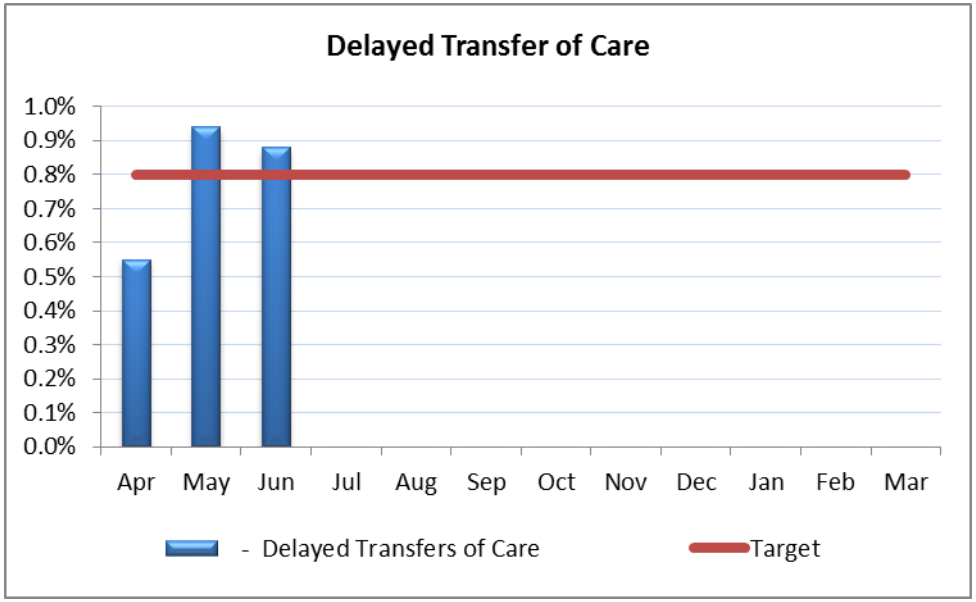


13 discharge emails to GPs were sent late this month. This was mainly a result of admin shortages at the Hartington Unit for which we have been unable to source cover.

Action taken: some admin cover has been provided by the crisis team.

All the wards to put in place formal contingency arrangements to ensure the correspondence is sent in a timely manner.

Delayed Transfers of Care



There remain 2 patients, both on ward 34, who are ready for discharge but whose discharge is being delayed. One delay is attributed to social care: awaiting provision of emergency accommodation; the other is attributed to both health and social care: awaiting funding and placement.

Campus Division Performance Dashboard 2017/18 Month 3

Quality, Safety and Experience					
Indicator	Period	Target	Actual	RAG	Previous months
CPA 7 day follow-up	Monthly	95%	100%	G	
Delayed transfers of care	Monthly	0.8%	0.9%	R	
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	1	N/A	
Crisis gatekeeping	Monthly	95%	100%	G	
Mixed sex accommodation breaches	Monthly	0	0	G	
Under 16 admissions to adult facilities	Monthly	0	0	G	
New complaints opened for investigation	Monthly	<=4	6	R	
New concerns	Monthly	<=7	6	G	
Complaints upheld/partially upheld	Monthly	<=2	2	G	
Compliments	Monthly	>=40	36	R	
Friends and Family Test % positive	Monthly	89%	75%	R	

Performance					
Indicator	Period	Target	Actual	RAG	Previous months
Hartington Unit bed occupancy – including leave	Monthly	85%	102%	R	
Hartington Unit bed occupancy – excluding leave	Monthly	85%	88%	R	
Hartington Unit length of stay	Monthly	36	49	R	
Radbourne Unit bed occupancy – including leave	Monthly	85%	103%	R	
Radbourne Unit bed occupancy – excluding leave	Monthly	85%	86%	R	
Radbourne Unit length of stay	Monthly	36	54	R	
Kingsway bed occupancy – including leave	Monthly	85%	78%	G	
Kingsway bed occupancy – excluding leave	Monthly	85%	76%	G	
Activity against contract – inpatient rehab.	Monthly	95%	74%	R	

People					
Indicator	Period	Target	Actual	RAG	Previous months
Vacancy rate	Monthly	10%	15.5%	R	
Turnover	Monthly	10%	12.0%	G	
Sickness – in month	Monthly	5%	5.9%	R	
Annual appraisals	Monthly	90%	79.7%	R	
Mandatory training	Monthly	85%	88.1%	G	
Agency staff use	Monthly	1.9%	0.83%	G	
Bank staff use	Monthly	5%	13.7%	R	
Clinical supervision	Yearly	100%	42%	R	
Managerial supervision	Yearly	100%	52%	R	

Pulse Check					
Indicator	Period	Target	Actual	RAG	Previous months
Kingsway					
Staff recommending as a place for care and treatment	Quarterly	79%	63%	R	
Staff recommending as a place to work	Quarterly	64%	39%	R	
Hartington Unit					
Staff recommending as a place for care and treatment	Quarterly	79%	Data not provided	N/A	
Staff recommending as a place to work	Quarterly	64%	Data not provided	N/A	

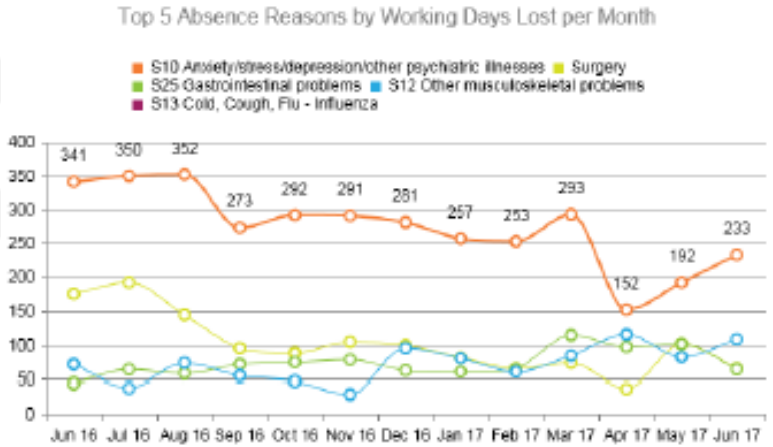
Campus Division Performance Dashboard 2017/18 Month 3

Radbourne Unit					
Staff recommending as a place for care and treatment	Quarterly	79%	Data not provided	N/A	
Staff recommending as a place to work	Quarterly	64%	Data not provided	N/A	

Finance					
Indicator	Period	Target	Actual	RAG	Previous months
Performance against budget £'000s	In month	2337	2559	R	
Performance against budget £'000s	Year to date	7392	7692	R	
Forecast outturn	Forecast	29,567,772	31,300,146	R	
Out of area placement expenditure £'000s	Year to date	121	514	R	
Out of area placement expenditure forecast	Forecast	486	2057	R	

General Manager Summary:

- **Delayed transfers of care**
  There remain 2 patients, both on ward 34, who are ready for discharge but whose discharge is being delayed. One delay is attributed to social care: awaiting provision of emergency accommodation; the other is attributed to both health and social care: awaiting funding and placement. Both should be resolved within the next few weeks.
- **New complaints, compliments and the friends and family test**
  The number of complaints received was above average and compliments was below average this month. There were only 16 responses to the friends and family survey, almost half of which related to ward 1. [FFT IT issue]
- **Adult acute inpatient occupancy and length of stay**
  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. Due to acute staffing issue at the moment we will be monitoring on a daily basis.
- **Inpatient rehabilitation**
  Several discharges happened at once which bought occupancy levels down, including the transfer of a patient back to acute services. Audrey House is currently fully occupied, 2 patients however are on a discharge pathway. Rehabilitation referral process is being streamlined. Inreach work weekly to source referrals to both Hartington and Radbourne. Once a week referral meetings and future weekly updates to the wards to advise of bed occupancy rates and any waiting lists. Some referrals continue to be inappropriate for Rehabilitation services. Management to attend operational meetings to discuss referral process. Meeting being arranged for all referrals to be sent electronically via Paris. Currently 20 of the 23 beds are occupied. Formal referral process to be issued this month. Rehab team formally review patients on the acute units on a weekly basis. We are also feeding back through the inpatient panel re patients placed out of area.
- **Sickness**
  Recruitment and Retention group is focusing on these issues trust-wide. Within Campus, given the current staffing pressures the overarching sickness rate is lower than would be expected. We are aware of individual areas of pressure and sickness management processes are in place. Drop-in sessions are in place in support of stress in the workplace.



- **Annual appraisals**
  The position has steadily been improving over time despite the rate of staff turnover and level of vacancy being carried. As a short-term emergency plan Band 7 staff will be working within numbers across Radbourne and Hartington Unit and we anticipate a negative effect on this trajectory.
- **Bank use**
  Additional temporary staffing was needed at the Radbourne Unit to cover vacancies and acuity. We anticipate a heightened bank use over the next few months.
- **Supervision**
  Owing to the way we report compliance on a rolling 12 months basis, any significant absence through maternity leave, long term sickness etc. makes the

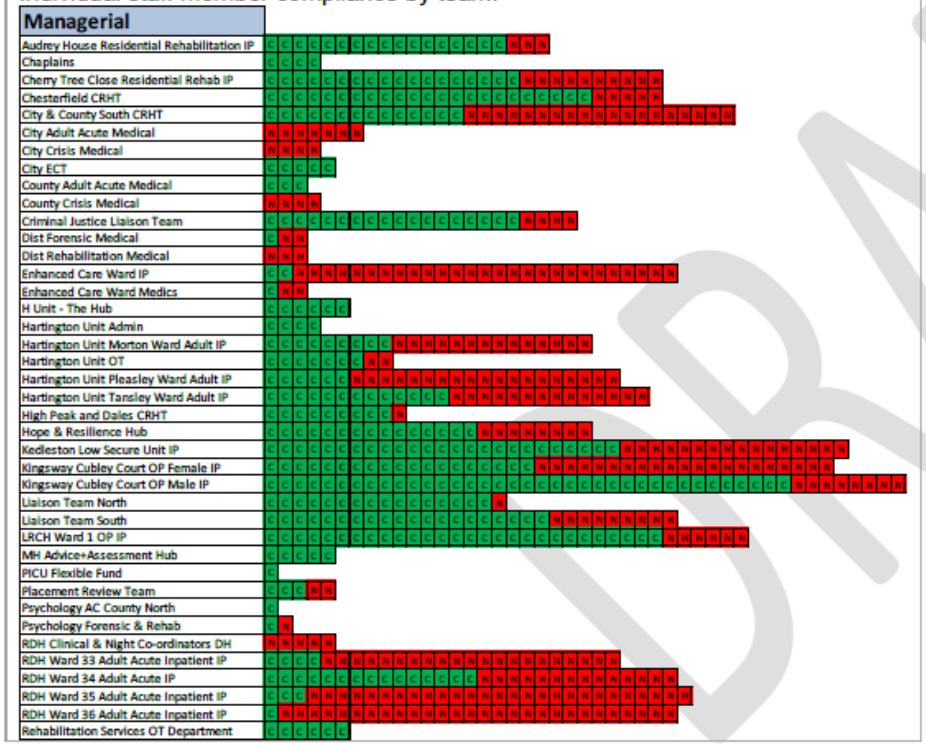
Campus Division Performance Dashboard 2017/18 Month 3

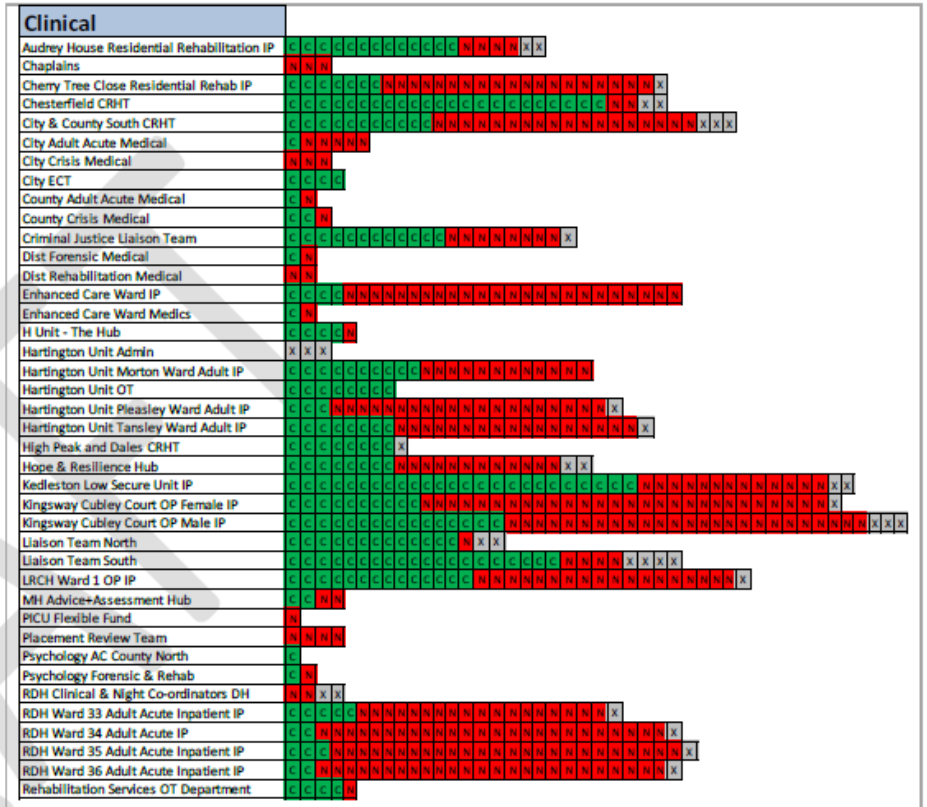
target unachievable. In Campus this is the case for 28 of our teams.

Capacity to undertake supervision is also a factor: inpatient nurses are required to undertake in excess of 11 days a year of training plus 2 days a year of supervision, yet only 6 days a year per nurse are factored into the funded establishment.

We are trying to develop options for group supervision and using practice development forums as an underlying strategy, but we anticipate the staffing difficulties impacting developments over the next 2 months.

Individual staff member compliance by team:





- **Finance**
  Overspend in June was as a result of a number of out of area placements and step down, plus a need for additional temporary staffing at the Radbourne Unit to cover vacancies and acuity. 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. A financial action plan is in place at the Radbourne Unit, which is a key area of overspend. Key actions include robust and effective rostering and effective monitoring of budgets and overspend.

Central Services Division Performance Dashboard 2017/18 Month 3

Quality, Safety and Experience

Indicator	Period	Target	Actual	RAG	Previous months
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	0	N/A	
New complaints opened for investigation	Monthly	<=2	1	G	
New concerns	Monthly	<=3	5	R	
Complaints upheld/partially upheld	Monthly	<=0	1	R	
Compliments	Monthly	>=11	6	R	
Friends and Family Test % positive	Monthly	89%	50%	R	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
Activity against contract – ASD assessments (cumulative)	Monthly	100%	82%	R	
Activity against contract – perinatal inpatient bed days	Monthly	100%	84%	R	
Activity against contract – perinatal south community contacts	Monthly	169	103	R	
Activity against contract – eating disorder service contacts	Monthly	204	163	R	
Waiting list - ASD assessment: total and average wait (weeks)	Monthly	<=18	368 44	R	
Waiting list - dietetics: total waiting and average wait (weeks)	Monthly	<=18	2 0.1	G	
Waiting list – eating disorders: total waiting and average wait (weeks)	Monthly	<=18	9 3.6	G	
Waits – LD speech & language therapy: total and average wait	Monthly	<=18	167 26	R	
Waiting list - physiotherapy: total waiting and average wait (weeks)	Monthly	<=18	47 8	G	
Waiting list – psychological therapies: total and average wait	Monthly	<=18	69 24	R	
IAPT step 2 discharges	Monthly	67	103	G	

Performance

Indicator	Period	Target	Actual	RAG	Previous months
IAPT step 3 discharges	Monthly	516	668	G	
IAPT recovery rate	Monthly	50%	52.9%	G	
IAPT reliable improvement & recovery rate	Monthly	65%	69.0%	G	
Substance Misuse City:					
TOPS compliance - start	Quarterly	80%	91%	G	
TOPS compliance - review	Quarterly	80%	97%	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%	83%	G	
TOPS compliance - review	Quarterly	80%	95%	G	
TOPS compliance - exit	Quarterly	80%	98%	G	
Waiting time into treatment over 21 days	Quarterly	0%	0%	G	

People

Indicator	Period	Target	Actual	RAG	Previous months
Vacancy rate	Monthly	10%	7.5%	G	
Turnover	Monthly	10%	8.9%	G	
Sickness – in month	Monthly	5%	3.8%	G	
Annual appraisals	Monthly	90%	76%	R	
Mandatory training	Monthly	85%	88%	G	
Agency staff use	Monthly	1.9%	1.0%	G	

Central Services Division Performance Dashboard 2017/18 Month 3

People					
Indicator	Period	Target	Actual	RAG	Previous months
Bank staff use	Monthly	5%	2.6%	G	
Clinical supervision	Yearly	100%	65%	R	
Managerial supervision	Yearly	100%	71%	R	

Pulse Check					
Indicator	Period	Target	Actual	RAG	Previous months
Learning Disability					
Staff recommending as a place for care and treatment	Quarterly	79%	65%	R	
Staff recommending as a place to work	Quarterly	64%	34%	R	
Substance misuse					
Staff recommending as a place for care and treatment	Quarterly	79%	78%	R	
Staff recommending as a place to work	Quarterly	64%	66%	G	

Finance					
Indicator	Period	Target	Actual	RAG	Previous months
Performance against budget £'000s	In month	1798	1825	R	
Performance against budget £'000s	Year to date	5358	5313	G	
Forecast outturn £s	Forecast	21,386,962	21,480,939	R	

General Manager Summary:

- **Concerns, complaints, compliments and the friends and family test**
  The level of both negative and positive feedback received by the Division is very low.
- **ASD assessments**
  Meeting the assessments target for 2016/17 resulted in a backlog reports to be written up. Writing up these reports has impacted on capacity to undertake assessments towards the start of the new financial year. The backlog has now been addressed and we anticipate that the level of assessments completed over the next few months and going forward will bring us back into line with target.
- **Perinatal inpatient and community**
  Referrals to the service have been lower across all three teams (including inpatients) which reflects a dip in the birth rate at the moment. Two clinicians (1 North and 1South) have reduced caseloads following returns from long term sickness. Dr Gandhi has introduced a joint antenatal clinic with maternity to screen cases which may have been referred to us previously.
- **Eating disorder service contacts**
  The full year target has been increased by 64% since 2016/17 and is set 12% higher than the level of activity achieved last financial year. Team has been briefed about the increased target and has considered ways to achieve compliance. In June there were reduced patient contacts owing to significant staff absence. This is expected to improve over the next 2 months.
- **Waiting times for LD speech and language therapy and for psychological therapies**
  Recruiting to vacancies
- **Annual appraisals and Supervision**
  We had made some progress with annual appraisals but it seems to have reached a plateau. This is a hot spot focus currently with the teams and actions and trajectories are being sought.
  Regarding supervision, owing to the way compliance is reported on a rolling 12 months basis, any significant absence through maternity leave, long term sickness etc. makes the target unachievable. In Central this is the case for 18 of our teams..
  The Executive Leadership Team has recently agreed to a list of exemptions from compliance calculations for training, supervision and appraisals as follows: staff on external secondments, career break, maternity leave or adoption leave; staff with sickness absence beyond 90 days; staff absent beyond 90 days; staff suspended. HR and IM&T are looking into how to implement this exemption in practice. Once implemented we should see
- **Pulse check**
  Substance Misuse Service has gone through re-tendering and Learning Disability Service is going through service development. Monitoring pulse check as indicator of engagement and outcomes.
- **Finance**
  Underspent at end June with forecast to come in on budget.

Children's Services Division Performance Dashboard 2017/18 Month 3

Quality, Safety and Experience					
Indicator	Period	Target	Actual	RAG	Previous months
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	1	N/A	
New complaints opened for investigation	Monthly	<=2	2	G	
New concerns	Monthly	<=6	10	R	
Complaints upheld/partially upheld	Monthly	<=1	1	G	
Compliments	Monthly	>=14	8	R	
Friends and Family Test % positive	Monthly	89%	100%	G	

Performance					
Indicator	Period	Target	Actual	RAG	Previous months
Children in care health assessments – children under 5	Monthly	73%	83%	G	
Children in care health assessments – children 5 and over	Monthly	75%	78%	G	
10-14 day breastfeeding coverage	Monthly	98%	99%	G	
6-8 week breastfeeding coverage	Monthly	98%	100%	G	
6-8 week breastfeeding prevalence	Monthly	43%	44%	G	
SEND process – letter 1 responses within 15 days	Monthly	80%	100%	G	
SEND process – letter 2 responses within 42 days	Monthly	49%	83%	G	

Performance					
Indicator	Period	Target	Actual	RAG	Previous months
Paediatric current waits < 18 weeks	Monthly	92%	60.9%	R	
Paediatric waiting list: number waiting and average wait (weeks)	Monthly	<=18	934 19	R	
Paediatric new referrals (A) and attended 1st appointments (B)	Monthly	B>A	A 264 B 335	G	
CAMHS current waits < 18 weeks	Monthly	92%	93.0%	G	
CAMHS waiting list: number waiting and average wait (weeks)	Monthly	<=18	341 11	G	
CAMHS activity – attended contacts	Monthly	2053	2222	G	
CAMHS caseload	Monthly	1980	1841	G	
CAMHS RISE – referrals from A&E seen same day	Monthly	59%	64%	G	
CAMHS RISE – discharges with completed ESQ	Monthly	38%	46%	G	
CAMHS RISE – discharges with completed SFQ	Monthly	46%	51%	G	
CAMHS RISE – A&E referral rate (as a percentage of total referrals)	Monthly	73%	80.0%	G	

People					
Indicator	Period	Target	Actual	RAG	Previous months
Vacancy rate	Monthly	10%	11.3%	R	
Turnover	Monthly	10%	13.0%	R	
Sickness – in month	Monthly	5%	5.9%	R	
Annual appraisals	Monthly	90%	82.8%	R	
Mandatory training	Monthly	85%	88.2%	G	
Agency staff use	Monthly	1.9%	1.6%	G	
Bank staff use	Monthly	5%	1.9%	G	
Clinical supervision	Yearly	100%	89%	R	
Managerial supervision	Yearly	100%	80%	R	

Children's Services Division Performance Dashboard 2017/18 Month 3

Pulse Check					
Indicator	Period	Target	Actual	RAG	Previous months
Child Therapy & Complex Needs					
Staff recommending as a place for care and treatment	Quarterly	79%	71%	R	
Staff recommending as a place to work	Quarterly	64%	50%	R	
Universal Children's Services					
Staff recommending as a place for care and treatment	Quarterly	79%	80%	G	
Staff recommending as a place to work	Quarterly	64%	50%	R	
Child & Adolescent Mental Health Services					
Staff recommending as a place for care and treatment	Quarterly	79%	45%	R	
Staff recommending as a place to work	Quarterly	64%	41%	R	

Finance					
Indicator	Period	Target	Actual	RAG	Previous months
Performance against budget £'000s	In month	£1220	£1159	G	
Performance against budget £'000s	Year to date	£3660	£3518	G	
Forecast outturn	Forecast	£14,641,107	£14,208,214	G	

General Manager Summary

- **Concerns and compliments**
  We continue to work through concerns as these are raised within the service. As discussed at recent performance review it would not seem appropriate to have a target for number of concerns raised. We should be encouraging service users to raise concerns about the service and using this to inform future service delivery. Receiving these concerns should also be regarded as evidence that the process about how to raise a concern is known amongst service users.
  As discussed at the recent performance review we need an electronic way to extract compliments submitted as part of F&F as currently these are not included in the above numbers and yet contain some wonderful comments and compliments.

