Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Meeting of the Board of Directors

Conference Rooms A and B, Centre for Research and Development, Kingsway Hospital
5 February 2019 09:30 - 5 February 2019 12:15

Derbyshire Healthcare NHS Foundation Trust

NOTICE OF PUBLIC BOARD MEETING – TUESDAY 5 FEBRUARY 2019
TO COMMENCE AT 9:3am IN CONFERENCE ROOMS A&B
FIRST FLOOR, CENTRE FOR RESEARCH & DEVELOPMENT, KINGSWAY HOSPITAL

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies for absence and Declarations of Interest Register	Caroline Maley
2.	9:35	Patient Story	Carolyn Green
3.	9:55	Minutes of Board of Directors meeting held on 4 December 2018	Caroline Maley
4.		Matters arising – Actions Matrix	Caroline Maley
5.		Questions from governors or members of the public	Caroline Maley
6.	10:00	Chair's Update	Caroline Maley
7.	10:05	Chief Executive's Update	Ifti Majid
OPERATIONAL PERFORMANCE, QUALITY AND STRATEGY			
8.	10:15	Integrated Performance and Activity Report - Staffing Update	Claire Wright/Amanda Rawlings/Carolyn Green/Mark Powell
9.	10:45	Quality Report – Quality and Strategy	Gareth Harry
11:05 B R E A K			
10.	11:20	Learning from Deaths Mortality Report	John Sykes
11.	11:30	Section 37/41 briefing on Secretary of State's position on the discharge of restricted patients on conditions that involve a deprivation of liberty	John Sykes
12.	11:40	Board Assurance Framework (BAF) Fourth issue for 2018/19	Sam Harrison
13.	11:50	Board Committee Assurance Summaries and Escalations: Mental Health Act Committee 7 December, People & Culture Committee 18 December 2018, Quality Committee 9 January, Audit & Risk Committee 15 January, Finance & Performance Committee 22 January 2019 *(minutes of these meetings are available upon request)*	Committee Chairs
CLOSING MATTERS			
14.	12:10	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Board Forward Plan - Meeting effectiveness	Caroline Maley
FOR INFORMATION			
Report from Council of Governors Meeting held 9 January 2019 Glossary of NHS Acronyms			

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

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

The next meeting will be held at 9.30am on 5 March 2018 in
Conference Rooms A & B, Centre for Research and Development, Kingsway, Derby DE22 3LZ

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

Derbyshire Healthcare
NHS Foundation Trust

Our vision

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

Making a positive difference

Our values

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

Our Trust values are:

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

Derbyshire Healthcare
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DECLARATION OF INTERESTS REGISTER 2018/19		
NAME	**INTEREST DISCLOSED**	**TYPE**
Margaret Gildea Non-Executive Director	• Director, Organisation Change Solutions Limited • Non-Executive Director, Derwent Living	(a, b) (a)
Carolyn Green Director of Nursing & Patient Experience	• Husband employed by Derbyshire Probation Service	(d)
Gareth Harry Director of Director of Business Improvement & Transformation	• Chairman, Marehay Cricket Club • Member of the Labour Party	(d) (e)
Geoff Lewins Non-Executive Director	• Director, Woodhouse May Ltd • Director, Arkwright Society Ltd	(a, b) (a)
Ifti Majid Chief Executive	• Board Member NHS Confederation Mental Health Network • Kate Majid (spouse) Chief Executive of the Shaw Mind Foundation which is a global mental health charity	(e) (a, d)
Mark Powell Chief Operating Officer	• Chair of Governors, Brookfield Primary School, Mickleover, Derby	(e)
Amanda Rawlings Director of People and Organisational Effectiveness (DHCFT)	• Director of People and Organisational Effectiveness, Derbyshire Community Healthcare Services (DCHS) • Co-optee Cross Keys Homes, Peterborough	(e) (e)
Dr Julia Tabreham Deputy Trust Chair and Non-Executive Director	• Non-Executive Director, Parliamentary and Health Service Ombudsman • Director of Research and Ambassador Carers Federation • Member of Sir Alex Allan's Parliamentary and Health Service Ombudsman's Clinical Advice Service Review • Daughter Sophie Elizabeth Barker-Tabreham is a head hunter for Europrojects an organisation that recruits staff from the NHS for private sector companies and special projects	(a) (d) (a) (e)
Dr John Sykes Medical Director	• Undertakes paid assessments of patients at the request of the local authorities under the Mental Health Act and Mental Capacity Act and acts likewise for solicitors representing patients.	(e)
Richard Wright Non-Executive Director	• Executive Director, Sheffield Chamber of Commerce • Chair Sheffield UTC Multi Academy Trust • Board Member, National Centre of Sport and Exercise Medicine Sheffield	(a) (a) (d)

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

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

Derbyshire Healthcare
NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

Held in Training Rooms 1 & 2
Research and Development Centre, Kingsway, Derby DE22 3LZ