- **Paediatric current waits < 18 weeks**
  Progress continues to be made towards achieving this objective. Recent performance review has requested paper detailing when 18 week wait is expected to be achieved. To be submitted in 4 weeks.
- **Turnover**
  As discussed at recent performance review the 0-19 Years Service (16%) is experiencing significantly high turnover rate at this time. We have analysed data from termination forms to identify factors influencing this. Also there has been a considerable recruitment programme to help mitigate against the impact of this turnover rate.
- **Sickness absence**
  Data has not been reliable as services have reported 131% sickness for May 2017. Awaiting assurance that data is now correct.
- **Supervision and annual appraisals**
  GM has generated a supervision and IPR dashboard for May 2017 and each SLM generated an action plan to address shortfall in performance. This is being monitored on fortnightly basis.
- **Pulse check**
  Staff survey action plan has been developed and now being implemented by all service lines within the division.

Neighbourhood Services Division Performance Dashboard 2017/18 Month 3

Quality, Safety and Experience					
Indicator	Period	Target	Actual	RAG	Previous months
Never events	Monthly	0	0	G	
Serious incidents reported to CCG via STEIS	Monthly	N/A	3	N/A	
New complaints opened for investigation	Monthly	<=5	5	G	
New concerns	Monthly	<=17	19	R	
Complaints upheld/partially upheld	Monthly	<=2	3	R	
Compliments	Monthly	27	25	R	
Friends and Family Test % positive	Monthly	89%	75%	R	

Performance					
Indicator	Period	Target	Actual	RAG	Previous months
North Derbyshire					
Community caseload per funded wte care coordinator (exc. waiting list)	6 - Monthly	<=35	50	R	
Community waiting list: number waiting and average wait (weeks)	Monthly	<=18	1961 17	G	
Community referrals (A) and discharges (B)	Monthly	B>A	A 879 B 1116	G	
Community activity	Monthly	5499	5591	G	
Outpatient memory assessment service caseload	Monthly	1116	1116	G	
Outpatient caseload (exc. MAS)	Monthly	5117	5117	G	
Outpatient waiting list < 18 weeks	Monthly	92%	99%	G	
Outpatient caseload % seen within the last 6 months	Monthly	75%	86%	G	
Outpatient caseload % seen within the last 12 months	Monthly	99%	98%	R	
South Derbyshire					
Community caseload per funded wte care coordinator (exc. waiting list)	6 - Monthly	<=35	41	R	

Performance					
Indicator	Period	Target	Actual	RAG	Previous months
Community waiting list: number waiting and average wait (weeks)	Monthly	<=18	1677 19	R	
Community referrals (A) and discharges (B)	Monthly	B>A	A 708 B 672	R	
Community activity	Monthly	4338	4412	G	
Outpatient memory assessment service caseload	Monthly	549	521	G	
Outpatient caseload (exc. MAS)	Monthly	3419	3412	G	
Outpatient waiting list < 18 weeks	Monthly	92%	95.9%	G	
Outpatient caseload % seen within the last 6 months	Monthly	75%	85%	G	
Outpatient caseload % seen within the last 12 months	Monthly	99%	97%	R	
Derby City					
Community caseload per funded wte care coordinator (exc. waiting list)	Monthly	<=35	45	R	
Community waiting list: number waiting and average wait (weeks)	Monthly	<=18	1211 13	G	
Community referrals (A) and discharges (B)	Monthly	B>A	A 598 B 591	R	
Community activity	Monthly	4373	4802	G	
Outpatient caseload	Monthly	3273	3351	R	
Outpatient waiting list < 18 weeks	Monthly	92%	89.4%	R	
Outpatient caseload % seen within the last 6 months	Monthly	75%	74%	R	
Outpatient caseload % seen within the last 12 months	Monthly	99%	90%	R	
Early Intervention County North					
Referral to treatment within 14 days – currently waiting	Monthly	50%	100%	G	
Referral to treatment within 14 days – completed	Monthly	50%	100%	G	

Neighbourhood Services Division Performance Dashboard 2017/18 Month 3

Performance					
Indicator	Period	Target	Actual	RAG	Previous months
Caseload	Monthly	144	173	R	
Early Intervention County South & City					
Referral to treatment within 14 days – currently waiting	Monthly	50%	56%	G	
Referral to treatment within 14 days – completed	Monthly	50%	67%	G	
Caseload	Monthly	211	236	R	

People					
Indicator	Period	Target	Actual	RAG	Previous months
Vacancy rate	Monthly	10%	8.7%	G	
Turnover	Monthly	10%	8.6%	G	
Sickness – in month	Monthly	5%	2%	G	
Annual appraisals	Monthly	90%	75%	R	
Mandatory training	Monthly	85%	86%	G	
Agency staff use	Monthly	1.9%	5.4%	R	
Bank staff use	Monthly	5%	1.6%	G	
Clinical supervision	Yearly	100%	61%	R	
Managerial supervision	Yearly	100%	70%	R	

Pulse Check					
Indicator	Period	Target	Actual	RAG	Previous months
Locality 1					
Staff recommending as a place for care and treatment	Quarterly	79%	70%	R	
Staff recommending as a place to work	Quarterly	64%	47%	R	
Response rate	Quarterly	25%	15% (74)	R	
Locality 2					
Staff recommending as a place for care and treatment	Quarterly	79%	79%	G	
Staff recommending as a place to work	Quarterly	64%	63%	R	
Response rate	Quarterly	25%	11% (19)	R	
Locality 3					
Staff recommending as a place for care and treatment	Quarterly	79%	100%	G	
Staff recommending as a place to work	Quarterly	64%	0%	R	
Response rate	Quarterly	25%	19% (5)	R	
Locality 4					
Staff recommending as a place for care and treatment	Quarterly	79%	42%	R	
Staff recommending as a place to work	Quarterly	64%	42%	R	
Response rate	Quarterly	25%	35% (12)	G	

Finance					
Indicator	Period	Target	Actual	RAG	Previous months
Performance against budget £'000s	In month	£2013	£1941	G	
Performance against budget £'000s	Year to date	£5874	£5673	G	
Forecast outturn	Forecast	£23,494,169	£23,226,874	G	

General Manager Summary

- **Concerns, complaints, compliments and friends and family test**

We are particularly worried about the situation in South Derbyshire Neighbourhood related to lack of consultant cover. This situation has been ongoing for several months with agency cover coming and going and periods where the post couldn't be covered at all. This has prompted an increase in the level of local complaint, concerns and formal complaints in that area. this in turn is difficult to manage within current timescales and given the capacity of the service manager, area service manager and general manager, all of whom have been working to try and

respond to these concern and complaints. There has also been a higher than usual level of concern expressed about the quality of some agency staff employed in the consultant post. Other areas have seen a rise in concerns related to waits, as well as quality issues. The levels of pressure and stress within teams accounts for the low number of returns for friends and family and poor feedback.

- **Community caseload per care coordinator**
  We have established a new way of recording in Paris that should make the waiting list for care coordinator more transparent, however more work is needed in this area as we are concerned about the percentage of individuals on caseload who are managed within the framework of CPA. The management team are concerned that this is low, when compared to the feedback on rise in complexity of cases across all areas. The assumption is that the perceived onerousness of managing care through the framework is making clinicians decide not to use the framework. We are addressing this operationally but the revised CPA policy and procedure is required with some urgency to facilitate this
- **Community referrals**
  This count refers to all referrals to NGH services, so the external waiting list is not clearly identified. The Paris work recently undertaken should help articulate all waits to appropriate services
- **Outpatient caseload seen within the last 6/12 months**
  This list is cleansed on a weekly basis to try and reduce the number of individuals who should have been discharged but have been left open on the system. However we do have areas of particular concern where people are not seen within the 12 month period and service managers and area service managers are trying to support medical secretaries and consultants in improving this situation. This is also discussed and actions are prescribed in the medical management group.
- **Outpatient 18 week referral to treatment in Derby City**
  Slots have been lost as a consultant left and the new incumbent hadn't started. There is also a lack of Junior Doctor support available for several of the Consultants in the City and this has been escalated to Medical Management.
- **Early intervention caseload**
  The caseloads of both teams are high. A piece of work is to be undertaken looking at capacity and demand within the teams.
- **Annual appraisals**
  It is becoming increasingly apparent that the capacity of the neighbourhood staff to meet key performance targets, including appraisals is challenged by the concentration on caseload and waiting lists. There is some capacity calculation work ongoing to seek some improvement with this. In the interim all managers are prioritising appraisal completion, together with supervision rates as an urgent matter.

- **Agency staff use**
  We have exceeded target for use of agency staff and this has varied over the year, and between teams, trajectories have been set repeatedly, but are undermined by changing situations. However improving staff well-being and recruitment are key priorities for neighbourhood services through the next 6 months, which should benefit high pressured areas where sickness absence has created gaps and high turnover.
  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. Similar to the nurse situation solutions are found in one area, but then issues crop up in another. However this does mean that we are able to refine our processes and have more speed about processing solutions where it is possible. The last month has seen the medical gaps being covered more consistently.
- **Supervision**
  Owing to the way we report compliance on a rolling 12 months basis, any significant absence through maternity leave, long term sickness etc. makes the target unachievable. Work is being set in motion to remove those unavailable for supervision from the report. In Neighbourhood this is the case for 33 of our teams. Operations are currently exploring ways to more effectively capture ad hoc clinical supervision, which should improve the position: anecdotally we are aware that ad hoc supervision takes place which is not being recorded. The capacity of Band 6 staff to undertake supervision is being limited by their having to manage large clinical caseloads. We are looking at freeing up capacity through reducing caseloads, although it is acknowledged this will have a negative impact on waiting lists. We have also set target percentage increases by team by month.
- **Pulse check**
  This is an area for work, we have a review of the neighbourhood model underway which should enable more positive feedback

WARD STAFFING

Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
AUDREY HOUSE RESIDENTIAL REHABILITATION	92.67%	159.1%	70.7%	90.0%	0.0%	Yes	We are now working on a basis that we should have 2 qualified on the early and late and 2 at night with no unqualified at night. The occasions where there are unqualified at night are due to clinical activity where a patient was being nursed on level 2 observations, also sickness and special leave where we covered with a regular bank nurse. We also had staff members on leave which I know is not ideal to cover with bank but there was not a second qualified available due to ensuring safe staffing during the day. We also require further qualified support on a Monday due to this being a MDM day, as 1 qualified is required for over half a day
CHILD BEARING INPATIENT	83.89%	70.6%	90.4%	103.3%	136.7%	Yes	
CTC RESIDENTIAL REHABILITATION	65.22%	113.1%	93.8%	120.0%	90.0%	No	We have a staff member who is registered who is struggling with duties and is under competencies so where possible is the third qual as they are also still under preceptorship and not safe to give meds independently. We are trying to book a second qual on the night shift where possible however have several qual vacancies as yet to fill.
KEDLESTON LOW SECURE UNIT	50.83%	90.3%	58.9%	100.0%	99.2%	Yes	We have had long term sickness with NA's and 2 NA's off sick last month. We also are low on numbers meaning staffing levels are currently reduced at present. So we will be under fill rate for next six months. Still maintaining 2 nurses on night shifts
KINGSWAY CUBLEY COURT - FEMALE	96.85%	114.6%	108.5%	58.4%	182.2%	Yes	Ward has broken the current fill rate tolerances due to staff vacancies, maternity and sickness. Registered nurses now recruited and will be starting soon.
KINGSWAY CUBLEY COURT - MALE	72.22%	74.9%	107.8%	75.0%	157.8%	Yes	There has been registered staff off long term sick Registered shifts have been backfilled with NA Bank have been unable to fill shifts both days and nights 3 Registered nurses to go into post 1 staring in August 1 September 1 October 2 Part time NA to take up post 1 in August 1 September
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP	105.00%	89.3%	110.5%	100.0%	168.4%	Yes	There has been 5 Registered Nurses and 3 Nursing Assistants who have retired we have vacancies that have been recruited into There are RN hours yet to be filled. The rota is rationalised to meet Patient safety and bank nurses used to support high patient numbers sickness is not an issue and decreasing Bank cover is not readily available to cover staff emergency leave and training/escorts

WARD STAFFING

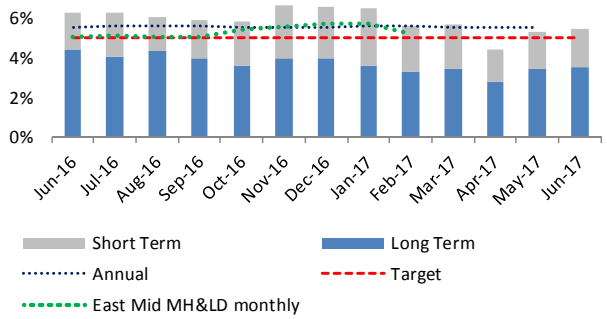
Ward name	Occupancy % Rate	Day		Night		Comments Required	Analysis and Action Plan for 'Average fill rate' above 125% and below 90%
		Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)		
HARTINGTON UNIT - MORTON WARD ADULT	91.53%	99.6%	129.4%	50.0%	246.7%	Yes	In response to the unavailability of registered staff on the Radbourne and Hartington Units during July, August and September the following mitigation has been put in place: • Recruitment of registered nurse agency staff where possible • Recruitment of bank registered nurse where possible • Safe offers of additional hours at appropriate rates to both inpatient and community based registered staff • Request for corporate staff who have a registered nursing qualification to be redeployed for 1 day a week to the units • Utilisation of additional nursing assistants to cover gaps in registered nurse availability [within agreed safe parameters] • Review of all secondments • Inpatient Band 7 Registered Nurses to be included in the numbers • Cease training unless essential for safety of the unit • Pilots developing regarding Pharmacy technicians within the skill mix • Pilots developing regarding OTs within the skill mix The situation remains fragile despite the mitigation in place and the units remain vulnerable in terms of the ability to cover for any further unanticipated absence. The situation is being closely monitored and ASMs and Divisional Nurses will escalate situations of heightened risk on a day to day basis.
HARTINGTON UNIT - PLEASLEY WARD ADULT	102.00%	90.4%	93.7%	34.4%	196.7%	Yes	
HARTINGTON UNIT - TANSLEY WARD ADULT	93.06%	84.6%	106.6%	58.3%	190.0%	Yes	
ENHANCED CARE WARD	97.67%	77.4%	139.8%	81.7%	175.0%	Yes	
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	103.17%	82.6%	160.7%	65.0%	240.0%	Yes	
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	104.50%	90.4%	131.1%	85.0%	190.0%	Yes	
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	106.67%	84.4%	133.8%	56.7%	116.7%	Yes	
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	102.50%	92.5%	124.7%	50.0%	243.3%	Yes	

Workforce Section

WORKFORCE DASHBOARD

Sickness Absence	Apr-17	May-17	Jun-17
(Monthly)	4.45%	5.30%	**5.49%**
(Annual)	5.53%	5.53%	**tbc**

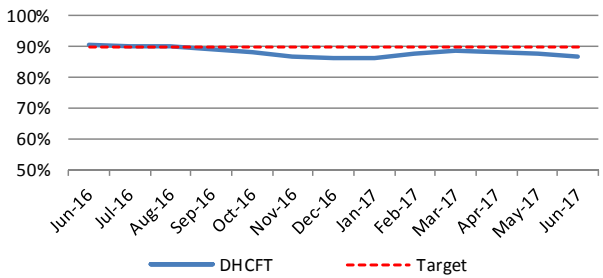
Target 5.04%



The monthly sickness absence rate is 0.19% higher than the previous month, however compared to the same period last year (June 2016) it is 0.79% lower. The Trust annual sickness absence rate is running at 5.53% (as at May 2017 latest available data). Anxiety / stress / depression / other psychiatric illnesses remains the Trusts highest sickness absence reason and accounts for 33.47% of all sickness absence, followed by surgery at 18.32% and other musculoskeletal problems at 8.08%. Compared to the previous month short term sickness absence has increased by 0.12% and long term sickness absence has increased by 0.07%.

Compulsory Training	Apr-17	May-17	Jun-17
(Staff in-date)	88.17%	87.73%	**86.96%**

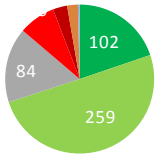
Target 90%

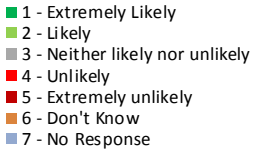


Compulsory training compliance continues to remain high running at 86.96%, a decrease of 0.77% compared to the previous month. Compared to the same period last year compliance rates are 3.53% lower. Compulsory training compliance remains above the 85% main contract commissioning for quality and innovation (CQUIN) target.

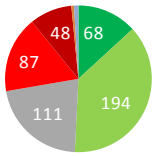
Staff FFT Q4 2016/17 (516 responses, 22.4% response rate) **& Staff Survey** 2016

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.



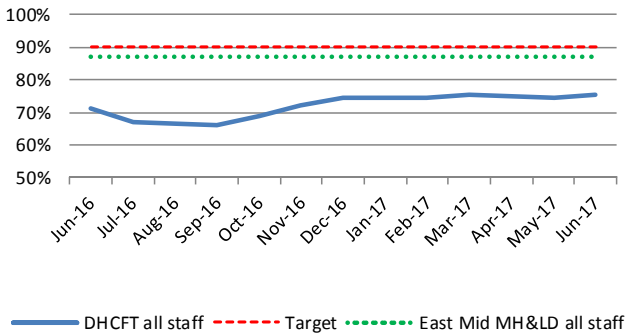
	2016	National average 2016	2015	National average 2015
Overall staff engagement:	**3.69**	3.84	3.73	3.81

WORKFORCE DASHBOARD

Appraisals (All staff)

Apr-17	May-17	Jun-17
74.71%	74.62%	**75.22%**

Target 90%

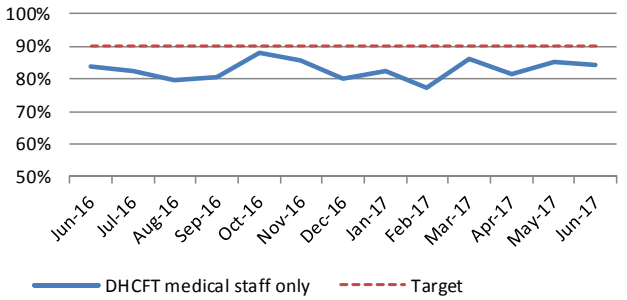


The number of employees who have received an appraisal within the last 12 months has increased by 0.60% during June 2017 to 75.22%. Compared to the same period last year, compliance rates are 3.93% higher. According to the 2016 staff survey results, the national average for Mental Health & Learning Disability Trusts is 88.79%. Local benchmarking data for a range of Trusts in the East Midlands shows an average completion rate of 83.57%.

Appraisals (Medical staff only)

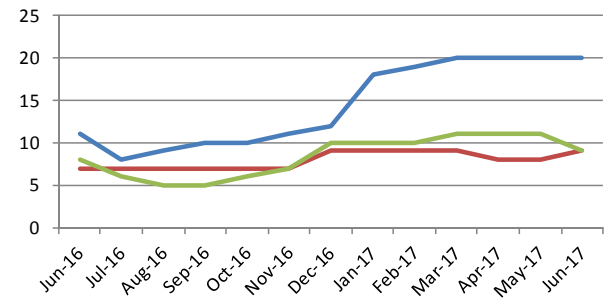
Apr-17	May-17	Jun-17
81.37%	85.29%	**84.16%**

Target 90%

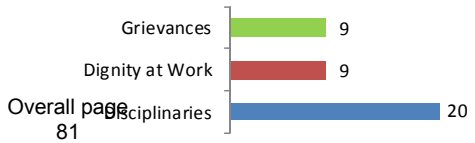


The number of Medical staff who have received an appraisal within the last 12 months has decreased by 1.13% to 84.16%. Compared to the same period last year, compliance rates are 0.20% higher. Junior Doctors on rotational training are excluded from the figures.

Grievances/Dignity at Work/Disciplinaries as at 30/06/2017



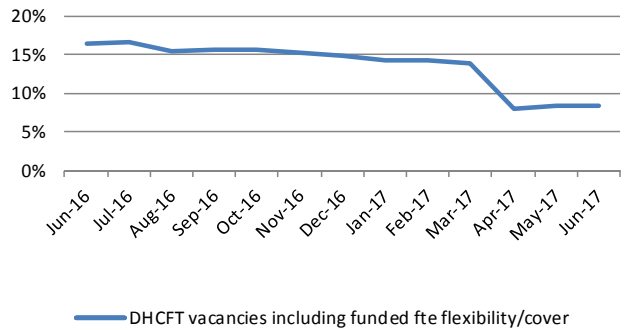
There are nine grievance cases lodged at the formal stage, no new grievances have been lodged and two cases have been resolved. There are 9 Dignity at Work cases, one new case in the period. There are 20 Disciplinary cases, one new case occurred in the period and one case has been resolved.



WORKFORCE DASHBOARD

Vacancy

(Funded full time equivalent) Including funded fte flexibility/cover	Apr-17	May-17	**Jun-17**
	8.04%	8.43%	**8.32%** ↘

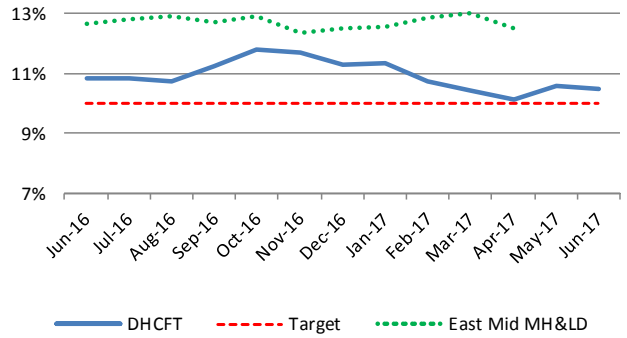


The Trust vacancy rate includes funded Fte surplus for flexibility including sickness and annual leave cover. Funded vacancy rates have decreased to 8.32% in June 2017. 2017/18 budget changes included a large reduction in Fte from 2016/17 investment not materialising and Cost Improvement Programmes. During the previous six months, 118 employees have left the Trust and 154 employees have joined the Trust.

Turnover

(Annual)	Apr-17	May-17	**Jun-17**
	10.16%	10.59%	**10.49%** ● ↘

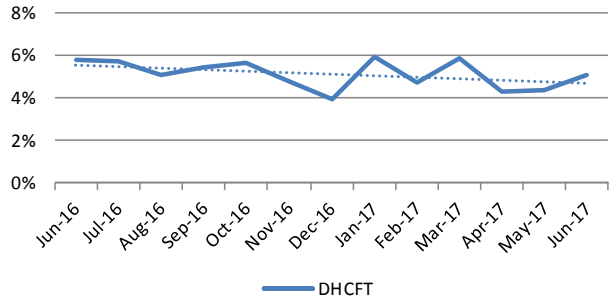
Target 10%



Annual turnover remains within Trust target parameters at 10.49% 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 0.25 to 21.00. During June 2017 21 employees left the Trust, a decrease of 3 compared to the same period last year (June 2016). June 2017 leavers included 8 retirements.

Agency Usage

(Spend)	Apr-17	May-17	**Jun-17**
	4.31%	4.33%	**5.09%** ↗



Total agency spend in June was 5.09% (5.79% including medical locums). Of total agency and locum spend for all staff groups, Qualified Nursing represented 1.2%, Medical 3.4% and other agency usage 0.5%. Agency Qualified Nursing spend against total Qualified Nursing spend in June was 3.3%. Agency Medical spend against total Medical spend in June was 18.4%. Year to date the level of Agency expenditure exceeded the ceiling set by NHSI by £232k.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors - 27 July 2017

Quality Position Statement

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

Executive Summary

This position statement sets out:

1. Safety - our safety planning in relation to fire
2. Effectiveness - a six month evaluation of an interagency model of safeguarding. What our partners say and early signs of progress.
3. Safety and Responsive - learning from very serious incidents
4. Well led - let's try again, model of recruitment and support for potential future employees
5. Well led - our CQC action plan performance

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
- The Care Act 2014
- There are legal issues under the Regulatory Reform (Fire) Safety Order 2005, the Health & Safety at Work etc. Act 1974 and the Health & Social Care Act 2010 contained within this Report
- Care Quality Commission Regulations this report provides assurance to
- Outcome 4 (Regulation 9) Care and Welfare of people who use services
- Outcome 10 (Regulation 15) Safety and suitability of premises
- Outcome 11 (Regulation 16) Safety, availability and suitability of equipment
- Outcome 12 Regulation 210) Requirements relating to workers
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Compliance with the Health & Safety at Work etc Act 1974 (HSWA)
- Compliance with the Regulatory Reform (Fire Safety) Order 2005

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people).

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

Actions to Mitigate/Minimise Identified Risks

Any impact or potential impact on equality is considered as a key part of all our quality work. Some of the examples are improving the equalities position for individuals and their families are fully in line with our duties and responsibly and due regard. The MASH developments have improved the protection of women in FGM and in Domestic Violence.

The outcomes for children and families are also positively impacted upon these developments.

Recommendations

The Board of Directors is requested to:

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

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

Quality Position Statement

1.1 Safety - Fire Safety

Following the Grenfell Tower fire during June 2017, Derbyshire Healthcare Foundation NHS Trust has taken the following action to ensure the safety of premises in our occupation.

All fire risk assessments have been reviewed in line with the annual programme prepared by the organisation, by the Trust Fire Safety Advisor. Only minor maintenance works were identified as part of this process and the Trust carries no significant Fire Safety risks.

All actions plans are monitored through to completion by the Trust Fire Safety Advisor.

At the request of NHSI, Derbyshire Fire and Rescue Services conducted a visual inspection of our in-patient premises 24/25 June 2017.

Fire safety is important to our organisation and we have increased the number of fire evacuations we are undertaking to build up the confidence of our staff to know what to do and how to respond. We believe that practice makes perfect. We have targeted higher risk areas such as our low secure unit and our older adults in-patient service and we will continue to enhance and continually improve our learning.

Action

It is foreseeable that fire safety will be subject to additional assurance checks and changes to legislation. In preparation for these changes, our executive team are proactively investing in a Band 5 Fire Safety Officer to increase our own capacity to respond effectively to a fire incident for our patients and staff. This is also in preparation for the potential for significant changes and additional assurance in these areas. This post is in the recruitment phase.

1.2 Effectiveness

The Trust has undertaken a 6 month evaluation of the Derby's City multi-agency Safeguarding hub. This is collectively Health, Police and Social care staff who undertake safeguarding information sharing and enquiries. This team suit side by side to share intelligence and plan.

The health team are two DHCFT Safeguarding team members funded on a one year pilot.

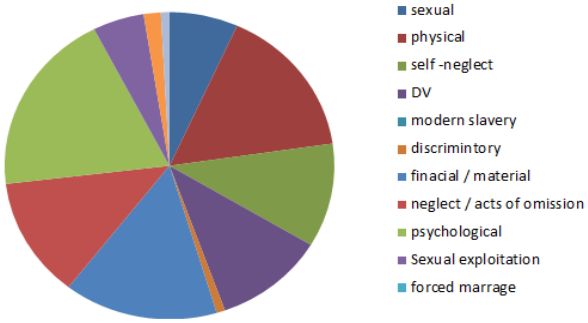
- These teams have instant access to information and instead of services taking weeks to share information, services are responding on the same day.
- MASH enables 100% attendance of strategy planning meetings.
- In one month for Safeguarding Children concerns, a total of 144 people were discussed in the meetings and discussions in May, including both adults and children. On occasions, other people were also mentioned in the meeting / discussions if agencies had a link to that person that was not named on the referral i.e. health may have more children registered at the address.

- This connectivity is changing how agencies interface and communicate. It is managing demand whilst supporting front line staff to provide direct care. This data reflects the amount of other requests we have received.
- Police and Social care data refers to requests in MASH, either by email or face to face. Examples of requests, such as to see if a family member is living at an address / check a date of birth / check if pregnancy is recorded .
- Tasks from Safeguarding Lead are normally from Karen Billyeald (Lead for Adults). However, some include tasks from the Safeguarding Unit for Children. These may include following up a query from other professionals in the Trust.
- Advice calls are low due to us being a fairly new service and other professionals not being aware of the mobile. The plan would be to develop this further which would be easier with a landline.
- Advice calls have been instigated by CPN's, Mental Health wards and GP's. One CPN fed back that the advice call made her feel 'empowered' to continue with her role.

Below is an example of one of the tables analysing referrals to give an insight into the work and issues that the MASH respond to.

Categories of abuse for Adults

Type of abuse (adult's)	Number of referrals
sexual	8
physical	19
self-neglect	13
DV	13
modern slavery	0
discriminatory	1
financial / material	18
neglect / acts of omission	15
psychological	23
Sexual exploitation	6
forced marriage	0
Organisational	2
HBV	1



Most referrals have a combination of different categories of abuse.
We have received no information exchanges for Modern Day Slavery, however, we have noted that social care have had several referrals and they expect this to increase as more awareness is raised around this. It is likely MASH health are not receiving these information exchanges as there is a very clear safeguarding process to follow.
It must also be noted that it is understood any type of abuse will have an emotional impact on the adults with care and support needs but we have only captured this if it is detailed in the referral.

Better together

4

- Feedback from the Police perspective - "it is a great addition to MASH. There have been many occasions when Health have brought to the table information which another agency does not hold and that has been fundamental in the safeguarding we do in here. The addresses, dates of birth that you have access to really help with us trying to trace family and then research on our systems. The unit would not function now without health sat in here."

- Feedback form other partners: Kate Twells, MASH Manager has stated that: "The MASH was launched in June 2013 – at that time – Health were compliant in around about 85% - 98% of strategy meetings – i.e. they were getting us the information and sharing in 85% of cases. I have sent the date to the Health Commissioner and designated Safeguarding Leads which evidences that since DHCFT/ Health have been in the MASH, there is now 100% compliance with the key performance indicators and has been consistently since January 2017.

- MASH Manager - "There is excellent multi–agency decision making. Health always form their own view/opinion and share these in strategy meetings. There is ownership and professionalism in any disagreements within strategy meetings and this is backed up using the threshold document and evidence based practice. All disagreements regarding actions are dealt with in a professional, non-confrontational manner. Social Workers and Police report good communication when liaising with you and this is done promptly."

- Feedback from Laura Oxby, Social Worker who is on the Triage panel - "I think Health within MASH is absolutely priceless! I really think the service that you both provide is fantastic, to have access to health records for our service users enables us to make safer and more appropriate decisions for the families that we work with. It is my opinion that both Louise and Leanne are super helpful, friendly and supportive to work with. Nothing is too much for either of you, even when you are snowed under with work. You always make time to help out anyone that asks. I feel that your decision making in relation to DV Triage is excellent. Your main focus is keeping children safe and this is always the focus of the discussions and decisions made as a multi-agency team.

- Lead Health Commissioners of the service. "*Please carry on doing an amazing job*!"

- This model was highly commended by the CQC and Ofsted review of the Derby City Safeguarding Board, which was rated as 'Outstanding' in 2017. The Safeguarding Board would like to thank staff and partners who attended the inspection and contributed to the Board's success.

Action

Continue to monitor this service, effectiveness and outcomes and build case scenarios of what impact this has had on children and families. This will be reviewed in full detail at the Safeguarding Committee.

1.3 Safety and Responsiveness - Learning From Very Serious Incidents

Mental Health homicides are our most serious incidents. In 2013, our Trust and our community experienced one of these incidents. An independent investigation has been undertaken and there are recommendations for learning. Our Safeguarding Adults team and Patient Safety team have met with staff to explore learning. We can never reflect enough on these very serious incidents. The Trust is dedicating a 'Spotlight leadership' event in 2017, to learning from this case and asking our most senior leaders to reflect upon what commitments they will make to reduce the likelihood of this

happening again and learning from what we got right and areas where we significantly need to improve.

Our thoughts and condolences are with the family and on behalf of the Board, we are deeply sorry for your loss and the impact upon your family.

Action

Executive Lead, Dr John Sykes is leading the session and report on the learning and the experience will be reviewed at the Safeguarding Committee.

1.4 Responsiveness - Learning From Our Patient Stories

In 2017 we had a Board story from a gentleman who fed back that he was really unclear on what advocacy service to access and how to gain support, mainly due to the complexity of commissioning arrangements between Derby City and Derbyshire Local authority. In the spirit of "You said, We Did." New advocacy posters have been re-designed and are on order and will be up in the service this month.

Action

We will be asking our Mental Health Alliance colleagues on ward visits to review the information and posters and tell us what they think. Derbyshire Mental Health Alliance and Healthwatch Derbyshire have agreed to a three month extension in ward visits and we will ask our expert by experience colleagues to tell us their view.

1.5 Well Led – Leadership

Let's try again approach

One of our Senior Nurses in a neighbourhood team has been developing a pilot approach to unsuccessful registered Nurse candidates who apply for posts, who perhaps have had a bad interview day or just not sure what the qualities or competencies are when moving from an in-patient setting or a nursing /care home into a community setting. Joanne Wombwell has been but is not the appointed.

We would like to try again. Let's try again together.

This year, you applied to work in Derbyshire Healthcare NHS Foundation Trust and from our records, we believe you were not successful that time.

We all have periods in our life where we don't succeed first time round.

Our Trust believes that everyone deserves a second chance to shine and we believe that you can shine with a little help.

We are hosting a number of events to introduce you to our organisation, talk to you about our Trust and Trust values and talk about what we are looking for in your interviews.

Interviews and confidence are often affected by just having a bad day. It is often easier to shine when you know what to expect and can meet our team to learn about what we are looking for in our staff.

This is an option to you, to come along meet our team and decide whether you would like to re-apply to our Trust and have a second chance interview?

We have a number of events for registered RMNs and RGN's. We look forward to seeing you soon.

Action

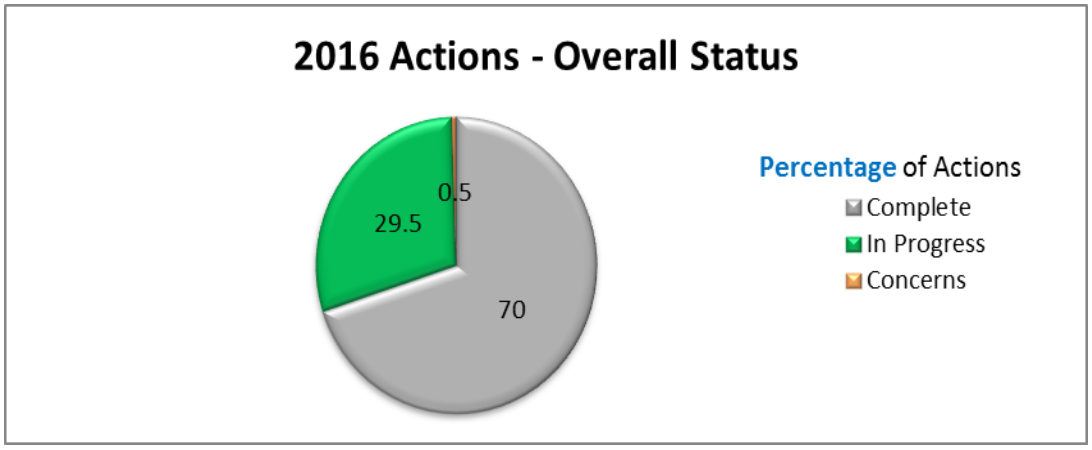
Nursing and additional resources put in place to support recruitment will work together to model this approach and pilot this idea put forward by one of our senior Nurses. We will measure the impact and whether this approach adds value.

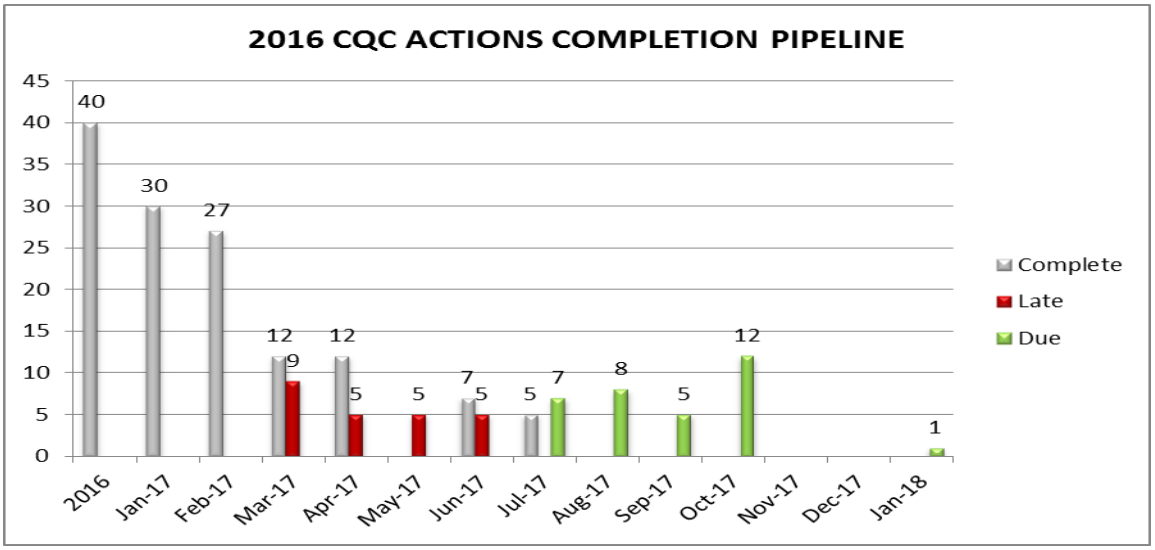
1.6 Well led – Care Quality Commission Comprehensive – completing our action plan

The learning from the Care Quality Commission Comprehensive visit continues and this is closely monitored by the Quality Committee.

There has been overall improvement in the status of the **2016** comprehesive inspections actions:

	Current 2016 Action Status			
Portal Review	**At Risk of Not Delivering**	**Concerns**	**In Progress and on Target**	**Completed**
October 2016	0	34	136	20
December 2016	0	22	128	40
January 2017	0	24	96	70
February 2017	0	12	81	97
March 2017	0	5	76	109
April 2017	0	4	65	121
May 2017	0	4	60	126
June 2017	0	1	56	133
Comparison To Previous Month (% of all actions)	**The Same**	**1.5% Decrease**	**2% Decrease**	**3.5% Increase**





Action

We continue to make progress on our CQC action and improvement plan and we will continue to ensure that these recommendations and actions are fully delivered.

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

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

Board Committee Summary Report to Trust Board
Quality Committee - meeting held 15 June 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	Agreed and ratified	Good assurance	See Minutes for full actions Risks with some overdue actions that need further information updated	One minor amendment made to Minutes	
Incident Response Plan	A revised incident response plan was submitted for approval	Full assurance and approval given	Recommendations made following the cyber attack	Action plan or confirmation of completion to be received at Quality Committee following its submission to TMT. Committee approved the Incident Response Plan	To be referred to TMT- Lead Mark Powell
Service Recipient Representative and Carer Representative Update	North Derbyshire Voluntary Action Group to suspend ward visits from 30 June 2017	Healthwatch need to agree future arrangements	Loss of organisation memory, knowledge and experience A known risk that executive lead is in liaison to support and minimise risks	Written report on the issues and mitigation plans scheduled for July 2017. Carolyn Green to retain the carer representatives until October 2017	
Policy Status Matrix and Quality Committee Attendance Log	List of policies submitted that require ratification by the Quality Committee	No out of date policies	Substantially improved governance in this area.	Approved Rachel Kempster's request to move the expiration date of the Untoward	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
				Incident Policy from 31 July to 31 August 2017	
Mental Capacity Act Developments	Deep dive analysis of the Mental Health Act Committee (MHAC) CQC related actions Dr J Sykes suggested ownership be devolved to the local units with support from named leads C Green disagreed with this approach as CQC as the improvement that is require dis sustained improvement	Limited assurance	Dr A Wright confirmed that the results of the compliance audits will need to be received by the MHAC before actions can be closed.	The actions need to be updated by the end of Summer. Monthly compliance checks are required – 75% compliance. For the action to be completed and a model of sustained checking and improvement sub actions to be expanded upon and this is the role of the Executive lead to ensure these areas are achieved. Compliance checks on key elements are required on a monthly basis and show demonstrable improvement (completion and quality) Dr E Komocki will design a report to audit and collect data, provide audit assurance (full learning and sustained improvement)	To be reviewed by the Quality team for submission to the CQC who receive all evidence in full and their assessment will be to scrutinize Dr J Sykes to discuss with the Executive Leadership team on timescales for delivery MHAC compliance actions will be reported to Audit and Risk Committee and Trust Board July 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)
Quality Dashboard	Dashboard presented with a summary of highlights and challenges through the use of high level quality indicators Substantial discussion re key indicators and the need for improvement	Assurance that rise in falls and complaints data is accurate		C Green to investigate at how other Trusts analyse restraint information for BAME/ Gender groups	
QUESTT Model	C Green gave a live demonstration on QUESTT This model is an early warning indicator monitoring systems against key criteria for all trust wide services	To identify and achieve KPI's / receive significant assurance	An early warning indicator can be given to show if a service is in decline. A summary of delays was shown due to naming conventions and teams between electronic staff record data and service directory data held in Finance	Improvement in hierarchy and team names between Trust wide data sets are required before this system can go live.	
Improvements and System Changes to IMT Reporting Systems	Update was given on work to help clinicians to make more effective use of systems re provision of high quality care	Assurance was given	Learning from previous incidents, serious case reviews and v serious incidents was the patient safety improvements in a full electronic patient record. This has substantially improved the clinical recording of	Maintain roll out of Electronic records and service improvements	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
			information- Achieved		
Support Clinical Staff in intersystem connectivity	Deferred to July	Deferred to July	Deferred to July	Deferred until July 2017 meeting	
Serious Incidents Report	SI report was presented.	Limited assurance received	Higher levels of externally reportable incidents have occurred	Continual monitoring is in place along with learning and changes practice	
Suicide Prevention Group Strategy Report	Sam Kelly gave an overview of the progress made against the 10 priorities for 2016 – 2018 set within the Trust's Suicide Prevention Strategy		Not sure how achievable the national target is, and the evidence of this level of reduction, does not translate at a county level The target is an aspirational and admirable national one to reduce harm through suicide.	To support the progress and actions of the group	
Ligature Risk Reduction	Update provided in relation to ligature risk reduction	Significant assurance received	Some newly 'red' risks have been added to the ligature reduction programme	Work to be undertaken to continue to progress. More funding or reallocation of works may be needed from the capital programme Red rated ligature risks given absolute priority in capital planning as	To be reviewed by capital planning