Tuesday 4 December 2018

MEETING HELD IN PUBLIC

Commenced: 9.30 Closed: 12:20

PRESENT	Caroline Maley	Trust Chair
	Margaret Gildea	Senior Independent Director
	Geoff Lewins	Non-Executive Director
	Dr Anne Wright	Non-Executive Director
	Richard Wright	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Director of Finance & Deputy Chief Executive
	Mark Powell	Chief Operating Officer
	Carolyn Green	Director of Nursing & Patient Experience
	Dr John Sykes	Medical Director
	Samantha Harrison	Director of Corporate Affairs
	Amanda Rawlings	Director of People Services & Organisational Effectiveness
	Gareth Harry	Director of Business Improvement & Transformation
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications & Involvement
	Sue Turner	Board Secretary
	Rachael Grainger	Information Management, Technology & Records Administrator
For item DCHFT2018/159	Noel O'Sullivan	Peer Support Worker
For item DCHFT2018/159	Alex Kerry	Occupational Therapist
For item DCHFT2018/167	Harinder Dhaliwal	Head of Equality, Diversity & Inclusion
For item DCHFT2018/167	Bal Singh	Reverse Mentor to Director of Finance & Deputy Chief Executive
For item DCHFT2018/167	Natasha Bain	Chair, BME Network
For item DCHFT2018/167	Tray Davidson	Practice Placement Facilitator, Reverse Mentor to CEO
For item DCHFT2018/167	Deep Sirur	Addiction Consultant
For item DCHFT2018/167	Suki Khatkar	Practice Placement Facilitator
For item DCHFT2018/167	Sharon Ramin	Vice Chair, BME Network, Reverse Mentor to DPOE
VISITORS	John Morrissey	Lead Governor
	Lynda Adim	Student Mental Health Nurse
	Roger Kerry	Appointed Governor, Voluntary Sector
	Sandra Austin	Derby City & South Derbyshire Mental Health Carer's Forum and Trust Volunteer
	Martyn Bell	Trust Member
APOLOGIES	Dr Julia Tabreham	Deputy Trust Chair and Non-Executive Director

DHCFT 2018/158	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** The Trust Chair, Caroline Maley, welcomed all to the meeting. Rachael Grainger from IMT and Records who had been invited to shadow the Chair at today's meeting was welcomed by the Board. Apologies for absence were noted from Deputy Trust Chair and Non-Executive Director, Julia Tabreham. The Declaration of Interests register, as included in the Board papers, was noted. No declarations of interest in agenda items were raised.
DHCFT 2018/159	**PATIENT STORY** Director of Nursing and Patient Experience, Carolyn Green introduced Noel O'Sullivan a Peer Support Worker (PSW) and Alex Kerry to the Board to discuss the role of PSWs who have 'lived experience' of mental health challenges and have personally accessed mental health services. Noel described how he had spent three months as an inpatient at the Radbourne Unit and how this experience had led to him becoming a PSW. He now regularly attends volunteer groups and supports service users and shares coping strategies and ideas about how to take control of their wellbeing to aid recovery. His work was recently recognised by the Trust when he won the Inclusion and Partnership award in November. Becoming a PSW has been a great aid to Noel's recovery. It has given him self-recognition and he now feels able to contribute. The Board discussed with Noel and Alex ways that the Trust could improve the care it provides to patients and how it could reach out to people who might not be aware that they are unwell. Noel suggested that this could include modernising the facilities at the Radbourne Unit and organising drop in centres at coffee mornings in the community where people could talk to health professionals in an informal environment. This led the Board to consider how this direction could be included in the ten year plan of mental health across the range of health services, including primary care and in local communities. Caroline congratulated Noel on wining his Inclusion and Partnership Award which she felt deservedly reflects the value that he provides to the Trust and its service users. She thanked him for describing the impact that the Trust's services had on his life and the clear steer he gave about how the environment impacts on recovery and what this will mean to our future clinical strategy.
DHCFT 2018/160	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 6 NOVEMBER 2018** The minutes of the previous meeting, held on 6 November 2018, were accepted as a correct record subject to an amendment to be made to DHCFT2018/155 relating to the identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework (BAF). The minute will be amended to reflect that the impact of out of area placements will be reviewed in the context of several BAF risks including those relating to finance, operational flow and clinical quality.

DHCFT 2018/161	**MATTERS ARISING – ACTIONS MATRIX** The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the actions matrix. All completed 'green' actions were scrutinised to ensure that they were fully complete and actions that were not complete were challenged with Executive Director leads.
DHCFT 2018/162	**QUESTIONS FROM GOVERNORS OR MEMBERS OF THE PUBLIC** No questions had been received from members of the public or governors in advance of the meeting.
DHCFT 2018/163	**CHAIR'S UPDATE** This report provided the Board with the Trust Chair's summary of activity she had undertaken since the previous Board meeting on 6 November 2018. Caroline reflected on the Delivering Excellence Awards event held on 22 November. She felt this had been the best awards ceremony carried out so far and thanked everyone involved in providing an opportunity for the Trust to recognise the good work of its staff and celebrate the success of the winners and finalists. The high participation of governors at the Council of Governors meeting held on 6 November was pleasing to note and was a testament to the high level of engagement by governors. Caroline met with Paul Wood, Chair of South Derbyshire CCG who chaired the recent Joined Up Care Derbyshire Board meeting and had received positive feedback from our work as a Trust within the STP. She thanked all Board members and their teams for their work in ensuring the Trust pays an active role in Joined Up Care Derbyshire. Caroline referred to the briefing she had attended on the NHS ten year plan by Claire Murdoch, National Director for Mental Health, NHS England and was pleased to report that she felt that mental health would have a key input into the ten year plan. **RESOLVED: The Board of Directors noted the activities of the Trust Chair since the last meeting held on 2 October 2018**
DHCFT 2018/164	**CHIEF EXECUTIVE'S UPDATE** This report provided the Board of Directors with feedback on changes within the national health and social care sector as well as providing an update on developments occurring within our local Derbyshire health and social care community. The report also updated the Board on feedback from external stakeholders such as commissioners and feedback from staff. Chief Executive, Ifti Majid reflected on the Chancellor's Autumn Budget Statement and that he was beginning to see early indications of a commitment to mental health services in the NHS ten year plan. He noted that having a single unified plan should give mental health services more opportunity for growth.

	Ifti drew attention to the impact that Brexit might have on the Trust. He assured the Board that all EU staff working for the Trust had been written to and reminded that they are valued and of the Trust's desire to support them to continue working for us. Although he felt it is unclear how the workforce supply and retention of EU nationals will be affected by Brexit, the Trust will be increasing its recruitment efforts to reduce the risk of competition across the NHS for staff. Regular updates on the effects of Brexit will be provided to the Executive Leadership Team and the People and Culture Committee. In terms of procurement in preparation for the UK's exit, Ifti was pleased to report that having completed an assessment of all of the Trust's contracts they have been categorised as having "no/minimal impact" and that contracts and services can continue to run in their existing state within volume, pricing and quality parameters following EU exit. Ifti referred to reports in the news of stockpiles of medicines and assured the Board that we will continue to have supplies of medicines as the majority of the Trust's contracts are held locally. He felt that the Trust was in the strongest place it possibly could be in terms of cross border exchanges of goods. **RESOLVED: The Board of Directors scrutinised the Chief Executive's update, noting the risks and actions being taken.**
DHCFT 2018/165	**<u>INTEGRATED PERFORMANCE AND ACTIVITY REPORT</u>** The Integrated Performance Report (IPR) provided the Board with an integrated overview of performance as at the end of October 2018. The focus of the report is on workforce, finance, operational delivery and quality performance. Chief Operating Officer, Mark Powell, drew attention to the 'people first' agenda and the addition of further enhancements being made around sickness absence management, training opportunities and appraisals. Challenges that these areas represent across the organisation will be discussed at the People & Culture Committee on 18 December. Discussion took place on the work that has been undertaken to improve capacity within the urgent care units. Mark Powell was pleased to report that 25 new nurses commenced employment at the Radbourne Unit and Hartington Unit between September and October 2018. The Board received assurance that all actions relating to the Urgent Care Improvement Plan are progressing well and positive feedback has been received from the CQC regarding the interventions that have been made to the urgent care units. Leadership has been enhanced to ensure extra support at both units and staff have been transferred to urgent care from other areas to ensure that that the standards in acute units are rapidly improved. In response to Non-Executive Director, Richard Wright's challenge that this could cause problems in other areas, Mark advised that risks associated with the movement of staff were being mitigated on a day to day basis. In addition to this staff continue to be recruited to the Trust through our vacancy management pipeline. The report showed eight out of area placements at the time of reporting but this had since reduced to six patients. Non-Executive Director, Geoff Lewins saw that some patients are placed out of area further away than would be preferred. This prompted discussion on PICU (Psychiatric Intensive Care Unit) out of area geographical places and patients with a length of stay above 50 days.

	In response to Non-Executive Director, Anne Wright asking how cases of length of stay longer than 50 days are reviewed and what care packages are available to people when they leave our services, Mark Powell advised that staff work with patients who are out of area and with their families and carers so they can be repatriated unless patients are happy to stay out of area. Discussion turned to the review of neighbourhood services that would be reported to the Quality Committee on 11 December. It is hoped that recommendations arising from the review will deliver against a clear specification for refining services for patients with specific needs. The outcome of the recommendations from this work will be fed into the clinical strategy that will be reviewed by the Executive Leadership Team. Director of Finance and Deputy Chief Executive, Claire Wright updated the Board on the organisation's finance position. The Trust is still forecast to meet its control total. The previous increases in out of area costs have lessened but this has been offset by increased staffing costs forecast for Radbourne and Hartington units. The Board was advised that detailed discussions are taking place within the Finance and Performance Committee to understand the risks relating to the financial Board Assurance Framework (BAF) risk and how this risk can be reduced from an extreme rated risk to a high risk. Director of Nursing and Patient Experience, Carolyn Green reflected that since the IPR had been condensed consideration should be given to reporting of safer staffing in inpatient areas. She undertook to work with the Chief Operating Officer to assure the Board in future reports that inpatient wards are safe. It was agreed that the Executive Leadership Team will discuss a model for these particular areas to take this report to the next level to stimulate debate and discussion. **ACTION: ELT to determine how safer staffing is to be reported in the IPR** **RESOLVED: The Board of Directors:** **1) Obtained limited assurance on current performance across the areas presented.** **2) Agreed that further assurance is required regarding safer staffing on inpatient wards** **3) Agreed that the Executive Leadership Team would determine how safer staffing is to feature in the IPR.**

DHCFT 2018/166	**QUALITY REPORT – CARING** The report provided the Board with a focused report on Caring as part of the wider expanded quality reporting relating to CQC domains and NHS Improvement (NHSI) requirements. The Board considered this to be a robust report that evidenced the Trust's strong compliance relating to how caring and compassionate our services are which was demonstrated by benchmarking information and the overall good CQC rating in this area. The report highlighted the improvements that had been made to accessible information standards. This was assessed as fully compliant in 2018 and an adaptation to communication aids was noted as an example of outstanding practice. Caroline Maley commended this work that had enabled simplified access of information for patients and their families. The Board endorsed the recommendations contained in the report that will be managed by the Quality Committee. This included the development of the Clinical Strategy that will outline the Trust's commitment to reduce waiting times. Work will also take place to redesign the Trust's clinical feedback systems aligned to the Quality Improvement Strategy. It was noted that Carolyn Green will be working to improve the Patient Experience Strategy and will re-write the Carers' Strategy to make sure it is quality improvement led to cover family inclusive practice. This will also include the introduction of informal clinics as discussed during today's patient story. **RESOLVED: The Board of Directors:** **1) Confirmed the levels of assurance as rated by the CQC as good** **2) Considered the current priorities for quality improvement in the domain of Caring and key opportunities for enhancing this area further.**
DHCFT 2018/167	**BME TALENT NETWORK** Ifti Majid introduced BME Network colleagues to the Board who had been invited to share their BME experience while working within the Trust. The BME Network, now known as the BME Talent Network has taken a significant step forward in improving our inclusive culture. This has aided opportunities for shared experience and learning of all cultures and has provided the chance to look at the representation of BME colleagues within different grades in the Trust. The BME Talent Network has encouraged people to be proud to be themselves and to develop their skills and knowledge in order to progress their career. The Board heard about the BME Talent Network's expectations of the Board with respect to changing inclusion practices within the Trust and benefits this would bring not just for BME colleagues but everyone. The Reverse Mentoring initiative was praised as this had promoted equality, diversity and inclusion which is supporting inclusive leadership and culture. The BME Talent Network has had a significant input to work to address the challenges that arise relating to bullying and harassment. Discussion took place on the importance of building an inclusive and compassionate leadership within the Trust that respects boundaries and behaviours.