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
				safety risks	
Patient Experience and Carer Committee Quarterly Report	Concern raised regarding the loss of carer and service receiver representatives	Significant assurance received	Smoking cessation-redesign of current strategy learning from national evidence is required.	Refresh strategy and plan. The model of implementation requires a review of cultural and behavioural changes required in the Trust (in design)	
Annual Medical Appraisal and Evaluation	Dr E Komocki presented the results of the Trust's annual organisational audit of its compliance with the Medical Professional Regulations as submitted to NHS England	Full assurance received on the outcome and benchmarked performance Improvements to be made on full compliance and performance of the staff with mitigation actions for next year.	Dr E Komocki challenged that the lack of remuneration for medical staff in this work may be an area of concern to medical staff. C Green challenged the lower levels of completion for service receiver and carer commentary and was provided with assurance of improvement over a five year trajectory	Medical management review of finances and decision by Medical Director, as required as Quality Committee is not the forum Recommended the approval of the Organisational Statement for return to NHS England by 30 September 2017	To be reviewed at Quality Committee
Information Governance Quarterly Report	Dr J Sykes presented the Information Governance (IG) Q1 2017/2018 report to show the Trust's progress towards	Solid governance model Full assurance	None noted	The IG toolkit v14 submission was acknowledged The progress within the IG work plan was	

Agenda Item	Summary of issue discussed	Assurance and actions required	Key risks identified	Decisions made	Escalations to Trust Board (or referral to other Committee)
	meeting the requirements of the 2017/2018 IG toolkit as well as any IG breach monitoring			acknowledged	
COAT Minutes	Minutes from the COAT meetings held in April and May were noted			Duly noted	

Board Committee Summary Report to Trust Board
Audit & Risk Committee
11 July 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 25 May Action Matrix and Matters Arising:	Minutes of the last meeting were approved. Updates were agreed and added to the matrix. Matters arising - Sam Harrison to complete analysis of themes emerging from conflict of interest policy. Item added to forward plan for October update.	Full assurance was received that actions were completed and that these could be archived.	None	Actions agreed as completed and noted.	None
Deep Dive BAF Risk 1a Clinical Quality Safety Standards	Discussed on Deep Dive report on Risk 1a and connection with the Care Quality Commission regulatory standards.	Limited assurance was agreed on Deep Dive findings. Ongoing monitoring required by Trust Management Team to provide assurance of effectiveness of Quality Leadership Teams.	Agreed additional risk to be added to the Board Assurance Framework regarding potential instability of Board. To note that this is likely to impact upon the risks to Quality and Safety through Board leadership.	Review Board Assurance Framework template with new content prior to next presentation at Board on 26 July. Detailed review of risks to be completed in October as set out in forward plan.	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)
Board Assurance Framework – Second Issue	Rachel Kempster presented the second issue of the BAF for 2017/18. Detailed discussions took place on the closure of 3 risks and the addition of one risk on potential Board instability. The future programme of Deep Dive reporting was discussed.	Significant assurance received that the new structure of the BAF was working well. CEO and Interim Director of Strategic Development to consider the extreme risks and how these will be presented and the role of the committee in this.	None	Second issue of BAF approved. Closure of risks 2b, 3c and 4c agreed. Agreement that Deep Dives on risks with current rating of extreme only to be presented to Audit and Risk Committee in the future and other Deep Dives to be undertaken by the identified Responsible Committee. The additional risk of potential turnover of Board that has been captured as BAF risk 3e to be circulated to Board members.	None
Update On Raising Concerns (Whistleblowing)	The 6 monthly update report on the implementation of the Trust's Raising Concerns (whistleblowing) policy was presented.	Significant assurance received on the update on the arrangements in place.	None	The Committee agreed that the proposed timescales for response to approaches at stage 3 of the policy to be introduced.	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)
Implementation of Internal and External Internal and External Audit Progress Report	Rachel Kempster presented this update report. Discussion took place on the exceptions and plans to mitigate actions which were overdue for completion.	Significant assurance was received from the improved processes in place and the mitigations for overdue actions.	None	Report received and noted and further reports to be received on a quarterly basis.	None
Standing Financial Instructions Waiver Report	The report was received and discussed.	Limited assurance received on the process followed to approve and record waivers based on other suppliers clearly being available. More work by the procurement team is required to explore whether some waivers should go to a competitive process.	None	Recommended that in future the Head of Procurement verifies whether a competitive process should be followed.	None
Review changes to Standing Financial Instructions and changes to Accounting Policies	The updates to the policy were discussed.	Significant assurance was received on the updates to the policy which had been developed with input from Counter Fraud and Internal Audit.	None	Proposed updates to standing Financial Instructions agreed.	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 Audit Report	The report was presented. Discussion took place on the proposal to combine the roles and responsibilities of the Research and Development Governance Committee and the Trust's Medical Training Committees into one and questioned that there was no analysis of the value added from Clinical Audits.	Limited assurance was received. Further work is to be completed to evaluate the effectiveness of the devolved Committee model.	None	Agreed for Quality Committee to continue to receive clinical audit process reports with annual attendance at the Audit and Risk Committee to avoid overlap of reporting. Recommended that the quality value from Clinical Audits is presented to the Quality Committee. Non-Executive Committee members to complete Clinical Audit Maturity Matrix questionnaire on behalf of the Committee.	None
Internal Audit Progress Report	The report was presented by KPMG and discussed took place about the new joint well led framework for governance reviews.	Full assurance received that arrangements are in place through Executive Leadership Team to prepare for future well led review as part of our own continuous	None	Report received and 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)
		improvement.			
Update on External Audit Progress	Verbal update received.	Full assurance received.	None	Verbal update noted.	None
Receive the External Auditors Annual Audit Letter	Annual audit letter and positive report presented by Joan Barnett from Grant Thornton. The benchmarking of our annual report was discussed and areas where we could make improvements in the future were identified.	Full assurance received. Sam Harrison to consider the earlier timetable for the completion of the annual report in 2018.	None	External Auditors Annual audit letter noted. Agreed for Audit and Risk Committee to receive draft of 2017/18 annual report in March 2018.	None
Counter Fraud Progress Report	The progress report was received and reactive referrals were discussed.	Significant assurance was received on systems and processes for Counter Fraud in place.	None	Report received and noted.	None
Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework	None	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)
2017/18 Forward Plan	Sam Harrison to complete work on themes emerging from conflict of interest policy. To be added to forward plan for October update. Earlier timetable for completion of annual report to be reflected in forward plan.	None	None	The forward plan was noted with additions agreed.	None
Meeting effectiveness	It was agreed that the Committee had been effective and well chaired with good discussion.	None	None	None	None

Board Committee Summary Report to Trust Board
People & Culture Committee - 20 July 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 18 May 2017** **Actions Matrix and Matters Arising**	None	None	None	None	None
Staff Story	Deferred to September 2017	None	None	None	None
Mindful Health and Wellbeing Strategy and current wellbeing initiatives	Insight into the current staff wellbeing offer. Strategy is out for consultation and feedback to Rose Boulton	Committee members to provide feedback on the strategy	None	None	None
Strategic Workforce Report	Discussion regarding IR35 Discussion about the plan for the Workforce and OD structure and concerns staff have about	To escalate that we have heard that trusts have found a route round IR35 Director of People and Organisational Effectiveness prepare a FAQ	Impact on attracting Consultant workforce Keeping the team engaged and supported through the change	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)
Leadership Development Strategy – deferred from May	Presented for input, sense of direction supported. Be clear on leadership and management. To complete a review of what training leaders have had to date. Sense of direction approved	Assurance taken on the sense of direction, committee members to provide further feedback to refine the next draft	Draft supported	None	None
Equalities Update	WRES and EDS 2 updated provided	Assurance provided on all the developments	None	Assurance taken	Report to be presented at the board
People Performance Report	Review of performance across recruitment, retention, attendance and training and appraisal performance	To review the exit interview process to gain a deeper understanding of our turnover	Staff retention	To bring back to the committee a revised exit interview process	None
Recruitment Progress Update	Update on the recruitment activity across professions and events attended	Introduction of the new employee survey. Committee acknowledged all the efforts being made	Ongoing issues with recruitment and workforce supply noted – BAF reflects the risk	None	None
India Trip Update	Updating on our visit to India and the relationship we have built with NIMHANS	Committee was pleased to hear about the progress made and ongoing focus	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)
DNA Compulsory Training Update	Current status shared with the committee	Committee acknowledge the challenges presented and the processes in place	None	None	None
Apprentice Levy Update	Current status shared with the committee	Committee acknowledge the challenges presented and the processes in	None	None	None
Corporate Induction Process Update	The revised corporate induction was presented. Committee acknowledged the revised approach	Ongoing evaluations of the induction process including market place to be conducted. Market place interaction will identify if the interaction with staff has improved	None	None	None
Any Other Business	GIAP review of embedded actions	To come back to the September meeting	None	None	None
Forward Plan	Full people plan for September	To come back to the September meeting	None	None	None
Items escalated to Board/other Committees Identified Risks/ Meeting	None	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)
effectiveness					
FOR INFORMATION					
Minutes/notes from: **Equality Forum** **JNCC** **Mindful Health and Wellbeing Group** **People & Culture Committee meeting dates and venues for 2017/18**	None	None	None	None	None

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors - 27 July 2017

Plan on a Page Methodology

Purpose of Report

This paper provides the Trust Board with an update on the performance management process of the 2017/18 'Plan on a Page'. It also outlines the process which 2018/19 Business Plans on a Page will be produced and performance monitored.

Executive Summary

- For the first time, in 2017/18 clinical divisions and corporate directorates developed Business Plans on a Page
- To provide assurance that these plans were being implemented, an action matrix was produced that is routinely reviewed at the Trust Management Team meeting (TMT)
- For the 2018/19 planning round, this process has been reviewed and updated to support the generation of plans that clearly articulate a team's priorities, milestones and deadlines, as well as a framework for ensuring compliance
- With support from the Strategy team, divisions are working towards the schedule below:

Process	Deadline	Lead
Meetings with general managers for first draft	End of July 2017	Head of Contracting and Commissioning
Internal service reviews of draft plans	15 September 2017	GMs
Final draft plan	End of September 2017	GMs
Challenge and confirm event	Oct/Nov	Director of Strategic Development
Implications of contract fed into divisions and plans amended accordingly	January 2018	GMs
Final plans and Plan on a Page summaries submitted	End of January 2018	GMs
Plans on a Page signed off	March Board 2018	Director of Strategic Development

- Each of the divisions and a number of directorates will have a pack tailored to them, with the attached Plan on a Page and action matrix being tailored by the Strategic Development Directorate

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 methodology has been developed based on the successful process applied in 2017/18, and in response to feedback from clinical, corporate and executive teams across the organisation
- By refining the planning process and encouraging teams to take ownership of their plans, we can mitigate against the identified risks

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	20 EXTREME	5	4
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 Finance and Performance Committee (Audit & Risk Committee)	20 EXTREME	5	4

Consultation

- The Business Planning Guidance Pack was presented to TMT on 17 July 2017

Governance or Legal Issues

- There are no legal/governance issues to note.

Public Sector Equality Duty & Equality Impact Risk Analysis The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people).	
There are no adverse effects on people with protected characteristics (REGARDS).	X
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	
Actions to Mitigate/Minimise Identified Risks There are no identified risks to REGARDS groups	

Recommendations

The Board of Directors is requested to:

1. Note the content of the paper
2. To agree the proposal on how performance and progress will be reported quarterly to the Board

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

Report prepared by: **Tom Foster**
Strategic Business and Partnership Manager

Business Plans on a Page

1) Business Planning Process 2017/18

1.1 Methodology 2017/18

For the last two years the Trust has asked Divisions to produce Business Plans which describe how services will be delivered over the coming year, outlining the future vision for their services. This has had variable levels of success. For the first time, in 2017/18 clinical divisions and corporate directorates produced Business Plans on a Page, with support from the Strategic Development Team. Please see Appendix A for an example of a Plan on a Page.

It was felt that these plans were an effective, user-friendly summary of each area's plan for the year that could be communicated across the organisation. The intention was that these plans would take into consideration any service-specific requirements from the Sustainability and Transformation Partnership (STP) and Five Year Forward View (FYFV), to ensure that teams are working towards the organisations overall Vision, Values and Strategic Objectives that constitute the Five Year Strategy.

Essentially, these plans sought to answer:

- What are your team's priorities for the year
- What do you need to do to achieve it
- By when
- By whom
- How will you measure success
- What are the links to the wider system

To supplement this, an action matrix was also developed to be reviewed periodically by senior management to:

- Monitor progress and provide updates for the vast quantity of actions
- Identify and mitigate risks to delivery
- Identify an 'owner' for each action

1.2 Performance Reporting: Clinical Divisions

Each clinical division will undergo a bi-monthly performance review in lieu of TMT, and included in that performance review will be the provision of an update for each action, as well as any newly identified risks to delivery. This will be done through the use of the standardised action matrix (see Appendix B).

The planned dates are as follows:

- 3 July 2017: Neighbourhood and Children's Services
- 11 September 2017: Campus and Central Services
- 9 October 2017: Neighbourhood and Children's Services
- 6 November 2017: Campus and Central Services
- 4 December 2017: Neighbourhood and Children's Services

- 15 January 2018: Campus and Central Services
- 12 February 2018: Neighbourhood and Children's Services

1.3 Performance Reporting: Corporate Directorates

Progress for each of the Corporate Plans on a Page will be reviewed quarterly, again through TMT with the use of the action matrix. The corporate teams that currently have plans for review are:

- Strategic Development
- People Plan
- Pharmacy
- Finance
- Information Management and Technology
- Estates and Facilities Management

Also included is a Trust-wide plan consisting of 'Objectives for us all'.

1.4 Performance Reporting: Board

The intention is to provide the Trust Board with a quarterly report summarising how many actions are identified as Red, Amber and Green per plan, measured by the number for each in the previous quarter. Where there are red rated areas a brief exception report will be produced to give assurance of actions being taken. This will help to give an overall picture of the progress being made and the actions taken.

The TMT will be the main forum for performance management.

2) Business Planning Process 2018/19

2.1 Methodology Next Steps: 2018/19

Although ultimately successful, the 2017/18 process was being continuously changed and updated, and the learning from this experience will be the driver behind the proposed process for 2018/19

To support divisions in the development of their plans, the Strategic Development Team has updated the Business Planning Guidance Pack. Within this pack is a three-stage approach to producing the business plans and Plans on a Page, including any necessary support materials / templates:

1. Analysis (of the current situation across the organisation and system)
2. Visioning (of the changes required as stipulated in the STP and other national mandates)
3. Planning (what you are going to deliver and what you need to do it)

Also within this workbook is a brief discussion of DHcFT's Vision, values and strategic priorities, as well as the various workstreams from the FYFV and STP, and a narrative explaining how all of this, including the business plans and Plans on a Page, fit together.

For more of the contents of the Business Planning Guidance please see Appendix C)

Plan on a Page Sample: Strategic Development

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	• National Procurement standards - Initial external pre-assessment of progress against Level 1	• April 2017 (initial); October 2017 (Final)
• Review internal procurement function	• Mobile Telecoms renegotiation	• June 2017
• Continue working with DCHS to achieve greater alignment of the Procurement function	• Procurement alignment with DCHS savings	• March 2018
• Provide assurance on all main contracts	• Actively participate in contractual meetings and further develop commissioner relationships	• March 2018
• Review all contracts to align financial payments	• Review all contracts and prioritise according to value and risk	• 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	• Category spend and contracts analysis is ongoing to identify further opportunities	• March 2018
• Build business planning and contracting capability within the trust	• Work with Divisions to upskill them on contracts and business planning	• 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 Action Matrix Sample: Strategic Development

Priority	RAG	Action	Owner	Target Date	Update / Evidence	Risks to delivery	Actual Close Date
•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	Richard Houghton	•March 2018	£142k savings already identified and delivered. Collaboratibe chilled and frozen mini-competition with DCHS in final stages with an additional £22k p.a.savings identified. This would take the annual savings to £164k	Failure to deliver shortfall of £28k savings	
•Achieve accreditation to Level 1 of National Procurement standards		•National Procurement standards - Initial external pre-assessment of progress against Level 1	Richard Houghton	•April 2017 (initial); October 2017 (Final)	Level 1 accreditation assesement booked for 7/8/17.		
•Review internal procurement function		•Mobile Telecoms renegotiation	Richard Houghton	•June 2017	An outline Business Case has been developed and is under consideration to re-organise the procurement function by the end of April 2018	Failure to reach agreement on revised procurement structure	
•Continue working with DCHS to achieve greater alignment of the Procurement function		•Procurement alignment with DCHS savings	Richard Houghton	•March 2018	The Trust and DCHS continue to work closely to identify collaborative procurement opportunites together with othe members of the Derbyshire STP Procurement workstream. An outline business case to reduce procurement costs is under consideration	Failure to reach agreement on revised procurement structure	
•Provide assurance on all main contracts		•Actively participate in contractual meetings and further develop commissioner relationships	Jenny Sutcliffe	•March 2018	Meetings attended for high risk/high value contracts,building links into divisions for lower risk/lower value agreements	Contract team capacity and delays to recruitment	Ongoing
•Review all contracts to align financial payments		•Review all contracts and prioritise according to value and risk	Jenny Sutcliffe	•March 2018	Contract audit up to date Require information from Finance to triangulate invoices with contract information	Contract team capacity and delays to recruitment Finance team capacity to provide information	
•Implementation of a SharePoint site to provide contract and business planning advice		•Deliver a functioning SharePoint site to provide information and advice	Jenny Sutcliffe	•June 2017	Ongoing problems with contract query portal	IM&T support to deliver functioning contract query portal and intranet site	
•Build business planning and contracting capability within the trust		•Work with Divisions to upskill them on contracts and business planning	Jenny Sutcliffe	•March 2018	Business Bytes programme to commence July 17	Uptake on workshops by staff	5th July 2017

Business Planning Guidance

Analysis

Current situation – where are we now, what is the history, what are our strengths, weaknesses etc. What works and what needs to change. Often a SWOT analysis is undertaken to look at Strengths, Weaknesses, Opportunities and Threats.

What is happening around us? – who else can deliver our services? Could we work with partners? What are the trends? Are there other markets? What are our service receiver/family/carer expectations? What are the system expectations? What national guidance might make us need to change? This is often known as a STEP analysis i.e. Social, Technological, Environmental and Political, often an 'L' is added for Legal.

Visioning

STP Impact – What changes are likely to be made to your services due to mandates within the STP? Are you familiar with, and able to deliver all objectives and milestones that are applicable to your services? Are there requirements for additional partnership working with other services or organisations?

Planning

Action – what are we going to do? Having identified the gaps we need to do something about it. This will usually mean stating what actions are being taken during the life of the plan. In this case we will need clear actions over 12 months (April 18 to March 19) with headline actions for the following 2 years to ensure we are heading in the right direction. There should always be one named person as responsible.

There are a number of key considerations to be made regarding what actions you and your teams are planning to take:

- To what extent do we need to involve other stakeholders, and does this impact / require input from teams within other services, divisions and organisations?
- What preparatory work is required before this can be implemented?
- What are the potential risks and complications and how will these be mitigated?
- How does this fit with work produced in previous or planned for future years?

Target setting – there should be clear and measurable targets so that you know 'what success looks like' These Key performance indicators will form part of the monthly performance monitoring process through TMT. They need to be SMART and have real measurable outcomes. However, there may be some 'softer' targets.

What are the gaps? – when considering how we transform services and move towards our 2021 vision we need to know what the gaps are i.e. workforce, IT, partnerships, accessibility, quality, finance etc. We need to know what we need to do!

Resource assessment – people, fixed assets, IT, finance etc. It is important to clearly identify what is required to make the changes, where investment might be needed in order to help the service change and become more efficient. However, it should be clear how cost improvements will be made and how the changes identified will contribute to the overall objective. This should be in detail for 18 months and outline for the following 3 years.

Plan on a Page

By following these steps, teams will be able to answer the aforementioned questions in the standardised format, thus producing their Business Plan on a Page for year three of the Five Year Strategy that can be shared across the organisation.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 27 July 2017

Deep Dive - Crisis and Home Treatment Service

Purpose of Report

To provide the Board of Directors with an overview of the key achievements and challenges within the Crisis and Home Treatment Service

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

Assurances

The deep dive should be considered in relation to the key risks identified in the Board Assurance Framework (BAF).

The report provides assurance across several BAF risks relating to workforce, operational performance, clinical quality and financial performance.

Consultation

The deep dive has had no consultation

Governance or Legal Issues

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Mental Health Act 1983
NHS Constitution
Health and Safety at Work Act 1974

Public Sector Equality Duty & Equality Impact Risk Analysis

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people).

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

Recommendations

The Board of Directors is requested to consider the content of the presentation by the Crisis and Home Treatment Service

Report presented by: **Fiona White,**
Area Service Manager, Assessment Services

Report prepared by: **Fiona White,**
Area Service Manager, Assessment Services

Derbyshire Healthcare
NHS Foundation Trust

Crisis Resolution Home Treatment Team Deep Dive – 27 July 2017

Fiona White - Area Service Manager
Sam Kelly - Consultant Nurse
Katie Evans - Service Manager
Cath Dunning - Senior Nurse

Introduction

- Derbyshire's Crisis Resolution Home Treatment Teams are based in three locations around, Derby, Chesterfield, and High Peak. Our service provision covers a large population, and serves eight Neighbourhoods.
- Our service is for people experiencing a severe mental health illness who without our intervention would be at risk of hospital admission. We are commissioned to see people between the ages of 18-65.
- We provide an assessment service, home treatment, least restrictive environment options, and a comprehensive discharge process.