	The NHS Workforce Race Equality Standards (WRES) indicators were referred to by Carolyn Green. She undertook to seek to address any inequalities when she produces the Nursing Strategy and asked the BME Network for their help in taking this action forward. Ifti Majid thanked the BME Talent Network for their work. He recognised that, as in all organisations, unconscious bias occurs within the Trust and this was important to redress. He proposed that the Board should involve the BME Network in discussing conscious and unconscious bias through a Board Development Session to identify clear action to take forwards. **ACTION: Conscious and unconscious bias to be included Board Development programme for March 2019.** **RESOLVED: The Board of Directors noted the BME colleagues' experience of working within the Trust and agreed to involve the BME Network in taking the Trust through to the next phase of equality, diversity and inclusion**
DHCFT 2018/168	**Report From The Quality Committee On Recommendations Arising From The Nhs Resolution Report On Learning From Suicide Related Claims** The publication of the national report on Learning from Suicide Related Claims from NHS Resolution was noted and briefly discussed at the Trust Board in October 2018. An initial report was requested to be reviewed by the Quality Committee in November with a report submitted to the Board for December. This 144 page report from NHS Resolution is an in-depth thematic review of the data held by NHS Resolution on compensation claims that relate to suicide (and non-fatal attempts) between 2015 and 2017. The recurring clinical themes contained in the report are related to substance misuse, communication (particularly inter-agency), risk assessment, observations, and issues relating to prison healthcare. The Board reflected on the key issue relating to communication, both with the service users and with their families and carers and undertook to improve the involvement of service users and carers/families in care plan discussions. A commitment was made to write directly with the service users themselves, copying in their families and carers where appropriate rather than writing to other health agencies. The Quality Committee discussed the report on 13 November and proposed that a more comprehensive report be submitted to the Committee in the new year from the Serious Incident Group (SIG) setting out recommendations and agreed actions relating to improvements in SIG reporting and analysis of data and the principles of communicating directly to patients, their families and carers in developing patient care plans. The Board understood that these improvement processes are currently being consulted through the Clinical Operational Assurance Teams (COATs) and agreed that work to meet and implement the NHS Resolution recommendations will be further monitored by the Quality Committee. **ACTION: Quality Committee to monitor the implementation of NHS Resolution Recommendations** **RESOLVED: The Board of Directors:** **1) Noted the content of this overview which represents a personal reflection**

	by the Medical Director modulated by input from the Executive Serious Incidents Group with suggested actions agreed. **2) Agreed that a more detailed report by the Executive SI Group would be submitted to the Quality Committee in the new year to allow significant time to analyse our data and consult in a in a meaningful way through the COATs.** **3) Received limited assurance with the report given the "work in progress" status of this report.**
DHCFT 2018/169	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES AND ESCALATIONS</u>** Assurance summaries were received from the Board Committees and highlights were provided by the respective Non-Executive Chair. **Quality Committee 13 November:** In the absence of the Committee chair, Anne Wright reported that the Quality Committee had reviewed the progress being made with physical healthcare delivery and had requested that more pace be given to aligning mental healthcare with physical healthcare intervention. The Committee also focussed on the completion of CQC actions arising from recent inspections. **Safeguarding Committee 15 November:** Chair Anne Wright said that the Committee received positive assurance with regard to increasing compliance with Section 42 training. Consideration was given to the development of single room accommodation rather than dormitory style facilities which will increase levels of patient experience and sexual safety. Sexual safety on wards will continue to be driven by the Safeguarding Committee and Quality Committee and will be added to Board Assurance Framework (BAF) Risk 1a relating to safety and quality standards. **Finance & Performance Committee:** Chair, Richard Wright reported that the Committee took assurance on the Cost Improvement Programme delivery projection for the end of this financial year. The financial BAF risks were considered and the Committee was assured on the known assumptions that were covered. Limited assurance was obtained on the commissioning interface due to evolving situations aligned to the STP. Significant assurance was obtained on the development of the Estates Strategy that will include explicit content relating to equality, diversity and inclusion. **RESOLVED: The Board of Directors received and noted the Board Committee Assurance Summaries**
DHCFT 2018/170	**<u>IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK</u>** No additional issues were raised in the meeting for updating and including in the Board Assurance Framework. It was suggested that issues relating to Brexit should be articulated in relevant areas with the BAF during the next review cycle.
DHCFT 2018/171	**<u>2018/19 BOARD FORWARD PLAN</u>** The forward plan was noted by the Board along with upcoming reports to be received at subsequent meetings. The 2019/20 forward plan is under development and dates of meetings have now been published on the Trust's website.