Better together

Key achievements

- Successfully commissioned a review of Crisis Resolution Home Treatment Service – working group underway
- Improving MDT working with OT and Social workers joining teams
- CQC actions updated and Outstanding in Safe, Caring, Effective and well Led in recent Quality visit.
- Continuously improving links with our neighbourhood teams, GP's , campus services, Social Care, Police and EMAS
- Succession planning for In house staff
- Carers champion in High Peak – developed trust wide carer feedback
- Papyrus Suicide event
- Review of triage and caseload activity in the south with support of consultant nurse.
- 100 % gate keeping recorded
- Involved with High Impact User Initiative

Better together

Key challenges

- Identified lack of resource (circa 20wte) in Derby Crisis team now raised to commissioners and NHSE
- Implementing and rolling out crisis review recommendations if staffing levels do not improve
- Lack of resource in neighbourhood teams to allocate patients to CPN
- In patient bed availability
- Supervision in the south team
- Recruitment across all professions
- North crisis team have taken on two new practices, increasing referral rates and distance covered, this impacts on neighbourhoods and response times
- Links with Stepping Hill
- Lack of crisis house provision in the North
- No service commissioned for over 65 year olds in crisis in the North

Better together

Plans for future improvement

- To deliver all recommendations from recent Crisis Review
- On going recruitment to improve staffing levels
- Aspire to deliver better patient flow with effective crisis clinical model in place, including a greater in reach philosophy and purposeful admissions
- Continue recruiting across all professional groups, including full time Consultant starting August 2017 (north)
- Nurse prescribing and nurse led clinics
- Continue with succession planning
- Use of patient and carer feedback to inform future developments
- Triangle of care becoming embedded into practice

Better together

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

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

Purpose of Report:

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

Executive Summary

- There are currently fourteen risks identified on the BAF for 2017/18. However there has been considerable movement of the risks during the last quarter, including the proposal that three of the risks be closed following consideration by the Board in July 2017. This is due to:
    - The decision to not proceed to merger with DCHS (risks 2b and 4c)
    - The Trust being informed that it is now compliant with all licence undertakings (risk 3c)
- Of the remaining risks, the current risk ratings for four are identified as extreme, five as high and two as moderate
- The programme for undertaking 'Deep Dives' for all risks remaining on the BAF is detailed. It has been agreed that the Deep Dives by the Audit and Risk Committee be undertaken for risks with a current rating of extreme and risks for which it is the Responsible Committee, and that the other Deep Dives be undertaken by the identified Responsible Committee for the risk. The programme outlined is based on the current risk rating at Q2 2017/18, and is therefore subject to change.
- At the Remuneration and Appointments Committee in June 2017, it was identified that a further risk be added to the BAF in relation to potential instability of the Board. This has been included (BAF Risk 3e).

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

Individual Executive Directors – during May/June 2017
Executive Leadership Team – June 2017
Audit and Risk Committee – 11 July 2017

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people	
There are no adverse effects on people with protected characteristics (REGARDS).	x
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	

Recommendations

The Board of Directors Committee is requested to agree and approve this second issue of the BAF for 2017/18, including the closure of three of the risks on the BAF and the addition of one.

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

Report prepared by: **Rachel Kempster**
Risk and Assurance Manager, and
Samantha Harrison
Director of Corporate Affairs and Trust Secretary

Board Assurance Framework 2017/18
Second issue

The Board Assurance Framework (BAF) is a high level report which enables the Board of Directors to demonstrate how it has identified and met its assurance needs, focused on the delivery of its objectives and subsequent principal risks. The BAF provides a central basis to support the Board's disclosure requirements with regard to the Annual Governance Statement (AGS), which the Chief Executive signs on behalf of the Board of Directors, as part of the statutory accounts and annual report. This is the second formal presentation of the Board Assurance Framework to the Board of Directors for 2017/18

1) Overview

A summary of all risks currently identified in the 2017/18 BAF is shown below, together with any movement in the risk ratings since last considered by the Board in April 2017.

BAF ID	Risk title	Director Lead	Risk rating April 2017 (LxI)	Current Risk rating	Movement
1a	Failure to achieve clinical quality safety standards required by our regulators	Executive Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)	⟷
1b	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients	Executive Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)	⟷
1c	Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)	HIGH (4x4)	⟷
1d	Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident	Acting Chief Operating Officer	MOD (3x3)	MOD (4x3)	↑
2a	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME (4x5)	EXTREME (4x5)	⟷
2b	Insufficient engagement with staff side and governors in relation to proposed merger with DCHS	Acting Chief Executive	*HIGH (4x4)*	*V LOW (1x1) RISK ACCEPTED*	↓
3a	Ability to attract and retain high quality clinical staff across all professions	Director of People and Organisational Effectiveness	EXTREME (4x5)	EXTREME (4x5)	⟷
3b	There is a risk to staff engagement and wellbeing by the Trust not having supportive and engaging leaders	Director of People and Organisational Effectiveness	HIGH (4x4)	HIGH (4x4)	⟷
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	MOD (3x4)	MOD (2x4) RISK ACCEPTED	↓

BAF ID	Risk title	Director Lead	Risk rating April 2017 (LxI)	Current Risk rating	Movement
3d	There is a risk that the Trust does not operate inclusively and may be unable to deliver equity of outcomes for staff and service users	Director of People and Organisational Effectiveness	MOD (4x2)	MOD (4x2)	⟷
3e	Potential turnover of Board members	Director of Corporate Affairs and Trust Secretary	New risk from July 2017	HIGH (3x4)	NA
4a	Failure to deliver financial plans	Executive Director of Finance	EXTREME (4x5)	EXTREME (4x5)	⟷
4b	Failure to deliver internal transformational change at pace	Interim Director of Strategic Development	EXTREME (4x5)	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)	V LOW (1x1) RISK ACCEPTED	⇩

2) Movement of risks

New risks: At the Board of Directors in April 2017 it was agreed that a new risk be added to the BAF - (2b) *Insufficient engagement with staff side and governors in relation to proposed merger with DCHS* - to reflect the risks raised by the Joint Integration Programme Committee. Following the decision of 6 June 2017 to withdraw from the merger it is proposed that following discussion at the July 2017 meeting of the Board, that this risk be removed from the BAF.

At the Remuneration and Appointments Committee in June 2017, it was identified that a further risk should be added to the BAF. This relates to the proposed appointment to five of the acting roles within the Trust Board. The risk relates to the potential instability that may result from this process. This has therefore been added to the BAF (Risk 3e).

Closed risks: In line with the decision to not proceed to merger with DCHS, it is proposed that risk (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* - be removed from the BAF as it no longer poses a significant risk to the achievement of the Trusts strategic objectives. The action remaining, in relation to the implementation of a revised model for delivering the operational human resources function, has been moved to risk 3b to allow future monitoring and review.

Risk 3c - *There is a risk that the Trust will continue to be subject to NHSI enforcement action and CQC requirement/warning notices,* has reduced during the last quarter with the receipt of a letter dated 24 May 2017 informing the Trust that it is now compliant with all licence undertakings. As this risk has now achieved its target risk rating and is within the limits of the agreed risk appetite, it is proposed that

the Board accept the risk and close it to further review through the BAF. The ongoing monitoring of compliance with required standards to avoid future CQC action are included in BAF risks 1a, 1c, 4a, 3a

Movement of risk ratings: The Board in June 2017 confirmed the change to the likelihood risk rating for risk 1d - *Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident* - from possible (3) to likely (4) based on the 'Cyber-attack and lessons learned report' which discussed the impact, response and actions from the recent cyber-attack and the level of assurance with this response.

Following discussion at the Board of Directors in May 2017 it was agreed that the ongoing issues relating to capacity and demand in the Trust needed to be reflected in the BAF. The committee is asked to note that these issues are reflected within a number of the BAF risks as an impact to achievement of the objectives.

Changes since Issue 1 are highlighted in blue text in the detailed word document attached.

2) Deep Dives

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

Following discussion about the Deep Dive process at the Audit and Risk Committee in July, it was agreed that:

- Deep Dives for Audit and Risk Committee be undertaken for risks with a current risk rating of extreme only.

- High level and other Deep Dives to be undertaken at the relevant Committee with assurance that this has been completed and associated discussions reported to the Audit and Risk Committee (potentially via the Committee Assurance Summary or via a fuller report to be determined). [1]Deloitte recommendations include that these Deep Dives should focus on controls and mitigating actions.

- Committee Chairs be involved in the Deep Dives presented to Audit and Risk Committee, where risks have a current risk rating of extreme. Deloitte recommendations include that these Deep Dives should focus on structures and processes in place to provide the Board with assurance.

- Robust processes are further developed to ensure Board Committees regularly consider BAF risks which fall under their remit, as well as considering the impact on any other organisational BAF risk as identified through Committee discussions. This process is in place with some

[1] Deloitte. Independent follow-up review of governance arrangements and HR related functions. 24 April 2017. Considered by Board of Directors 28 June 2017

Committees and can be made more robust by ensuring these are included as standing items on all Committees.

- Risk 1a be updated to include additional information on controls and assurances presented as part of Deep Dive. This has been completed

Based on the above proposals, the plan for Deep Dives for 2017/18 is shown below, in line with the Q2 17/18 position for the current risks on the BAF.

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

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

This programme is based on the expectation that the Board in July 2017 will agree for the three risks (2b, 3c, 4c) to be closed on the BAF, therefore no longer requiring Deep Dives reviews to be completed.

Summary of Board Assurance Framework Risks 2017/18 Issue 2.2

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)
Strategic Outcome 1. We will deliver quality in everything we do providing safe, effective and person centred care			
1a	Failure to achieve clinical quality safety standards required by our regulators	Executive Director of Nursing and Patient Experience	HIGH (4x4)
1b	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients	Executive Director of Nursing and Patient Experience	HIGH (4x4)
1c	Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)
1d	Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident	Acting Chief Operating Officer	MODERATE (4x3)
Strategic Outcome 2: We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time			
2a	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME (4x5)
2b*	Insufficient engagement with staff side and governors in relation to proposed merger with DCHS	Acting Chief Executive	V LOW (1x1) RISK ACCEPTED
Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff			
3a	Ability to attract and retain high quality clinical staff across all professions	Interim Director of People and Organisational Effectiveness	EXTREME (4x5)
3b	There is a risk to staff engagement and wellbeing by the trust not having supportive and engaging leaders	Interim Director of People and Organisational Effectiveness	HIGH (4x4)
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 (2x4) RISK ACCEPTED
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 (4x2)
3e	Potential turnover of board members	Director of Corporate Affairs and Board Secretary	HIGH (3x4)
Strategic Outcome 4. We will transform services to achieve long-term financial sustainability			
4a	Failure to deliver financial plans	Executive 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	V LOW (1x1) RISK ACCEPTED

*New risk added following Board discussion April 2017, initially rated as high. Proposed that risk be removed from BAF following consideration by Board, July 2017

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
g) Interconnectivity with Risk 1c (MCA/MHA) and Risk 3a (retention of staff)
h) Compliance with CQC standards

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

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

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Quality governance structures, teams and processes to identify quality related issues; Implementation of Safe Wards programme; Induction and mandatory training; 'Duty of Candour' processes; clinical audits, health and safety audits and fire risk assessments. Detective – Quality dashboard reporting; Quality visit programme (including commissioner involvement); Incident, complaints and risk investigation and learning - including monitoring	Quality dashboard Scrutiny of Quality Account (pre-submission) by committees and governors Clinical analysis and triangulation from across governance reports leading to actions to rectify clinical practice concerns through Patient Experience Reports to be followed by QUEST model reporting	National enquiry into suicide and homicide identifies rates lower than national average, although increase in homicide incidents evident for 2017. NHLSA Scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark

actions plans; Annual Training Needs Analysis; Directive – Quality Framework (Strategy) outlining how quality is managed within the Trust Corrective – Board committee structures and processes ensuring escalation of quality issues; Annual skill mix review; CQC and GIAP action plans; Incident investigation and learning; Actions following clinical and compliance audits; Workforce issues escalation procedures; Reporting to commissioner led Quality Assurance Group on compliance with quality standards		Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review identified 4 services rated as 'good' for safety 2016/17 BAF and Risk Register Review Schedule 4/6 analysis and scrutiny by commissioners Results of Section 11 Safeguarding Children Inspection, July 2017

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
Ability to recruit and retain adequate numbers of staff to ensure safe practice	Workforce plan to be implemented, with annual action plan [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	Number of successful recruitment days, chesterfield area and CAMHS. Still substantial vacancies in campus and neighbourhood services. Further expansion of recruitment strategies underway for OT, social workers and RGN's in core areas. Additional monitoring by DoN and COO re campus areas to ensure safety standards are met	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]	31/12/2017	Two reviews considered by QAG – neighbourhood and crisis. Actions identified. New primary mental health service model with STP's being developed	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]	31/01/2018	Neighbourhood improvement plan completed. To be reviewed by Quality Committee Sept 2017	High
Seclusion room at Kedleston Unit not fit for purpose	Rebuild underway to meet standards required [ACTION OWNER DOF]	Completed	Completed June 2017	Achieved
Staff competence and knowledge in suicide prevention	Suicide reduction strategy in place and roll out of patient safety planning to be completed [ACTION	31/03/2018	Update provided to Quality Committee June 2017 against safety prevention plan	Medium

	OWNER DON]		(Sign Up to Safety). Safety planning completion monitoring through Quality Dashboard	
Early warning signs of service failure and independent service modelling	Plans in place to implement QUESTT from Sept 2017 Explore and commission remodelling exercise of community mental health services and inpatient beds [ACTION OWNER DON]	30/09/2017	Final draft of QUESTT completed. Data validation underway Jul/Aug 2017. Roll out to commence Sept 2017.	Low ⇩
Non commissioned services for Derbyshire based PICU beds and a secure and effective forensic pathway, and CAMHS Tier 4 beds	Improvement plan with commissioners in place [ACTION OWNER DON]	31/08/2017	New project in development for CAMHS Tier 3.5 service. PICU provision now responsibility of commissioners. No adverse incidents currently	Medium
Embedded security and safeguarding culture	Complete security action plan and ongoing investigations [ACTION OWNER DON]	Completed	Policy amendments completed. Ward security investigation completed and reported to SIG 20/07/2017	Achieved
Compliance with medicines management code, including storage compliance	Improvement plan in place to deliver [ACTION OWNER DON]	31/08/2017	Audits demonstrate considerable improvements. Updated pharmacy plan to be presented to Aug 2017 Quality Committee	Medium
Lack of effective forensic clinical service pathway following prison release. In addition new policy to release IPP prisoners (indeterminate imprisonment for public protection) increases risks.	Interagency solutions being sought, including proposal for commissioner solutions including benchmarking and mitigation plans [ACTION OWNER MD]	30/09/2017	To be included in new STP priorities. Progress report considered by Quality Committee (confidential) June 2017. Email received from CCG COO accepting risk. Exploring potential commissioning solutions	High
Fully integrated Quality Leadership Teams and escalation to Quality Committee	Executive team to continue to act down to support campus and neighbourhood QLT's in particular to develop model to level of children's and central QLT's.	30/09/2017		Medium
Gaps in assurances:	Actions to close gaps in assurances:	Action/ review due:	Progress on action:	Risk to delivery.
CQC comprehensive review identified 6 services as 'requires improvement' for safety	Fully implement CQC actions plan, with subsequent plan to raise all services identified as requires improvement to a rating of good [ACTION OWNER DON]	31/03/2018	Significant improvement reported. Warning notice lifted. Remaining actions monitored monthly and reported to the Quality Committee.	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]	30/09/2017	Contract negotiations underway to prioritise neighbourhoods and paediatric structural deficits, led by STP workstreams	High
Participate in national 'Sign Up to Safety' campaign to meet contractual requirements	Implement CQUIN improvement plan including 'Sign up to Safety'. Each integrated quality leadership team to complete one quality improvement project of their design [ACTION OWNER DON]	31/03/2018	First draft improvement plan for 'Sign Up to Safety' submitted to commissioners July 2017	Low

Increase in number of mental health related homicides (3 incidents over 3 month period during 2017), and inpatient deaths (2 over recent 3 month period)	Learning reviews by DHCFT. Elevating commissioning risk for forensic pathway with commissioners [ACTION OWNER DON]	31/08/2017	External investigators assigned for all homicide investigations	High
Gap in governance and system processes to meet revised essential CQC standards to meet 110 changes of PIR	Develop automated process to meet requirements of revised CQC PIR	30/09/2017	Draft completed	Medium

Related operational high/extreme risks:

867	Neighbourhood Services	Clinical - Staffing levels	Capacity of adult recovery teams
3262	Community Paediatrics	Clinical - Staffing levels	Long waiting lists following reduction in paediatrician staffing levels
3385	Neighbourhood Services	Clinical - Staffing levels	Waiting Times for Psychological Assessment and Intervention
3386	Campus - Radbourne Unit	Clinical - Staffing levels	Radbourne Unit - Staffing risk assessment
3410	Campus - Radbourne Unit	Clinical - Staffing levels	Ward 34 Vacancy levels above 30%_Ward 34
20867	Learning Disabilities Services	Clinical - Staffing levels	Lengthy waiting times for psychological involvement
20928	Neighbourhood Services - North	Clinical - Staffing levels	Long waiting times for MAS Diagnosis
20946	Neighbourhood Services - City	Clinical - Staffing levels	Staffing Levels
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
21044	Neighbourhood Services - North	Clinical - Staffing levels	reduction in medical support
21070	Neighbourhood Services - North	Clinical - Staffing levels	Extreme Pressures in team
21123	Neighbourhood Services - South	Clinical - Staffing levels	Low staffing levels
21124	Neighbourhood Services - South	Clinical risk - Other	No consultant psychiatrist
21013	Campus - Radbourne Unit	H&S - Violence and Aggression	Sec 136 suite

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: 21107

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

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, Agreed clinical policies and standards, available to all staff via Connect.	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

Corrective – Board committee structures and processes ensuring escalation of quality issues;				
Gaps in control:	**Actions to close gaps in control:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery:**
Clinical buy in to review of NICE guidelines	Clinical buy in to review of NICE guidelines [ACTION OWNER DON]	30/09/2017	Task and finish group to redefine process. Policy to be revised following review	High
Embeddedness of integrated clinical/leadership teams	Integrated 'plan on a page' to be developed for each clinical pathway [ACTION OWNER DON] CPD support plan for Chairs of integrated quality meetings [ACTION OWNER DON]	Completed 30/09/2017	Performance management plan through Trust Management Team (TMT) from July 2017 Evaluation of QLT's in place and completed 6 monthly. Positive assurance received. CPD for Chairs to be developed from Oct 2017 onwards	High
Embedded personalised care planning, physical health cheeks and clinical standards	Implement CQC action plan around care planning [ACTION OWNER DON]	31/07/2017		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]	30/09/2017	Contract negotiations underway to prioritise neighbourhoods and paediatric structural deficits, led by STP workstreams. Development of non-medical consultant and advanced clinical practitioner posts	High
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	Review of CPA policy commenced. Triangle of care implementation plan underway	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	In roll out phase	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	DON meeting with new providers. Interventions to support current providers	Medium
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery.**
CQC inspection comprehensive review identified 9 services as requiring improvement for effectiveness	Fully implement CQC actions plan, with subsequent plan to raise all services identified as requires improvement to a rating of good [ACTION OWNER DON]	31/03/2018	Significant improvement reported. Warning notice lifted. Remaining actions monitored monthly and reported to the Quality Committee	Medium
Related operational high/extreme risks:				

20857	Neighbourhood Services - North	Clinical risk - Other	Transfer of patients through the change in neighbourhood boundaries
21031	Neighbourhood Services - City	Clinical risk - Other	Non-Adherence to Waiting List Management Policy and Procedure
3260	Neighbourhood Services	Commissioning Risk	Lack of ADHD service for adults
21002	Campus	Commissioning Risk	Withdrawal of police support for inter-facility transport of patients
21106	Children's Therapies & Complex Needs	Commissioning Risk	Sexual Abuse Referrals

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: 21108

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

Key controls:	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 directors via next in line managers; Improved monitoring and reporting processes for seclusion	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

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/ review due:	Progress on action:	Risk to delivery:
Electronic reminders to undertake assessments	Develop electronic reminders for capacity assessments and Best Interest assessments [ACTION OWNER MD]	Completed	Electronic reminders in place and running	Achieved
Appointment of Deputy Medical Director to lead on compliance reporting from clinical directors	Appointment of a Deputy Medical Director [ACTION OWNER MD]	Completed	Appointed April 2017. Commenced in post	Achieved
Consistent application of seclusion and segregation	Embed consistent application in clinical practice led by Chief Nurse [ACTION OWNER DON] Improve training for junior doctors regarding seclusion reviews [ACTION OWNER MD]	Completed Completed	Regular reports to Quality Committee and Mental Health Act Committee demonstrate improved compliance. Consistent reporting evidenced on Datix. Reporting determined solely for MHAC going forward due to level of assurance received. Training now part of Dr Toolkit	Achieved
Delays by local authorities in undertaking DoLS assessments	Continue to monitor and report compliance to the MHA Committee including where escalation to local authorities where illegal detention is a risk [ACTION OWNER MD]	30/09/2017	Discussed at MHA Committee June 2017. Trust monitoring and reporting now robust. Work commenced to triangulate LA data set with Trusts data to report to MHAC Sept 17.	Low
Monitoring of application of MHA against equality standards	Year-end analysis to be completed and presented to MHA Committee Aug 2017 [ACTION OWNER MD]	31/08/2017	To be provided as part of MHA Managers annual report to MHA Committee – Aug 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]	31/08/2017	Largely completed. Small number of outstanding actions from 2016 review still to be finalised	Medium
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]	Completed	All actions completed. Updated reported to MHAC June 2017	Achieved
Assurance of junior doctor supervision taking place, which includes focus on MHA/MCA compliance	Improving systems to consistently record supervision [ACTION OWNER MD]	31/08/2017	Supervision reporting supported by medial secretaries from electronic timetables. Trajectory for performance improvement to be clarified.	Medium
Evidence of compliance with CTO and Section 37/41 reviews undertaken by Responsible Clinicians (RC's) to a sufficient degree to protect patients and the public	Audit of compliance of clinical practice of RC's. Implementation of a 90 day improvement cycle, including undertaking system change if issues identified	30/09/2017		Medium
Related operational high/extreme risks: None specifically identified				

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

Principal risk:

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

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

Root causes:

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

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 3	Impact 5	Rating MOD	Likelihood 4	Impact 3	Direction ⇧	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, response plans tested during recent cyber-attack and found to be robust Directive – Emergency Plan, Business Continuity	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 e) Training needs and delivery	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)

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				
Gaps in control:	**Actions to close gaps in control:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery:**
Learning review following cyber-attack in May 2017 has identified some gaps in control. None have been identified as major.	Action plan developed to include: Laptops and computers infrequently logged onto the network (to enable anti-virus patches to be applied) will be permanently disabled following a risk assessment of the impact Business continuity plans to be developed by departments in the event of an IT major incident (other types of incidents could cause business continuity to be required)	30/09/2017 30/09/2017	Action plan developed following cyber attach. Agreed by Board June 2017 EPRR lead to progress	Medium
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]	31/10/2017	Training being delivered during March and further sessions will be provided before the end of June 2017. Completed for majority of staff, further 'mop up' session to be completed later in year	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]	30/09/2017	Work underway with CareCERT to understand the validity of the vulnerabilities and actions required to address if applicable. Meetings held with Arden GEM on a monthly basis to control the action plan.	Low
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery.**
4 Core standards remain amber, resulting in the Trust being graded as substantial compliance and not fully compliant	Deliver actions set out in Core Standards action plan and embed ongoing review process, via EPRR steering group, for all standards. [ACTION OWNER: COO]	30/09/2017	Ongoing monitoring through Quality Committee	Low

	Progress reported to TMT and QC via EPRR reporting process			

Related operational high/extreme risks:

20819	Neighbourhood Services - City	Operational - Business Continuity	Waiting lists for assessment and interventions, Neighbourhood City
21016	IM & T	Operational - Information Security	Introduction of a Virus \ malware via an unpatched server or PC

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

Principal risk:

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

Impact:

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

Root causes:

a) Financial constraints nationally and locally
b) Lack of confidence by Acute providers in the delivery of local STP outcomes
c) Lack of system wide leadership and 'grip'
d) Lack of engagement with staff groups
e) Lack of engagement with staff from other organisations
f) Changing national directives
g) Regulatory bodies imposing different rules and boundaries

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ⟷	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? Directive- National agreement of Derbyshire's	Reports to Board regarding any system wide changes or risks Regular progress feedback to F&P on system change Updates and feedback at TMT and ELT in order to update on system change or 'blockers' Engagement with Governors in order to get feedback and update them on progress	NHSE/I agreement of plans Minutes of CMB

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	Engagement with staff though managers, staff side, focus groups etc.	