DHCFT 2018/172	**MEETING EFFECTIVENESS** Attendees and visitors were thanked for their attendance at today's meeting. The Board considered that effective discussion had taken place on strategic planning, out of area placements and workforce issues.
There will be no Board meeting held in January 2019. The next meeting of the Board to be held in public session will take place at 9.30 on Tuesday 5 February 2019 in Conference Rooms A&B, Research and Development Centre, Kingsway, Derby DE22 3LZ.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - FEBRUARY 2019			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
6.11.2018	DHCFT 2018/147	Chief Executive's Update	Ifti Majid	Formal report on the Race and Work Charter to be received at the next meeting in December	~~4.12.2018~~ 5.2.2019	Race and Work Charter will be factored into Board Development on 20 March	Green
4.12.2018	DHCFT 2018/165	Integrated Pperformance Report	Ifti Majid	ELT to determine how safer staffing is to be reported in the IPR	5.2.2019	Deep Dive on staffing incorporated in February IPR. Ongoing reporting on Safer Staffing will be routinely reported in IPR.	Green
4.12.2018	DHCFT 2018/167	BME Talent Network	Sam Harrison	Conscious and unconscious bias to be included in Board Development programme for March 2019	5.2.2019	Board Development Programme updated to include unconscious bias for the Equality and Diversity training session on 20 March	Green
4.12.2018	DHCFT 2018/168	Report from Quality Committee on Recommendations arising from the NHS Resolution Report on Learning From Suicide Related Claims	Carolyn Green	Quality Committee to monitor the implementation of NHS Resolution Recommendations	5.2.2019	This will be monitored via a detailed report to be received by the Quality Committee on 12 March following the previous report that went to Quality Committee in November and Board in December	Yellow

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 5 February 2019

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 2 December 2018. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

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

2. On 27 November I spent an energetic morning with the Estates and Facilities teams. I started at the Kingsway Restaurant, visited the porters and stores teams; had morning tea with the domestics, and then visited the facilities management and capital team and finally some of the estates team showed me around their area, including filling me in on information about the old hospital and use of the building in our history. In the catering unit, I was delighted to be able to congratulate Dave Harrison on 44 years to the day in the NHS. What was palpable was the patient focus that the team had and how they took pride in the work that they did to support the rest of the Trust – although some felt that they were not valued and appreciated.

3. A number of days in early December were taken up in judging the Christmas Decorations competition across the Trust. This was a delightful task to undertake along with Ifti Majid, Lynn Dunham, and Harinder Dhaliwal and had been organised by April Saunders, Staff Governor. Whilst this was an exhausting job, it was wonderful to see how engaged staff were in the competition and the creativity, inclusion and efforts that had been made to deliver an outcome worthy of a prize. I am sure that my fellow judges would agree that there was a real sense of the Team Derbyshire Healthcare as we travelled around the Trust locations seeing staff and admiring their work. I was pleased to be able to call the winners of the competition (two main winners and nine special awards were given) and to hear their delight in success.

4. On 12 December I dropped in to meet staff in People Services who support our Trust and staff. It was good to see the way that the People Services are now being delivered following the creation of the new people services team with DCHS. It was good to meet some familiar faces as well as new staff new to supporting Team Derbyshire.

5. On 23 January I visited the CAMHS (Child and Adolescent Mental Health Service) Eating Disorders team at Temple House, Derby. I joined one of their team meetings and was able to hear a couple of case reviews that were being discussed. It is obvious how much the family is impacted by the illness of a child and the caring response from our services. A number of issues were raised with me which link clearly with our People Strategy, and the recruitment and retention of staff in particular. However, it is clear that the staff are focussed on delivering good care for their service users and are intent on making a positive difference.

Council of Governors

6. On 11 December, the governors' Governance Committee was hosted at the School of Health Sciences, University of Nottingham at the Royal Derby Hospital. At this meeting I was able to welcome Rob Poole, new governor for Bolsover and North East Derbyshire, to the Trust. Rob is a retired primary school head teacher. After this meeting I met with governors to receive input into the appraisals of Non-Executive Directors, Anne Wright, Geoff Lewins and Richard Wright. This has been a change of approach, supported by a much simplified form to enable governors to provide feedback.

7. Senior Independent Director, Margaret Gildea chaired the Council of Governors meeting on 9 January in my absence on annual leave. The Council received a report on care planning in the Trust and also an update on co-production and service user involvement. This is an area of some interest to governors.

8. We have sought nominations for public governors in Chesterfield, Derby City East, Erewash and Surrounding Areas, as well as a medical staff governor. Nominations closed on 30 January. Elections will take place shortly and I look forward to welcoming new (and possibly returning) governors to the Trust.

9. The next meeting of the Council of Governors will be on 5 March. The next Governance Committee takes place on 12 February. The next meeting of the Nomination and Remuneration Committee takes place on 13 March 2019. At this meeting, a consolidated report on NED (Non-Executive Director) appraisals will be presented.

Board of Directors

10. I chaired the Mental Health Act Committee on 7 December on behalf of Anne Wright, who was ill. We also met with the Associate Hospital Managers to review the appointment, future appraisal and role that they currently carry out on behalf of the Board. This session was facilitated by Margaret Gildea, member of the Mental Health Act Committee. The Independent Review of the Mental Health Act

1983 recommendations may change the role of the Associate Hospital Manager, and there is some concern amongst our managers about this.

11. Julia Tabreham has been given a leave of absence from the Board for health reasons. Suzanne Overton-Edwards, a NeXT Director with Nottinghamshire Healthcare has joined the Trust on a secondment to provide support to the NED team whilst Julia is away. I welcome Suzanne to the Trust and I am confident that she will learn from her placement, and we will benefit from her input to the Board and committees. I am a keen advocate of the NeXT Director Scheme, hosted by NHS Improvement, and am also pleased that Suzanne's profile meets my desired profile for a NeXT Director on placement with us, being from a BME background. Suzanne has a long career in education, most recently having been Principal, CEO and Accounting Officer of Gateway College, Leicester.