Gaps in control:	Actions to close gaps in control:	Action/ review 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 30/09/2017	STP system leadership have reviewed governance structures and instigated implementation of revised plan	High
Lack of clarity around collaboration and competition	Continue working with NHSI to gain clarity [ACTION OWNER DSD]	30/09/2017	Further update expected, not yet received	Medium
Issues of communication owing to divergent messages between NHSE and NHSI	Communication between differing groups – replay the message [ACTION OWNER DSD]	30/09/2017	STP governance now includes NHSI and NHSE membership. Restructuring should then impact.	High
Lack of long term strategic partnerships to deliver quality, sustainable services	Aim to develop partnerships through collaborative working [ACTION OWNER DSD]	30/09/2017	Review of partnerships took place. STP pathways will require strong partnership with other organisations	Medium
Lack of capacity within DHCFT to fully contribute to system wide programmes of change	Work collaboratively with CCG's and other partners to release system wide capacity to deliver programme [ACTION OWNER DSD]	30/09/2017	Discussion taken place and people initially identified to support programme	Medium
Lack of engagement with staff internally and staff from other organisations who will be key to success	Development of a robust 'Engagement Plan' overseen by the MH System Delivery Board.[ACTION OWNER CEO/DSD]	30/09/2017	MHSDD only recently formed – engagement is integral to delivery	High
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery.**
Feedback from system wide groups	Maintenance of relationships and involvement in relevant groups [ACTION OWNER CO/DSD]	30/09/2017	Trust fully involved with system wide groups and re-establishment of the STP	Medium
The provision of reliable system wide information	Maintenance of relationships and involvement in relevant groups [ACTION OWNER CO/DSD]	30/09/2017	System wide information is integral to success of STP and remains under review	Medium
Robust feedback methodology from engagement with internal staff and those from other organisations	Delivery of Engagement Plan and implementation of actions arising. (ACTION OWNER: CEO/DSD)	30/09/2017	MHSDD only recently formed – engagement is integral to delivery	High

Related operational high/extreme risks:

3260	Neighbourhood Services	Commissioning Risk	Lack of ADHD service for adults
21002	Campus	Commissioning Risk	Withdrawal of police support for inter-facility transport of patients

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

Principal risk:

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

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

Root causes:

a) National shortage of key occupations
b) Future commissions of key posts insufficient for current and expected demand
c) Trust reputation as a place to work
d) Trust seen as small with limited development opportunities
e) Lack of a workforce plan and sufficient funding to accelerate the introduction of alternative workforce models
f) Organisational appetite to try and test alternative workforce models
g) Turnover of key personnel/professions

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ⟷	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'. Improvement from staff survey to pulse check evident for Q1 17/18	CQC visits identify caring and engaging staff

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
Workforce plan to include alternative workforce models	Develop a precise workforce plan to include a bottom up workforce plan with owners of new roles that is costed with a timeline as to what the trust can afford to implement and by when [ACTION OWNER DPOE] In development. To be considered by People and Culture Committee March 2017	31/07/2017	Workforce plan considered at People and Culture Committee March and May 2017. Due for approval by Board June 2017 India trip has built pipeline for 13 medics to join the Trust over next 2 years. First person commenced on 12/06/17. Medical vacancies halved over last 3-6 months.	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	31/07/2017	Staff survey actions in place (see actions for risk 21111) The Recruitment and Retention Group continues to meet. Survey being conducted around how recruitment could be done better. Rotation Policy being developed which is aimed to be adopted to retain nurses across the county, along the lines as the OT rotation policy currently in operation within the Trust. A Retire and Return Scheme is being developed.	Medium
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action/ review 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]	31/08/2017	Pre-Election, all Learning Beyond Registration money on hold until post-Election. STP workforce development available monies still unknown	High

Related operational high/extreme risks:

867	Neighbourhood Services	Clinical - Staffing levels	Capacity of adult recovery teams
3262	Community Paediatrics	Clinical - Staffing levels	Long waiting lists following reduction in paediatrician staffing levels

3385	Neighbourhood Services	Clinical - Staffing levels	Waiting Times for Psychological Assessment and Intervention
3386	Campus - Radbourne Unit	Clinical - Staffing levels	Radbourne Unit - Staffing risk assessment
3410	Campus - Radbourne Unit	Clinical - Staffing levels	Ward 34 Vacancy levels above 30%_Ward 34
20867	Learning Disabilities Services	Clinical - Staffing levels	Lengthy waiting times for psychological involvement
20928	Neighbourhood Services - North	Clinical - Staffing levels	Long waiting times for MAS Diagnosis
20946	Neighbourhood Services - City	Clinical - Staffing levels	Staffing Levels
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
21044	Neighbourhood Services - North	Clinical - Staffing levels	reduction in medical support
21070	Neighbourhood Services - North	Clinical - Staffing levels	Extreme Pressures in team
21123	Neighbourhood Services - South	Clinical - Staffing levels	Low staffing levels
21124	Neighbourhood Services - South	Clinical risk - Other	No consultant psychiatrist
21101	Workforce, Organisational Development & Culture	Strategic risk - Other	Insufficient safeguarding children's training resources.

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

Principal risk:

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

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

Root causes:

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

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 4	Impact 4	Rating HIGH	Likelihood 4	Impact 4	Direction ⟷	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. Directive – Leadership development training supporting managers to implement policies	Quarterly Pulse check. Improvement from staff survey to pulse check evident for Q1 17/18	

Corrective – appraisal and supervision processes				
Gaps in control:	**Actions to close gaps in control:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery:**
Lack of a Leadership Development Strategy	Develop and implement a Leadership Development Strategy	30/09/2017	Leadership Development Strategy drafted for discussion with ELT and People and Culture Committee. Plan for implementation from Sept 2017 onwards.	Medium
- Recruitment of leaders for their leadership talents	Develop leadership recruitment process [ACTION OWNER DPOE]	30/09/2017	Agreeing framework of how to recruit – includes leadership development guide and coaching and mentoring support	Medium
- Clearly defined leadership expectations, monitored via appraisals and the detective tools	Develop a leadership expectation guide and leadership induction process [ACTION OWNER DPOE]	30/09/2017	To be developed following agreement of Leadership Development Strategy	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	As per action above - agree framework of how to recruit including leadership development guide and coaching and mentoring support	Medium
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery.**
Annual staff survey results	Actions to be focused on: ensuring staff have 'tools to do the job', ensuring staff have a voice, staffing, leadership development [ACTION OWNER DPOE]	30/09/2017	Bi-monthly monitoring by Trust Management Team of local area staff survey plans and progress. Engagement group overseeing overarching action pan and reporting to People and Culture Committee	Medium
Lack of capacity in operational HR department	Delivery of revised model for operational HR [Action Owner :DPOE]	30/09/2017	Consultation has commenced on the restructure and joining together of the HR Teams within DCHC and DHCFT. This is scheduled to be implemented by September 2017. The effect will be to increase the resilience of the HR Team in DHCFT by broadening the number of staff available	Moderate
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: 21112

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating HIGH	Likelihood 3	Impact 5	Rating MOD	Likelihood 2	Impact 4	Direction ↓	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 deliver the governance improvement action plan including reporting to ELT and monthly reporting to Board, 'Blue Form' final sign off of GIAP actions	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) 2016/17 CQC action plan (completed, awaiting final report)

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 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/ review due:	Progress on action:	Risk to delivery:
Identified in the governance improvement action plan.	Implement actions from Governance Improvement Action Plan [ACTION OWNER CEO]	Completed	GIAP fully completed, as agreed by Board May 2017.	Achieved
Identified in the CQC comprehensive reports and the separate warning notice received from the CQC	Complete 190 actions detailed in the CQC action plan hosted on the CQC portal [ACTION OWNER DON]	Action to be monitored through BAF risks 1a, 1c, 4a, 3a	The warning notice has been lifted, the NHS licence conditions have been removed. However there are still circa 60 actions to be completed	See BAF risks 1a, 1c, 4a, 3a
Deloitte well led report, CQC reports, Yates report	As above. Also, NHSI to undertake licence review Q4 16/17 [ACTION OWNER CEO]	Completed Transfer action to ELT	Letter to confirm compliance with all licence undertakings received by the Trust 24/5/17 Working with Deloitte and NHSI on revised plan for further review. Expected Q1 17/18. To be monitored through ELT and escalated to BAF if specific concerns arise	Achieved
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action/ review 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]	Completed	Full external assurance review undertaken by Deloitte Feb – April 2017	Achieved
Fully delivered GIAP and CQC improvement plans	Fully deliver GIAP and CQC improvement plans [ACTION OWNER CEO]	Completed	GIAP full completed, as agreed by Board May 2017. All improvement notices relating to June 2016, now lifted CQC actions to be monitored through BAF risks 1a, 1c, 4a, 3a, with overall monitoring of CQC improvement overseen by Quality Committee	See BAF risks 1a, 1c, 4a, 3a

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		Achieved
Related operational high/extreme risks: None specifically identified				

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

Principal risk:

Risk: **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: 20936

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

Key controls:	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/ review due:	Progress on action:	Risk to delivery:
Delivered equality strategic action plan	Reporting on progress to Equalities Forum, Quality Committee, and People and Culture Committee [ACTION OWNER: DPOE]	30/09/2017	Reporting identifies progress, all objectives on target to achieve amber rating by Q3 17/18. Board paper April 2017 updated against EDS2 goals. EDS2 2018	Low ⇓

			implementation plan presented to Board June 2017. 'You said: We did' report to be shared with stakeholders and Board Sept 2017.	
Evidence of managers supporting staff to work in culturally ways	Delivering equality training. Undertake EDS assessment of services. [ACTION OWNER: DPOE]	30/09/2017	Equality training commenced through induction and EIRA training. Plan to deliver managing inclusion workshop. Board Development session planned for April 2017, completed. Papers to Board re progress on EDS outcomes and board development actions.	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	Draft Board Equality action plan identifies how will be managed and timescales using the Integrated Performance Report to mainstream existing processes.	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 People and Culture Committee. New template, and training with Board, has resulted in improved standards. Audit to be completed Feb 2018	Low
Gaps in assurances:	Actions to close gaps in assurances:	Action/ review due:	Progress on action:	Risk to delivery.
Implementation plan for undertaking EDS2 national performance framework	Plan against EDS2 national performance framework to be developed and implemented [ACTION OWNER: DPOE]	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 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff

Principal risk:

Risk: **Potential turnover of board members**

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

Root causes:

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

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 4	Impact 5	Rating MOD	Likelihood 3	Impact 4	Direction New Risk	Rating LOW	Likelihood 1	Impact 1	Accepted	Tolerated	Not accepted

Key controls:	Assurances on Controls (internal):	Positive assurances on Controls (external):
Preventative – Deputising posts in place for Chief Executive and Chair; Succession plan for Board members; Existing NED/Chair of Audit and Risk Committee able to extend appointment until replacement post in place Directive – Notice periods for Board Members Corrective – Recruitment processes commencing July 2017		Deloitte Well Led review

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
Full populated cascade for Board member succession planning	To develop full populated cascade for succession of Board members	30/09/2017	To be considered by the Remuneration and Appointments Committee Sept 2017	Moderate
Communication and engagement plan for trust staff	Communicate with trust staff to raise awareness of forthcoming advertisements and plans to recruit to	31/07/2017		Low

	substantive posts			
Gaps in assurances:	Actions to close gaps in assurances:	Action/ review due:	Progress on action:	Risk to delivery.
Related operational high/extreme risks: None specifically identified				

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

Principal risk:

Risk: **Failure to deliver financial plans**

Impact: Trust becomes financially unsustainable.

Root causes:

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

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

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 5	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ⟷	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 implementation	Financial performance reports to Trust Board and Finance and Performance Committee evidence the overall actual performance as well as the forecast performance. Includes several sections covering the efficacy of controls include: - CIP delivery achievement - Agency expenditure - Balance sheet cash value The Integrated Performance Report evidences delivery of services, workforce information, quality information set against the financial performance evidencing whether we deliver services within our resources Service Line Reporting define financial performance for each service line.	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

Gaps in control:	Actions to close gaps in control:	Action/ review 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 some 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 average £250k per month agency spend (or less)	30/09/2017	This is 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	QIPP and CIP incorporated into the mental health STP workstream [ACTION OWNER COO/DSD] Increased CIP meetings and project scrutiny, management action via TMT {ACTION OWNER – COO] AIM: full CIP programme, quality assured	31/07/2017	Commissioners are now following the 'QIPP' approach, however a substantive amount of QIPP is yet to be agreed and may overlap with CIP. New PMO approach in train for CIP CIP progress reported each F&P and Board meeting	High ⬆
Commissioners appear to not be following the 'QIPP' approach that was agreed as part of contract sign off	QIPP and CIP incorporated into the mental health STP workstream [ACTION OWNER COO/DSD] AIM: agreed plan showing income reduction is matched by cost reduction	31/07/2017	Commissioners are now following the 'QIPP' approach, however a substantive amount of QIPP is yet to be agreed. Regular workstream meetings overseen by Board	Medium
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery.**
Agency costs exceed NHSI ceiling by >50% and generate 'use of resources' agency score of 4.	Weekly agency meetings to reduce costs. Implementation of recruitment drive and incentives AIM: To have a UoR agency score of 2 or 3 for agency as a minimum)[ACTION OWNER: COO]	Completed	As of month 2, performance shows use of resources agency score as 1. Forecast for 3 by year end. Evidence reported to F&P, Board and People and Culture committee now evidences improvement in performance	Achieved
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: 30/09/2017 for licence and	Aim 1: Completed: Rated as segment 2. Full compliance with licence conditions as of 24/05/2017	Low

	AIM 1: Trust released from NHSI licence conditions and rated as segment 1 or 2. [ACTION OWNER: DCA&TS] AIM 2: Clean VFM opinion for 17/18 accounts [ACTION OWNER: DCA&TS]	segment - complete Aim 2: 31/03/2018 for updated audit opinion	Audit Opinion updates cannot be delivered until 17/18 audit	
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: 21114

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating EXTREME	Likelihood 5	Impact 5	Rating EXTREME	Likelihood 4	Impact 5	Direction ⟷	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 'must do's'	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 them and gain feedback	Reporting to NHSI Updates to CMDG/CMB

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	Engagement with staff though managers, staff side, focus groups etc.	

Gaps in control:	Actions to close gaps in control:	Action/ review due:	Progress on action:	Risk to delivery:
No clear links to external transformation	Be proactive in STP programme [ACTION OWNER DSD]	30/09/2017	CEO leading mental health pathway transformation. 1 of 5 clinical pathways	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]	30/09/2017	Regular updates with Trust Management Team (TMT) linked to internal CIP. Managers and clinicians being identified for external STP programme	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]	30/09/2017	Performance management framework being set up for TMT via Chief Operating Officer. CMDG and CMB continue to monitor contractual activity.	High
Gaps in assurances:	**Actions to close gaps in assurances:**	**Action/ review due:**	**Progress on action:**	**Risk to delivery.**
Evidence of real change	Implementation of PDSA cycles and rapid improvement [ACTION OWNER DSD]	30/09/2017	Several examples of rapid improvement events over Q1 17/18 lined to neighbourhood and inpatient areas i.e. 90 Day Project	Medium
Feedback from project groups	Clear project management structures [ACTION OWNER DSD]	Ongoing. Review by 30/09/2017	Regular reports to TMT in place. Escalated to ELT where necessary	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: 21115

Inherent risk rating:			**Current risk rating:**				Target risk rating:			Risk appetite:		
Rating	Likelihood	Impact	Rating	Likelihood	Impact	Direction	Rating	Likelihood	Impact	Accepted	Tolerated	Not accepted
HIGH	4	5	V LOW	1	1	↓	MODERATE	4	3			

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 early risk identification. Datix system giving early	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 reporting to Board	External due diligence process (planned) PRM feedback letters CQC revisit reports for Older adult services and low secure services

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.	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/ review due:	Progress on action:	Risk to delivery:
Clear communication and engagement plan	Joint communication plan being developed [ACTION OWNER: DCA&TS]	Action closed	On 6 June 2017, the Trust Board of Directors reached a decision to no longer proceed with the proposed merger of the Trust with DCHS. DCHS and NHSI have been informed of the decision. Details of the rationale behind the decision have been shared at the public session of the Board on 28 June 2017	Not applicable
Clear communication and engagement plan	Chair and Chief Executive led Q&A sessions[ACTION OWNER:CEO]	Action closed		Not applicable
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]	Action closed		Not applicable
	Review priorities of Directors and senior leaders to meet current and anticipated demands (Action Owner :CEO)	Action closed		Not applicable
Detailed analysis of capacity required to run programme	Engage with specialist advisors regarding capacity requirements [ACTION OWNER:CEO]	Action closed		Not applicable

Supervision compliance is not consistent	Increase delivery and capacity for supervision in clinical and operational teams [Action Owner :DPOE]	Action closed		Not applicable
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]	Action to be monitored through BAF risks 3b	Consultation has commenced on the restructure and joining together of the HR Teams within DCHC and DHCFT. This is scheduled to be implemented by September 2017. The effect will be to increase the resilience of the HR Team in DHCFT by broadening the number of staff available	See BAF risk 3b
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]	Completed	Non-disclosure agreements agreed and in place	Achieved
Gaps in assurances:	Actions to close gaps in assurances:	Action/ review due:	Progress on action:	Risk to delivery.
Staff survey reported February 2017	Delivery of all components of staff survey action plan (Owner :DPOE)	Action to be monitored through BAF risks 3a		See BAF risks 3a
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

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

Derbyshire Healthcare NHS Foundation Trust
Report Board of Directors 27 July 2017

Workforce Race Equality Standard 2017 (WRES)

Purpose of Report

The purpose of this paper to update the Board on our annual Workforce Race Equality Standard submission, including Board statement for consideration and sign off. It sets out our current performance against those indicators and how they will be used to track progress and steps we are taking to close the gaps. WRES action plan 2017 will be reviewed in partnership with the BME Staff Support network, who is very interested in supporting progress relevant to the standard.

Executive Summary

1. Context

The WRES is a mandatory requirement and supports the delivery of our corporate priorities set out in our People Plan and Board Equality Action Plan to be a best in class/employer of choice, by building an inclusive culture, where everyone's contribution is valued, a representative diverse workforce and meeting our compliance obligations.

Board Equality Action Plan top priority 2: Board developing engaging and inclusive leadership. Corporate Equality Objective 4: better understand the profile and experiences of our employees and achieve a diverse workforce.

The WRES and EDS2 are complementary but distinct. Therefore, there should not be any unnecessary duplication in the collection of data for the two initiatives. The data and analyses for the WRES indicators will assist organisations when implementing EDS2, in particular, with the outcomes under EDS2 Goals 3 and 4, as shown below:

- EDS2 Goal 3: Empowered, engaged and well supported staff and Workforce Race Equality Standard *(Is the Trust a good and fair employer for all REGARDS groups)*

- EDS2 Goal 4: Inclusive leadership *(leaders, showing strong and sustained commitment to promoting equality within and beyond organisation. Engaging and responding to the needs of the diverse REGARDS groups).*

- EDS2 Outcome 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination. Evidence for this will be drawn from new engagement group, work streams, workforce data, surveys, Workforce Race Equality Standard analysis and BME Staff Support Network.

2. **Workforce Race Equality Standard 2017 : Board statement of commitment** (draft for consideration and approval)

Working with 'due REGARDS' and respect so that everyone can be the best they can be

As we publish our Workforce Race Equality Standard (WRES) data, it is a reminder to us at DHCFT of the inequities that can still persist for many of those working in or receiving services. The Trust wholeheartedly supports the WRES as a caring, inclusive and progressive organisation that promotes equality, values and celebrates diversity. This means that we work to ensure that all our staff provides inclusive services that are equally good to all service users, which meet their needs and are delivered with kindness, dignity and respect.

We want to ensure that all our staff are engaged, valued and treated equally with kindness, dignity and respect. We are committed to continually striving to ensure every person who works, or seeks to work, for the Trust feels valued and has equality of opportunity to reach their full potential. The WRES helps us to ensure staff from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. We recognise that this can act as 'barometer of our culture' and ultimately benefits everyone, because creating a welcoming, respectful and inclusive workplace, will have a positive impact on the treatment and experience of all REGARDS people and our wider workforce community.

The NHS Workforce Race Equality Standard (WRES) includes 9 indicators and requires NHS organisations to close the gap between BME and white staff experience of those indicators. So for example research suggests the likelihood of BME staff being appointed from a shortlisting is significantly less than that of White staff (Kline, R, 2013, 'Discrimination by Appointment'), with white staff being 1.74 times more likely to be appointed from a shortlist that BME staff. It has also been demonstrated that BME staff are twice as likely to enter disciplinary processes and more likely to be disciplined for similar offences. (Archibong et al, 2010).

In the long-term, the WRES should create a shift in processes and cultures within organisations. This would be visible improvement in the BME workforce data and representation at senior and leadership levels across the NHS. This would also include greater staff and service user satisfaction, greater efficiency and productivity across the NHS as a result.

3. **Current Performance: key findings** WRES 2017 template is attached at Appendix 1.

Indicator 1 – percentage of staff in each of AfC bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. The data indicates an increase for both white and BME staff groups. Clinical staff increase – white 0.71 percentage points and BME 2.39 percentage points. Non-clinical staff shows a slight increase with white 0.71 percentage point and BME 0.01 percentage point.

Additional data analysis can be found at table 1: Ethnicity and Banding. The Trust reports annual Workforce diversity data on banding by ethnicity as part of Public Sector duties under the Equality Act 2010. Please refer to Appendix 2 -3 for details regarding workforce diversity and representation.

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

Consultant	89% BME 34 from 38 staff
Executive	25% BME (1 from 4 staff)
Band 9	0%
Band 8D	0% BME (0 from 5 staff)
Band 8C	0% BME (0 from 20 staff)
Band 8B	4.34% BME (1 from 23 staff)
Band 8A	7.84% BME (8 from 102 staff)
Band 7	9.17% BME (20 staff from 218)
Band 6	10.45% BME (55 from 526 staff)
Band 5	14.64% BME (47 from 321 staff)
Band 4	5.78% BME (10 from 173 staff)
Band 3	15.17 % BME (49 from 323 staff)
Band 2	18.66% BME (28 from 150 staff)
Band 1	30.76% BME (12 from 39 staff)

- WRES Indicator 2: White shortlisted job applicants are 1.47 times more likely to be appointed from shortlisting than BME shortlisted applicants, who remain noticeably absent from senior grades within Agenda for Change (AfC) pay bands. However, data indicated a decrease from last year by 0.16% points. As part of our Workforce Plan we need to understand what may be happening for each band boundary, talent pool and succession planning.

- WRES Indicator 3: BME staff 1.60 times more likely to be disciplined than white staff members. This has increased from last year 0.43. This requires further exploration.

- Indicator 4: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff 0.97. This is a 0.12 difference compared to last year 0.85. A figure below '1' would indicate that white staff members are less likely to access non-mandatory training and CPD than BME. Further work needs to be done to explore and understand this data, including career development and progression opportunities such as funding/sponsorship, acting up, projects and secondments between different groups.

- WRES Indicator 5: KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months appears to have decreased by 5.42% white staff and 8.49% for BME staff.

White 27% (32.42% 2016) and BME 29% (40.91% 2016). Further exploration is required to understand this difference and triangulated with internal Datix system reporting.

- WRES Indicator 6: KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months has increased by 2.2 % points for BME staff 21% (18.8% 2016) compared to white staff decrease by 0.53 percentage points at 22% (22.53% 2016).

- WRES Indicator 7: KF 21. The percentage of staff believing the trust provides equal opportunities for career progression or promotion has fallen for both white and BME staff groups compared to last year. The white group 8.57 % points show a greater difference compared to BME staff 7 % points. White staff 75% (83.57% 2016) compared to BME 73% (80.0% 2016).

- Indicator 8: Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues. This has decreased across both groups - White 6% (6.85 % 2016) and BME 10% (13.64% 2016). The difference is white by 0.5 percentage points and greater drop BME 3.41 percentage points.

- WRES Indicator 9 - compare the difference for white and BME staff: Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce. This data indicates the percentage of BME Voting Board Members is 8.3% compared with the Trust 12.3% (this includes NEDS voting members of the Board). This is a difference of 4 percentage points.

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4. WRES Action Plan: the steps we are taking to address the variations.

A SMART action plan will be refined to address the disproportion in partnership with BME Staff Support Network, to help us understand the root causes, as opposed to making assumptions and addressing the symptoms.

It is important to note that this current data is fairly high level and requires greater analysis (strategic and at service lines/team level) to understand experiences, where the key issues, potential barriers and solutions lie. For example, to understand the data regarding senior managers it will be important to consider the 'pipeline' below the most senior levels in bands 5-7 at service and team level. In looking at the data for appointments from shortlists is also important to understand the potential bias in the system and to benchmark our performance with other similar organisations.

a) Aim to build BME talent pipeline, leadership capacity and capability in the Trust. Positive action programmes to support BME staff to progress within the organisation, including increasing representation at the Board.

b) To establish a Workforce Positive Action Task Group subgroup of Equality Forum who will develop a detailed action plan to address potential under-representation. The group will also proactively look at how to establish a

growing BME talent pipeline to widen the talent pool for senior posts. The task group will engage with the Trust's BME Staff Network to explore these issues, ensure BME voice and establish their views more widely in the Trust.

c) Neighbourhood & Service inclusion profile and equality impact performance management – drilling down and further disaggregation of our key service lines, departments and professions is a core part of this work to demonstrate continuous improvement in closing the differences. This will require inclusive leadership by Senior/General Managers to understand the profile, talent pipeline and lived experience (triangulate staff employment cycle-representations, staff survey data, recruitment, appointment, career development and progression opportunities and Datix incidents) of their respective areas/teams. Board to seek assurance of that workforce reflects the local neighbourhood population, fair employment and that we are leveraging the talents/assets and community knowledge of our workforce.

d) Alignment to annual Equality Delivery System self-assessment, triangulation of evidence and subsequent grading by staff, BME Staff Support Network, Trust engagement group and reverse mentoring pilot evaluation by Nottingham University.

e) Inclusive leadership workshop and toolkits - REGARDS, cultural competence and unconscious bias training to be delivered to managers to compliment suite of people management courses to encourage a conscious mindfulness approach to decision making and behaviours so that we can build and sustain an inclusive organisational culture. By understanding we all have bias, the impact of unconscious bias and overcoming it at critical moments, individuals can make better decisions – from finding the best talent (no matter what the background) to acknowledging a great idea (no matter who it came from) and build a workforce and workplace that supports and encourages diverse views and contributions.

f) Employee relations – review data to understand systemic and individual issues and themes and set mitigating actions to work with Workforce team to explore in detail why BME staff are more statistically likely to be involved in disciplinary. Monitor via Equalities Forum and Staff Engagement Group 'The voice' and report at People and Culture Committee.

g) Leadership development programmes- review BME attendance at the Trust internal and external leadership development programmes, including mentoring, coaching and impact of courses on career progression and development.

h) BME Staff Support Network and action plan – continue to support, resourcing and self-management of BME staff support network within the workforce of the trust and to provide opportunities for people who consider they are part of one of these groups to share, learn and contribute to improving the trust. This will particularly seek to capture the perspectives from underrepresented groups with the workforce of the trust. The network facilitates an annual conference, has developed a vison and action plan that dovetails with the

WRES action plan. Executives have engaged and involved BME staff network in number of initiatives. BME Staff Network Chair invited to be a member of the People and Culture Committee. The BME Staff Support network and Reverse Mentoring pilot is championed by Ifti Majid Trust, Acting Chief Executive.

i) Driving culture change - Reverse Mentoring for Equality, Diversity and Inclusion (ReMeDI Pilot in (action research) in partnership with University Of Nottingham and BME Staff Support Network- we are committed to sharing good practice and pioneering interventions to kick start culture change. The Board has signed up to this to raise the confidence and profile of BME staff in the Trust and consider the contribution this might make to increase the diversity of the leadership. This intervention will enable senior leaders (initially Executives as mentees) to gain insight into the lived experience of BME staff and support development of cultural competence, inclusive culture and environment. Moreover, support the delivery of People Plan and DHCFT Workforce Race Equality Standard action plan to address variations across the 9 indicators, in terms of growing BME leadership pool through existing and new development and talent management approaches. As a learning organisation we are keen to support this research and generate new evidence based practice.

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

Assurances

- The Equality Forum together with Quality Assurance and People and Culture (PCC) Committees will ensure the Trust meets its statutory duties under the Human Rights Act (1998). Equality Act (2010) and Public Sector Equality Duty. This includes the Annual Diversity workforce demographic report, WRES action plan, FFT and staff survey.
- Public Sector Equalities Duty & EDS2 17/18 implementation and work plan (approved by Board 28th June 2017)
- Board Equality Action Plan top priority 2: Board developing engaging and inclusive leadership (approved 28th June 2017)
- Equality Objective 4: better understand the profile and experiences of our employees and achieve a diverse workforce.
- Board Assurance Framework risk 3d is regularly presented to Equality Forum

and PPC to discuss control. Controls to ensure data completion (85% target)
- CCGs and Standard Contract - Quality Assurance Schedule 2017/18 reporting e.g. EDS2, WRES, publishing equality information on website.
- Tackling potential inequalities in our services and employment and thus helping to deliver our corporate vision and strategy by building an inclusive culture, productive diverse workforce, recruitment and retention of staff.
- Informs better decision making based on evidence based working.
- Information is being collected and acted on to ensure learning informs changes in practice.
- More effective targeting of policy and resources.
- More effective use of talent and networks in the workforce. #

Consultation

The Trust will continue to engage with stakeholders through existing mechanisms, including the staff engagement group 'The Voice', with BME Staff network, staff-side and other communities of interest in implementing the WRES and action plan to close the gaps across the indicators.

The BME Staff Network in particular, is fully involved in the organisation's work on implementing the WRES. Staff who are supported by their leaders will make the WRES work in the best way. The Trust has re-established BME staff support network as an important source of knowledge, support and experience. This has included an annual conference (17th March 2017) and action plan to deliver the network mission.
BME staff network mission: to achieve open and fair access to opportunities, development and progression to ensure equality in career outcomes.
Objectives: Representation, having a voice and visibility (to be heard, seen and listened to). BME staff and wider staff reporting positive working experience and environment. Ensure BME people no longer feel bullied. Diverse, skilled, talented and experienced workforce providing quality service based on individual need. To have a happy and healthy workforce and community. Equality and fairness - recognition by Trust and accessibility.

Ifti Majid, Acting Chief Executive and Amanda Rawlings, Director People and Organisational Effectiveness and other Executive Board members have met with BME Staff Support Network to hear at first hand, their experiences of the workplace. In implementing the WRES, the Trust will continue to engage and involve BME staff support network in identifying the challenges in making continuous improvements against the WRES indicators. Involve engagement and evaluation with University of Nottingham as part of Reverse Mentoring.

Governance or Legal Issues
WRES is considered as part of the "well led" domain in the Care Quality Commission (CQC) inspection for both NHS, independent and voluntary providers.

All providers subject to the NHS standard contract except primary care are expected to implement the WRES. Schedule 6 Requirements 2017 / 2018 – WRES

compliance.

Showing “due regard” in using the WRES in helping to improve workplace experiences and representation at all levels for their own BME staff. Equality Act 2010 - the legal duty to comply with the Public Sector Equality Duty (PSED) The Equality Act provides legal protections for 9 characteristics: age; gender; ethnicity; disability; religion; sexual orientation; gender-reassignment; marriage & civil partnership, and pregnancy & maternity. These are referred to as protected characteristics or protected groups. Under the Equality Act, public sector bodies have a duty to publish evidence on how they have: eliminated discrimination against protected groups, advanced equal opportunities for protected groups, and fostered good relations between those in protected groups and those outside of them. There is also a duty to set equality objectives every 4 years.

Public Sector Equality Duty/Equality Impact Risk Analysis
The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people)

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

Actions to Mitigate/Minimise Identified Risks

WRES indicators and variations between White and BME staff are outlined in the key findings section of the report and at Appendix 1. The step change required in implementing the WRES is in requiring organisations to collect data, but to analyse and act on it. This is completely consistent with the approach taken in the Equality Act 2010 and the Public Sector Duty 2011.

There has been significant research in recent years including West, M (2011) and Dawson, J (2009) linking the experience of staff and the care provided to patients and cost to both employers and patient of not treating staff well. Professor West developed these themes further with regards to the experience of the Black, Minority and Ethnic (BME) workforce and the care of patients. More recent research, Kline, R (2014) has demonstrated that the treatment and experience of BME staff within the NHS is significantly worse, on average than white staff. In the Snowy White Peaks in the NHs (2014), Kline demonstrated that BME staff were absent from the leadership of many NHS organisation including areas such as London, where organisations provided services to large BME populations.

The WRES action plan and BME Staff Network action plan will focus on addressing workforce and employment journey differences between white and BME staff, including understating barriers, intervention/opportunities to encourage progression and minimising potential bias in recruitment and glass ceiling highlighted through this analysis. This will include the Reverse Mentoring Pilot intervention, which will help to us to understand the reported variations in BME staff lived experience in the work place and promote good relations between different groups of people. This will

inform the People Plan and Board Equality Action Plan priorities.
http://www.nhsstaffsurveyresults.com/workforce-race-equality-standard-wres/

Recommendations
The Committee is requested to:

1) Approve that WRES 17/18 submission/reporting template and findings, including board statement prior to submission to NHS England National WRES team 1st August, 2017 and sharing with Hardwick CCG and external website (in line with WRES technical guidance). Appendix 1

2) Note link to Board Equality Action Plan priority 2: Board developing engaging and inclusive leadership -key performance indicators to drive culture change, address under-representation, potential barriers and continuous improvement in equality performance and benchmarking.

3) Equality Impact: neighbourhood/service inclusion profiles and equality performance: Board to seek assurance that workforce reflects the local neighbourhood population, fair employment and that we are leveraging the talents/assets and community knowledge of our workforce.

4) Note that a WRES 2017 action plan to demonstrate our intention in closing the differences between the treatment and experience of white and BME staff will be refined in partnership with BME Staff Network. This will be tabled at Equalities Forum and key committees as part of reporting schedule, including Board update on the 27th September 2017.

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

Report prepared by: **Harinder Dhaliwal**
Assistant Director for Engagement & Inclusion

Appendix 1: DHCFT WRES 2017 Reporting Template
Appendix 2: Workforce ethnicity report – bands and recruitment 2017
Appendix 3: Workforce ethnicity representation and population comparison March 2017

Workforce Race Equality Standard

REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation

Derbyshire Healthcare NHS Foundation Trust

Date of report: month/year

July 2017

Name and title of Board lead for the Workforce Race Equality Standard

Ifti Majid, Acting Chief Executive

Name and contact details of lead manager compiling this report

Harinder Dhaliwal, Assistant Director Engagement & Inclusion - Harinder.dhaliwal@derbyshcft.nhs.uk

Names of commissioners this report has been sent to (complete as applicable)

Hardwick CCG

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

David Gardner, Assistant Director of Procurement & Commissioning - David.Gardner@hardwickccg.nhs.uk

Unique URL link on which this Report and associated Action Plan will be found

http://www.derbyshirehealthcareft.nhs.uk/standards/equality-diversity/

This report has been signed off by on behalf of the Board on (insert name and date)

Ifti Majid, Acting Chief Executive - 27/7/2017

Publications Gateway Reference Number: 05067

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data

Responses for indicators 5-8 are based on the 2016 staff Survey results.

b. Any matters relating to reliability of comparisons with previous years

Improved data quality in ESR means that 2016 data onwards is the most accurate and better reflects the workforce.

2. Total numbers of staff

a. Employed within this organisation at the date of the report

2389

b. Proportion of BME staff employed within this organisation at the date of the report

294

Report on the WRES indicators, continued

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

94.89%

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

ESR Self Service was launched in October 2014 and continues to give staff the ability to view their own ethnicity and update their own protected characteristics.

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

ESR Self Service will be promoted to staff during the year.

4. Workforce data

a. What period does the organisation's workforce data refer to?

31 March 2016 and 31 March 2017

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Clinical staff: White 59.06% & BME 9.54% Non-Clinical staff: White 23.52% & BME 2.76% 5.11% not stated.	Clinical staff: White 55.78% / BME 7.15%. Non Clinical staff: White 22.81% / BME 2.75%. Medical staff/not stated: 11.51%	The data indicates an increase for both White and BME staff groups. Cinical staff increase : White 3.29% and BME 2.39 % Non-Clinical slight increase White 0.71% and BME 0.01%	the Trust has estabilised Recruitment & Retention Group who will develop a detailed action plan to address potential under-representation. The group will also proactively look at how to establish a growing BME talent pipeline to widen the talent pool for senior posts. The task group will engage with the Trust's BME Staff Network to explore these issues, ensure BME voice and establish
2	Relative likelihood of staff being appointed from shortlisting across all posts.	Relative likelihood of white staff being appointed from shortlisting compared to BME staff 1.47 greater	Relative likelihood of white staff being appointed from shortlisting compared to BME staff 1.63 greater	The data indicates an decrease in the likelihood of White candidates being appointed of compared to BME.	As Indicator 1. Workforce Positive Action Task group to work with BME Staff Support Network to explore potential barriers and bias across the employment pathway e.g. interviews and values assessment. • To analyse where the increase in appointments is taking place and why? • Wider options include introducing good practice
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.	Relative likelihood of BME staff entering formal disciplinary process compared to White staff 1.60	Relative likelihood of BME staff entering formal disciplinary process compared to White staff 1.17	The data indicates an increase 0.43 in the likelihood of BME colleagues entering a formal disciplinary process compared to White staff.	To work with the BME Staff Network to understand the lived experiences of BME people in the workforce. Reverse Mentoring for equality, diversity and inclusion (Executives mentored by BME staff) to facilaite understanding of the lived expeirence, potenital bias and barriers faced by BME staff Analysis to be undertaken to understand why and
4	Relative likelihood of staff accessing non-mandatory training and CPD.	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff 0.97	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff 0.85	The data indicates a fall in the likelihood of White colleagues accessing non-mandatory training and CPD compared to BME.	As indicator 1

Report on the WRES indicators, continued

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White 26.93% BME 29.21%	White 32.42% BME 40.91%		• Staff survey action plan lead by Organisational Development and Workforce team, to engage with BME Staff Support Network to understand perceptions and barriers • Further analysis of data to identify any patterns
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White 22.21% BME 21.35%	White 22.53% BME 18.18%		As indicator 5.
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White 75.43% BME 73.21%	White 83.57% BME 80.00%		As indicator 5.
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White 6.35% BME 10.23%	White 6.85% BME 13.64%		As indicator 5.
	Board representation indicator For this indicator, compare the difference for White and BME staff.				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	4%	3.8%	The Trust has 12.3% overall workforce by BME and BME Voting 8.3% Board Members - percentage difference is 4% Trust overall BME worfkorce 12.3% and Total Board BME Members 7.7% - percentage	Further exploration of the Trust's data across staff working in the city and county, to provide greater insight into proportionality • Executive lead for WRES (to be agreed at ELT) • Board Self-assessment and looking ahead to

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

Report on the WRES indicators, continued

6. Are there any other factors or data which should be taken into consideration in assessing progress?

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

http://www.derbyshirehealthcareft.nhs.uk/standards/equality-diversity/

Click to lock all form fields and prevent future editing

Produced by NHS England, April 2016

Appendix 2 Workforce Ethnicity

Table 1: Ethnicity and banding

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

Table 2:

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

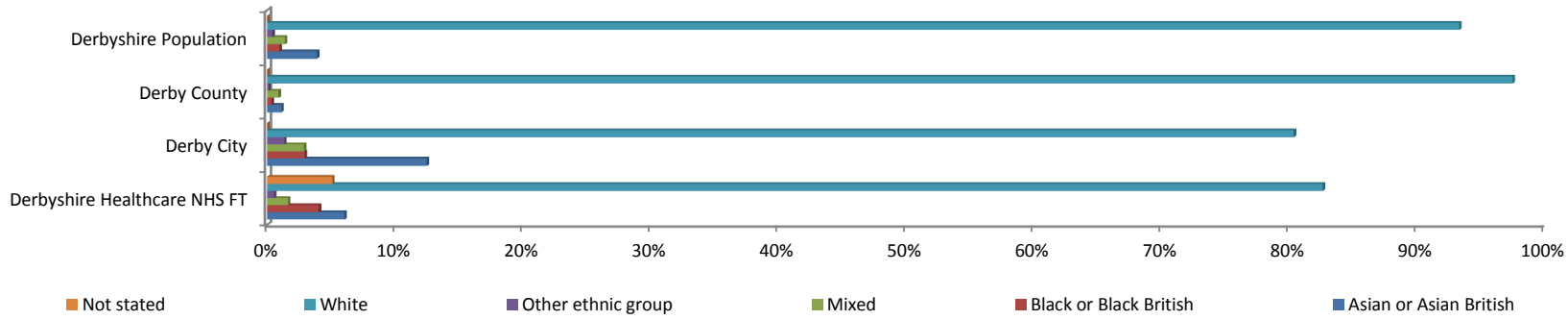
Derbyshire Healthcare NHS FT Workforce Demographics (as at 31/03/17)

Workforce demographic data is first captured during the recruitment process when an employee applies for a post through NHS Jobs. This data transfers to ESR (Electronic Staff Record) when an employee becomes successful in being appointment to a post within the Trust. Data from NHS Jobs and ESR is used to create Workforce Profiles on REGARDS data which is published annually in the Annual Report & Accounts and uploaded onto both the Trust's intranet and internet page.