12. Board Development on 18 December ensured that the Board was sighted on cyber security risks, and also enabled us to complete our mandatory data security training. We also met with two leaders from the LGBT+ group and received insight into what they have achieved over the past year.

13. Board Development on 16 January focussed on the softer / interpersonal skills of the Board, and how we work together to our very best, ensuring that the unitary board is being as effective as it can. This was a valuable investment of development time and an area we will make time for in future meetings to continue reflection on our behaviours.

14. The Remuneration and Appointment Committee met on 18 December. This was a routine quarterly meeting. A further meeting of this Committee took place on 16 January to consider a recent recommendation from NHS Improvement on "very senior management" pay which affects our executive team.

15. Board appraisals for NEDs continue with Richard Wright appraised on 12 December. Geoff Lewins' and Anne Wright's appraisals are in progress. NED appraisals are completed on the anniversary of their appointment and reported to the next planned Nomination and Remuneration Committee.

16. I have met with Geoff Lewins as part of my routine quarterly meetings with NEDs. During these meetings we review performances against objectives set at the beginning of the appointment / review cycle, as well as discuss generally mutual views on the progress of the NED and the Trust.

System Collaboration

17. On 13 December, I visited the NGS (Next-Generation Sequencing for Cancer Diagnostics) Cancer Unit at the Chesterfield Royal at the invitation of the Chair, Helen Philips. This is an impressive unit and shows the impact that investment from charitable sources can have on the services provided by the NHS.

18. I was not able to attend the JUCD (Joined Up Care Derbyshire) Board meeting on 21 December as I was on annual leave. I attended the JUCD Board on 16 January. There was a discussion on the implications of the ten year plan and the planning process that is required to support this. It also noted some

proposed changes to the JUCD structure and programme in order to meet the requirements of the ten year plan. This will be covered in more detail in the CEO report.

Regulators; NHS Providers and NHS Confederation and others

19. NHS Providers Chiefs and Chairs meeting took place on 6 December and was attended by Ifti Majid and me. The agenda included presentations from Ian Dalton on the planning for 2019/20 and the five year delivery plan; Lord Prior of Brampton, chair of NHS England, with his perspective on the ten year plan, and a summary on Brexit and what the implications for the NHS. I was pleased that a session of the agenda focussed on the Reverse Mentoring Programme, and Ifti was one of the presenters for the session. Chris Hopson, CEO of NHS Providers gave a good view on the strategic and policy issues, all of which appointed to the ongoing uncertainty around Brexit and the ten year plan, which at that stage had not been published.

20. HFMA (Healthcare Financial Management Association) hosted a Chairs Conference in London on 15 January. The keynote presentation was from Peter Wyman, Chair of CQC. Rather than reflecting on the key challenges affecting the NHS, Peter reflected on the ten top areas that chairs should be focussed on. This was a good pointer for chairs on what is important, whilst also perhaps an indication of areas that may draw comment or review by CQC:

1.	Culture	2.	Governance
3.	Strategy	4.	Stakeholders
5.	People	6.	Technology
7.	Risk	8.	Quality improvement
9.	Efficiency	10.	Regulation

I believe that there is good synergy between this list and the areas that we focus on as a board.

Beyond our Boundaries

21. I am taking part in the assessment panels for the Regional Talent Board (Aspire Together). The vision of Aspire Together is to move talent management from individual organisations to a place where it is owned and valued by the whole system. The first of the assessment days that I took part in were held on 3 December in Leicester. This is a pilot scheme being carried out in the Midlands and East and Dido Harding (Chair of NHS Improvement) has an appetite to move faster with the pilot to identify more potential directors for a national talent pool.

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

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work.

With respect to our work with governors - we work actively to encourage a wide

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

Demonstrating inclusive leadership at Board level

Through the Trust's involvement in the NeXT Director scheme, hosting a placement for Suzanne Overton-Edwards, we are supporting the development of those who may find it more difficult to be appointed as a NED in the NHS.

Through the Trust's LGBT+ activities and other groups reflecting those with protected characteristics, we are raising awareness through demonstrating inclusive leadership at all levels in the Trust.

Recommendations

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

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

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. This report has a more detailed focus on three national policy releases

- The NHS 10 Year plan
- The Workforce Race Equality Standard report
- EU Exit planning and assurance

The report should be used to support strategic discussion on the delivery of the Trust strategy.

National Context

1. Board members will be aware that the 120 page NHS long term plan has been published in January 2019. The plan follows last June's announcement of a £20.5bn annual real terms uplift for the NHS by 2023/24. The plan sets out ambitions for ensuring the NHS is fit for the future and covers a ten year window. A consultation and engagement period will now begin on the Plan which will run until summer 2019. It is worth stating the obvious for the Board that this is a plan for the NHS and doesn't include plans relating to social care including public health services.

   The NHS long term plan details expectations and commitments that will impact across the NHS:

   - *Reform* such as the future shape of integrated care systems and development of primary care networks
   - *Clinical Priorities* for all of the national priority areas including of specific note given our portfolio of services, Children's, Mental Health and Learning Disability.
   - *Workforce* expectations and challenges
   - The role of *digital* in both efficiency and service delivery.

   It is important that we see the Long Term Plan as a framework that we develop more details around. It is already clear that to understand more about the practicalities of implementation more work is needed on for example:

   - Clinical Review of standards
   - Workforce Implementation Plan
   - Social Care Green Paper, Prevention Green Paper, the Spending Review

   Looking to understand more about the specific areas that impact on our organisation, as a Board we should note:

   Maternity and Neonatal Services

   - The NHS will accelerate action to achieve 50% reductions in stillbirth, maternal

mortality, neonatal mortality and serious brain injury by 2025
- By March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally, following the launch of continuity of carer teams
- The Saving Babies Lives Care Bundle (SBLCB) will be rolled out across every maternity unit in England, including a focus on preventing pre-term birth and the development of specialist pre-term birth clinics
- Access to evidence-based care for women with moderate to severe perinatal mental health difficulties in the community.

Children and Young Peoples Mental Health Services

- Over the coming decade 100% of children and young people who need specialist mental health care will be able to access it
- Funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending
- By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school/college-based MH Support Teams
- Current service models will be extended to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults
- A children and young people's transformation programme will be created to oversee the delivery of the children and young people's commitments in the plan
- Improvements in childhood immunisation will be prioritised
- By 2028 transitions will be based on need not age.

Adult Mental Health Services

Our Board should recognise many aspects of the mental health specific requirements as they are a build on the MH 5 Year Forward View

- Investment increases to a further £2.3bn a year by 2023/24
- Waiting times for emergency MH services in place 2020
- New and integrated models of primary and community mental healthcare will give 370,000 adults and older adults with severe mental illnesses greater choice and control over their care and support them to live well in their communities by 2023/24
- By 2023/24 an additional 380,000 people per year will be able to access NICE-approved IAPT services
- By 2023/24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis
- Increase alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute mental health pathways
- Families and staff who are bereaved by suicide will also have access to post crisis support
- Mental health liaison services will be available in all acute hospital A&E departments and 70% will be at 'core 24' standards in 2023/24, expanding to 100% thereafter
- Introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms.

Learning Disability and Autism Services

- The NHS will tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people
- Uptake of the existing annual health check in primary care for people aged over 14 years with a learning disability will be improved, so that at least 75% of those eligible have a health check each year
- The STOMP-STAMP programmes will be expanded to stop the overmedication of people with a learning disability, autism or both
- By March 2023/24, inpatient provision will have reduced to less than half of 2015 levels.

We will be working with our local commissioners and system colleagues to understand the phasing of these developments, how they complement existing services and importantly our upcoming work around clinical strategy/model development must take into account planning for these national expectations.

The plan also contains clarity on the direction of travel towards development of Integrated Care Systems (ICS) across all 44 STP footprints by April 2021. Some of the key points of note relating to ongoing development of ICS includes:

- Every ICS will have:
    - A partnership board drawn from commissioners, trusts, primary care networks, local authorities, voluntary and community sector and others
    - A non-executive chair locally appointed and approved by NHSE and NHSI
    - Full engagement with primary care through a named accountable clinical director of each primary care network
    - A single, leaner more strategic CCG for each ICS area

- All providers with an ICS will be required to contribute to ICS performance, underpinned by:
    - Potential new licence conditions supporting providers to take responsibility with system partners, for wider objectives on resource use and population health
    - Longer-term NHS contracts with all providers including care requirements to collaborate to achieve system objectives
    - Changes to align clinical leadership with ICSs including ensuring Cancer Alliances and Clinical Senates align with one or more ICS
    - A new Integrated Care Provider contract will be made available for use from 2019 to be held by public statutory providers
    - A new ICS accountability and performance framework will provide a consistent and comparable set of performance measures, including a new ‘integration index’

- NHSE/I will support CCGs and local authorities to blend health and social care budgets.

- ICSs will agree system wide objectives with the relevant NHSE/I regional director and be accountable for their performance against these objectives

The plan talks about new entities being develop called Primary Care Networks. These networks will cover populations up to circa 50,000 and will be key in delivering the ‘how’ of the £4.5bn prioritised to boost out of hospital and community care (universal

services). In addition the Plan indicates that core community mental health services should be redesigned and reorganised to align with these networks

We shouldn't lose sight of the fact the plan gives a revised timetable for the NHS to return to financial balance: the aggregate provider deficit should reduce each year, and the provider sector as a whole should balance by 2020/21. This is two years later than the aspiration set out in the 2018/19 planning guidance, for the sector to be back in the black by the end of the current financial year. Meanwhile, the number of trusts and commissioners in deficit should also decrease. The number of trusts reporting a deficit in 2019/20 is expected to halve, and all NHS organisations should be in balance by 2023/24.

2. In common with all NHS organisations we have been submitting Workforce Race Equality Standard (WRES) since 2016. As a whole over this period the NHS is seeing 'steady' improvement against a range (but not all) of the 9 WRES indicators. Continued focus and prioritisation is required by Boards to ensure the improvements are more sustainable and more consistent. I am keen to remind our Board that this mission is critical to the achievement of our vision as an organisation. Evidence is clear that tackling workforce race equality improves staff experience, patient outcomes and organisational efficiency.

   Given the importance of this topic for us as a Board I have summarised some of the key findings from the 2018 report:

   - BME Staff make up 19.1% of the workforce of the NHS, 10,407 more than in 2017. This headline increase could hide the fact that BME staff are concentrated in AFC bands 1-4 and under-represented in senior VSM bands with just 6.9% of VSM colleagues being front a BME background. (This is an increase from 2017.) In midlands and East we have seen an increase of 3.9% in BME staff in the workforce.
   - White applicants are 1.45 times more likely to be appointed following shortlisted than BME staff (small improvement) though good to see 32% of all staff shortlisted were from BME backgrounds. Sadly in the midlands and east our appointment rate has slightly worsened.
   - BME staff remain 1.24 times more likely to enter the disciplinary process than white colleagues. In the Midlands and east this figure is 1.12 times more likely.
   - White staff remain relatively more likely to access training that is non mandatory than BME staff. Difficult to quantify as some Trusts don't hold this data however there has been a small improvement from last year but we remain worse across the NHS that we were in 2016.
   - 38.7% of BME staff reported harassment, bullying or abuse from, patients or the public in 2018 – the same as in 2017. This correlates to 27.7% of white staff reporting the same.
   - The number of BME staff reporting bullying, harassment or abuse from other staff alarmingly has increased this year from 26% in 2017 to 27.8% in 2018. This compares to 23.3% for white staff. In Midlands and East the figure has increased from 25.5% to 26.7%.
   - Only 71.5% of BME staff felt their Organisation gave them equal opportunities for career progression compared to 86.6% of white colleagues. This is a reduction from last year.
   - The percentage of BME staff that experienced discrimination in the last 12 months has worryingly increased from 13.8% to 15.0%. This contrasts with 6.6% of white staff directly experiencing bullying at work. This differential existed in 97% of Trusts.
   - With respect to Trust Board composition 7.4% of Board members of NHS Trusts