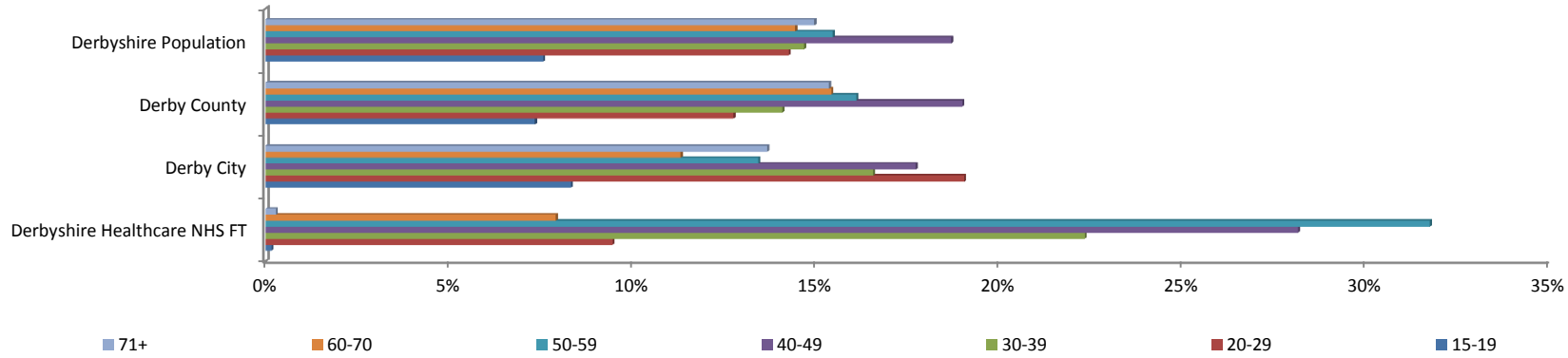
Data validation exercises have been carried out previously to give employees the opportunity to check and update their REGARDS data and more recently ESR Employee Self Service has been rolled out which enables employees to check and update their own REGARDS data electronically at any time. It is hoped that this new functionality will reduce the number of 'not stated' entries that we currently have recorded, particularly in the Sexual Orientation and Religious Belief category's, which will improve our data quality.

The following data tables and graphs compare the Workforce profile of Derbyshire Healthcare NHS FT against the population of Derbyshire (population source: Office of National Statistics). In the 2011 Census the Derbyshire County population was 1,018,400 which consisted of 769,700 living within Derbyshire and 248,700 within Derby City.

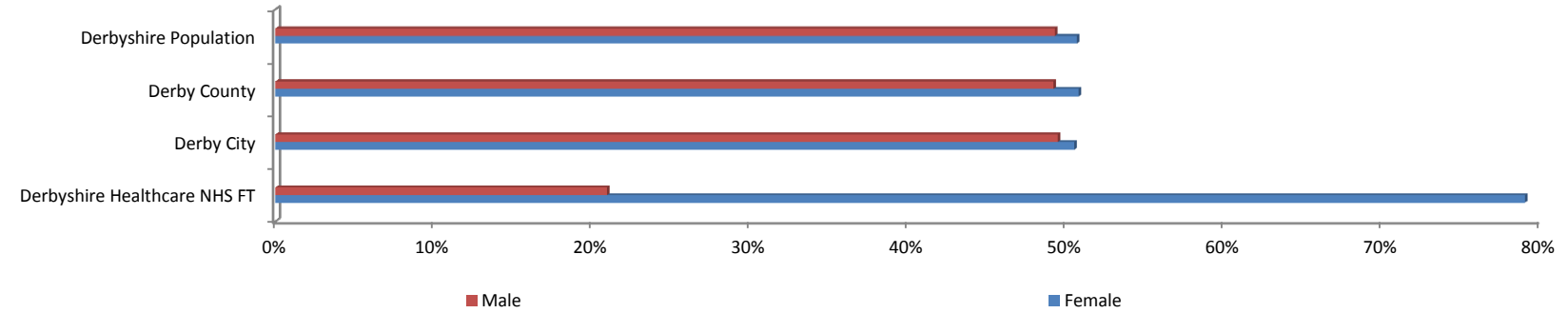
Ethnicity	Derbyshire Healthcare NHS FT	Derby City	Derby County	Derbyshire Population	Variance (Derbyshire Healthcare vs Derbyshire)
Asian or Asian British	6.07%	12.50%	1.14%	3.92%	2.15%
Black or Black British	4.06%	2.94%	0.36%	0.99%	3.07%
Mixed	1.63%	2.91%	0.92%	1.41%	0.22%
Other ethnic group	0.54%	1.35%	0.12%	0.42%	0.12%
White	82.59%	80.30%	97.45%	93.26%	-10.67%
Not stated	5.11%	0.00%	0.00%	0.00%	5.11%



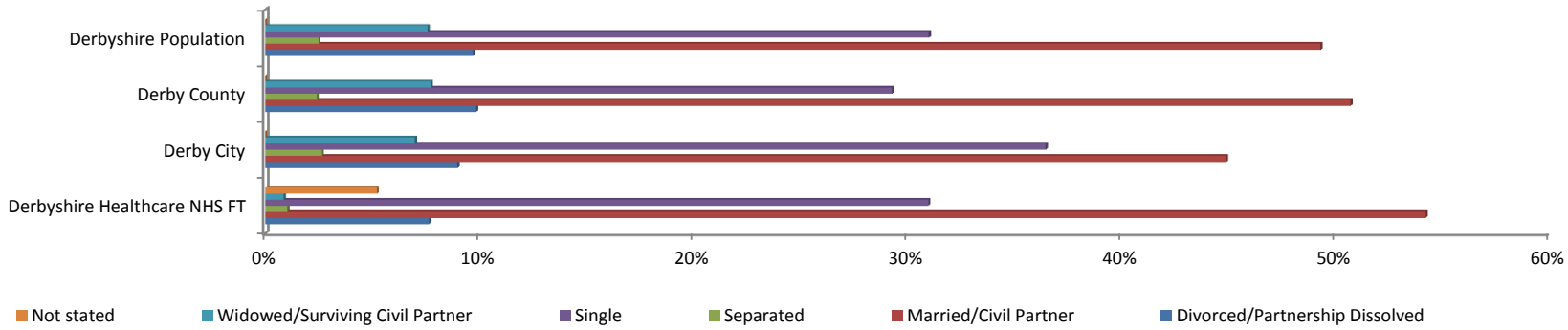
Age Group	Derbyshire Healthcare NHS FT	Derby City	Derby County	Derbyshire Population	Variance (Derbyshire Healthcare vs Derbyshire)
15-19	0.17%	8.32%	7.34%	7.57%	-7.40%
20-29	9.46%	19.03%	12.75%	14.25%	-4.79%
30-39	22.31%	16.55%	14.08%	14.67%	7.64%
40-49	28.13%	17.71%	18.98%	18.68%	9.45%
50-59	31.73%	13.42%	16.09%	15.45%	16.28%
60-70	7.91%	11.31%	15.41%	14.43%	-6.52%
71+	0.29%	13.67%	15.35%	14.95%	-14.66%



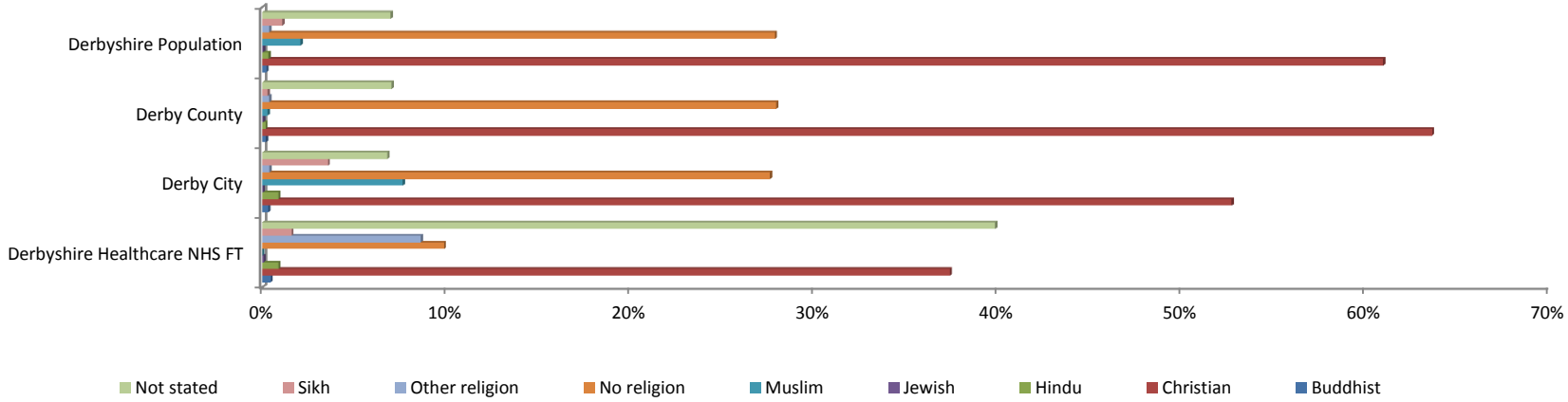
Gender	Derbyshire Healthcare NHS FT	Derby City	Derby County	Derbyshire Population	Variance (Derbyshire Healthcare vs Derbyshire)
Female	79.03%	50.53%	50.79%	50.70%	28.33%
Male	20.97%	49.47%	49.21%	49.30%	-28.33%



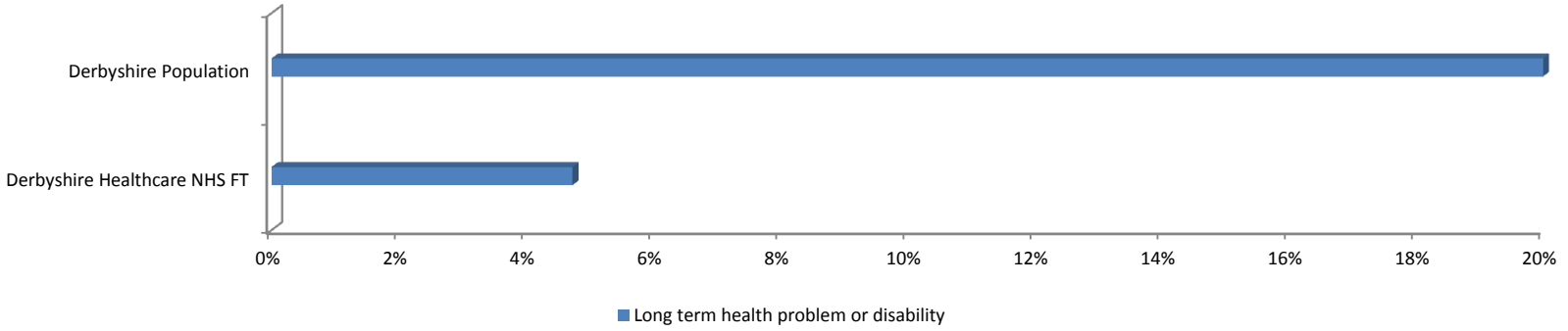
Marital Status (16 year olds +)	Derbyshire Healthcare NHS FT	Derby City	Derby County	Derbyshire Population	Variance (Derbyshire Healthcare vs Derbyshire)
Divorced/Partnership Dissolved	7.66%	8.99%	9.86%	9.70%	-2.04%
Married/Civil Partner	54.21%	44.89%	50.70%	49.30%	4.91%
Separated	1.05%	2.66%	2.42%	2.50%	-1.45%
Single	30.98%	36.46%	29.28%	31.00%	-0.02%
Widowed/Surviving Civil Partner	0.88%	7.00%	7.75%	7.60%	-6.72%
Not stated	5.23%	0.00%	0.00%	0.00%	5.23%



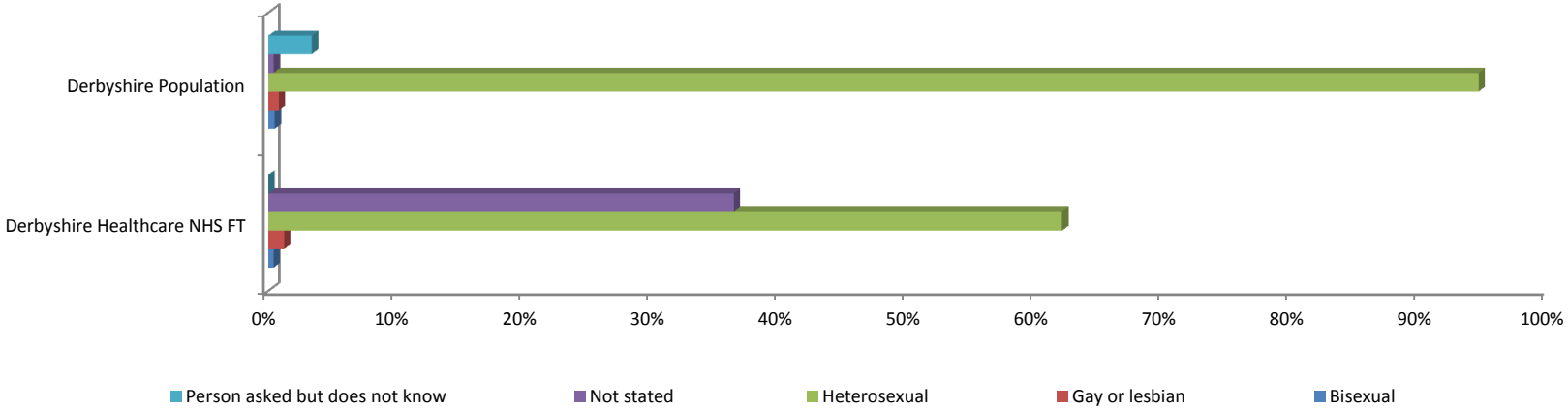
Religious Belief	Derbyshire Healthcare NHS FT	Derby City	Derby County	Derbyshire Population	Variance (Derbyshire Healthcare vs Derbyshire)
Buddhist	0.46%	0.33%	0.20%	0.23%	0.23%
Christian	37.38%	52.71%	63.62%	60.96%	-23.58%
Hindu	0.88%	0.88%	0.18%	0.35%	0.53%
Jewish	0.08%	0.04%	0.05%	0.05%	0.03%
Muslim	0.00%	7.64%	0.29%	2.08%	-2.08%
No religion	9.88%	27.61%	27.95%	27.87%	-17.99%
Other religion	8.62%	0.40%	0.38%	0.38%	8.24%
Sikh	1.59%	3.57%	0.30%	1.10%	0.49%
Not stated	39.85%	6.81%	7.04%	6.98%	32.87%



Disability	Derbyshire Healthcare NHS FT	Derbyshire Population	Variance
Long term health problem or disability	4.73%	19.98%	-15.25%



Sexual Orientation	Derbyshire Healthcare NHS FT	Derbyshire Population	Variance
Bisexual	0.38%	0.50%	-0.12%
Gay or lesbian	1.21%	0.80%	0.41%
Heterosexual	62.02%	94.60%	-32.58%
Not stated	36.38%	0.40%	35.98%
Person asked but does not know	0.00%	3.40%	-3.40%



Further detailed data tables and graphs of the Workforce Profile of Derbyshire Healthcare NHS FT are available in appendices and cover the following areas:

Recruitment profile by Applications, Shortlistings and Appointments
Workforce profile by Pay Band
Leavers analysis
Workforce Profile (Annual Report)

Data source:
Derbyshire Healthcare NHS FT: ESR (NHS Electronic Staff Record) as at 31st March 2017
Derbyshire Population: ONS (Office of National Statistics) 2011 Census

Summary of Board Assurance Framework Risks 2017/18 Issue 2.2

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)
Strategic Outcome 1. We will deliver quality in everything we do providing safe, effective and person centred care			
1a	Failure to achieve clinical quality safety standards required by our regulators	Executive Director of Nursing and Patient Experience	HIGH (4x4)
1b	Failure to achieve clinical quality standards required by our regulators in relation to providing effective care for our patients	Executive Director of Nursing and Patient Experience	HIGH (4x4)
1c	Failure to fully comply with the statutory requirements of the Mental Health Act (MHA) Code of Practice and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)
1d	Risk of inadequate systems to ensure business continuity is maintained in the event of a major incident	Acting Chief Operating Officer	MODERATE (4x3)
Strategic Outcome 2: We will develop strong, effective, credible and sustainable partnerships with key stakeholders to deliver care in the right place at the right time			
2a	Inability to deliver system wide change due to changing commissioner landscape and financial constraints within the health and social care system	Interim Director of Strategic Development	EXTREME (4x5)
2b*	Insufficient engagement with staff side and governors in relation to proposed merger with DCHS	Acting Chief Executive	V LOW (1x1) RISK ACCEPTED
Strategic Outcome 3. We will develop our people to allow them to be innovative, empowered, engage and motivated. We will retain and attract the best staff			
3a	Ability to attract and retain high quality clinical staff across all professions	Interim Director of People and Organisational Effectiveness	EXTREME (4x5)
3b	There is a risk to staff engagement and wellbeing by the trust not having supportive and engaging leaders	Interim Director of People and Organisational Effectiveness	HIGH (4x4)
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 (2x4) RISK ACCEPTED
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 (4x2)
3e	Potential turnover of board members	Director of Corporate Affairs and Board Secretary	HIGH (3x4)
Strategic Outcome 4. We will transform services to achieve long-term financial sustainability			
4a	Failure to deliver financial plans	Executive 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	V LOW (1x1) RISK ACCEPTED

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Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 27 July 2017

Report from the Council of Governors 18 July 2017

The Council of Governors has met once since reporting to the June Public Board. The Council of Governors met on Tuesday 18 July in the Conference Room, Research & Development Centre, Kingsway. The meeting was chaired by Caroline Maley, Acting Trust Chair. Twelve governors attended.

Chief Executive Report

The report updated governors on changes within the national health and social care sector as well as providing local updates within the health and social care community. The report supports the Council in its duty of holding the Board to account by way of informing members on internal and external developments.

Following improvements made around CQC compliance confirmation that all breach requirements have been met, the Trust had received formal notification from NHS England, as part of the routine quarterly Nottinghamshire and Derbyshire Quality Surveillance Group (QSG), that the Trust's rating in respect of partners' shared view of risks to quality across NHS commissioned services had returned to green - the highest possible rating that can be achieved.

Governors noted the update on the Derbyshire Sustainability and Transformation Partnership. As the lead for the Mental Health Workstream, the Acting Chief Executive will be focussing on the following domains:

- Mental Health Primary Care Support
- Responsive Community Services
- Dementia and Delirium
- Forensic and Rehabilitation pathways

The Trust had carried out an internal review of all fire risk assessments. All buildings and inpatient facilities had been assessed by Derbyshire Fire & Rescue Service. No major issues were found.

Ifti Majid also highlighted that the Trust is extremely busy. There are high levels of activity, pressures on capacity and increasing acuity is being seen in patients receiving services.

Annual Audit Letter on the 2016/17 Annual Report & Accounts

Joan Barnett, Engagement Manager with the Trust's External Auditors, Grant Thornton presented the Annual Audit Letter. The Annual Audit Letter reflected satisfaction with the Trust's Annual Report, confirming it was consistent with the audited financial statements. Grant Thornton were satisfied that, except for the specific governance issues related to NHSI's enforcement action that was still in place as at 31 March 2017, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the period ending 31 March 2017. The Quality Report received an unqualified limited assurance opinion. Joan Barnett commended the Trust for its

positive report and outcomes in what had been a busy year in responding to the CQC and delivering the Governance Improvement Action Plan.

Governors' Nominations & Remuneration Committee
The Council of Governors received and noted the summary of the exit interview and appraisal conducted with Maura Teager before her departure from the Trust in March 2017. The Committee's year-end report was received, demonstrating its effectiveness in performing to its Terms of Reference. Recommendations on amendments to the Terms of Reference of the Governors' Nominations & Remuneration Committee were approved and two new members elected; Carole Riley, Public Governor and Kelly Sims, Staff Governor.

Integrated Performance Report
Claire Wright, Deputy Chief Executive & Finance Director presented the Integrated Performance Report to provide governors with an overview of performance as at the end of May 2017 with regards to workforce, finance, operational delivery and quality performance. Board Committee Chairs reported on how the report is used to hold Executive Leads to account in each of the Board Committees.

Staff Engagement Update
Margaret Gildea, Non-Executive Director and Chair of People & Culture Committee presented the report on Progress with the Staff Survey. An overview of the 2016 staff survey and quarter one pulse check was highlighted and the approach and actions being taken to improve staff engagement across the Trust was outlined. A Staff Engagement Forum is being developed where staff representatives will be able to meet with directors and shape decisions and initiatives.

Non-Executive Director Update on Audit & Risk Committee
Barry Mellor, Non-Executive Director and Chair of Audit & Risk Committee gave an update on the work of the Audit & Risk Committee, highlighting the purpose and membership of the Committee. A summary of the work of the committee during 2016/17 and its priorities for 2017/18 was provided.

Governance Committee Report
Shelley Comery, Deputy Chair of Governance Committee, presented an update on meetings of the Governance Committee held on 17 May and 3 July 2017. Notably the Committee had reviewed its Terms of Reference, at the conclusion of its first year and presented revisions, which were approved.

Update on Governor Appointments & Resignations
An update on appointments and resignations since May 2017 was noted. Five governors have resigned. Three new governors have joined. Elections for public governors are scheduled for the autumn and an election for a Staff Governor – Nursing & Allied Professions, will take place in September.

Final Governance Improvement Action Plan
Claire Wright presented the report, as delivered to Public Trust Board on 24 May 2017, which confirmed the completion of all actions to address Governance Improvement Action Plan recommendations (GIAP). The Council of Governors

recognised the enormous achievement associated with this work across the organisation.

Confidential Session
A brief confidential session followed the public meeting where governors were briefed on an historic serious incident.

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

Report prepared by:	**Donna Cameron, Assistant Trust Secretary**
Report presented by:	**Samantha Harrison** **Director of Corporate Affairs & Trust Secretary**

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									
AR	Approval of Equality Delivery System2 (EDS2) 2017/18	Strategic Outcome 3 and 4					X					
SH	Review SOs, SFIs, SoD	FT Constitution Standing Orders					AR					
SH	Trust Sealings	FT Constitution Standing Orders	AR									
SH	Annual Review of Register of Interests	FT Constitution Annual Reporting Manual	AR									

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	Board Assurance Framework Update	Licence Condition FT4	X				X		X		X	
SH	Raising Concerns (whistleblowing)	Strategic Outcome 1 Public Interest Disclosure Act			X							
SH	Committee Assurance Summaries (following every meeting) - Audit & Risk Committee - Finance & Performance - Confidential - Mental Health Act Committee - Quality Committee - Safeguarding Committee - People & Culture Committee	Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X
SH	Governance Improvement Action Plan	Licence Condition FT4	X	X	X	X	X	X	X	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	Business Plan 2017-18 Monitoring		X			X		X			X	
LWS	Measuring the Trust Strategy			X								
OPERATIONAL PERFORMANCE												
CG, CW, AR, MP	Integrated performance and activity report to include Finance, Workforce, performance and Quality Dashboard	Licence Condition FT 4 Strategic outcome 1 Strategic Outcome 3	X	X	X	X	X	X	X	X	X	X
QUALITY GOVERNANCE												

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	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
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