are from a BME background – this percentage is increasing and there are 11 more BME Board members this year than last year. However there remains a significant disparity between the 7.4% BME Board members and the 19.1% total BME workforce. This pattern relates to something we see in our Trust which is a reduction in BME colleagues in senior leadership positions most significantly seen at Band 7 and above.

Analyses of WRES data between 2016 and 2018 show continuous improvement across the range of workforce indicators. The three workforce WRES indicators (2, 3 and 4) are beginning to show continuous improvement over time. Much of this improvement can be attributed to the provision of WRES implementation support across the NHS, and in the sharing and implementing evidence-based good practice examples of operational interventions. In our Trust the BME Talent network holds senior leaders to account for the development and delivery of specific action plans to improve these three key areas of leadership performance.

In contrast, the NHS staff survey indicators (5, 6, 7 and 8), which reflects organisational culture, have remained largely unchanged since 2016. These indicators require alternative staff and leadership development methods to be implemented in order to have an impact. Examples of this sort of initiative include the Reverse mentoring Project we have implemented within our Trust.

These national challenges will not be a surprise to our Board having heard first hand from colleagues in our BME Talent network about some of the challenges they face and have faced in their careers. As our staff survey results become public the Board will receive a direct comparison report with the national dataset briefed here.

In addition Board members will be aware that our March Board development session has a specific focus on unintentional bias and we will be joined by members from all of our Networks to discuss this key area.

3. On 21 December 2018 the Department of Health and Social Care released EU Exit Operational Readiness Guidance. The guidance has been developed and agreed with NHS England and Improvement. This guidance sets out the local actions that providers and commissioners of health and adult social care services in England should take to prepare for EU Exit. The Department, with the support of NHS England and Improvement, and Public Health England, has set up a national Operational Response Centre. This will lead on responding to any disruption to the delivery of health and care services in England that may be caused or affected by EU Exit.

   NHS providers and commissioners will be supported by NHS England and Improvement local teams to resolve issues caused or affected by EU Exit as close to the front line as possible.

   The guidance requires all trusts to identify an EU Exit Executive Lead and given the links with Business Continuity for our Trust, Mark Powell, COO will carry out this role. The guidance also recommends all trusts carry out a local EU Exit readiness assessment that includes a review of seven key areas of risk identified by the Department of Health and Social Care:

   - Supply of medicines and vaccines
   - Supply of medical devices and clinical consumables
   - Supply of non-clinical consumables, goods and services
   - Workforce

- Reciprocal healthcare
- Research and clinical trials
- Data sharing, processing and access.

In addition actions associated with business continuity planning, annual leave and on call availability and staff communications are also required.

We have identified Executive Leads for each area defined above and have completed the required risk assessments with table top business continuity testing to occur during February. I can confirm to the Board that as a healthcare provider we remain at low risk of serious implications following a 'no deal' EU Exit with the caveat that centrally led mitigations around medicines and fuel supplies remain robust and effective.

The action matrix for the risk assessments is attached as appendix 1 for the Board's assurance of compliance.

Local Context

4. The Joined up Care Derbyshire (JUCD) Board met on 17 January 2019. Key issues discussed included:

- We discussed plans for the System Leaders OD programme aimed at supporting the development of a leadership culture to support our journey to becoming an Integrated Care System (ICS). We agreed that the programme would consist of three stages:

    - CEOs and Chief officers
    - Executive Teams, STP Central Team and Place clinical leads
    - Chairs and Non Executives

    We agreed this programme would run through Q4 18/19 and Q1 19/20 and an external facilitator familiar with the cultural requirements of an ICS would be sought.

- We agreed the set of 11 principles by which we would operate subject to any minor alterations following the system leadership OD programme.
- We discussed the ambitious planning cycle for 2019/20 and as respective leads of priority work streams (Mental Health/Learning Disability in my case) agreed to work with our work stream teams to provide an outline 'strategic plan on a page' by 31 January.
- We recognised more work was needed with respect to transparently sharing information to support a system approach to contracting and planning for 2019/20 with the hope of avoiding bilateral commissioning discussions. Further discussion on this matter was delegated to the CEO/DoFs meeting to agree a process by which commissioner QIPP, provider CIP and activity assumptions could be shared ahead of the planning deadlines.
- Financially the system remain challenged at month 8 with several providers reporting off plan financial performance and noting difficulties that both providers and commissioners are having achieving CIP/QIPP plans.
- We discussed the setup of the 'engagement committee' that was approved in November reviewing terms of reference. The main point of addition was the need to factor in public governors of all four foundation trusts as a great way to engage local people.

Within our Trust

5. During December along with Caroline Maley, Harinder Dhaliwal and Lynn Dunham, I had the great pleasure of being part of the judging panel for our Christmas decorations 2018 competition. The competition attracted significant interest from both clinical and non-clinical teams and provided the panel with two days of fun traveling around our team bases looking at some of the fantastic and innovative decorations. Many teams reported how much they had enjoyed preparing for the competition and how it had provided a focus for team development. It was a seriously difficult task that resulted in a number of consolation awards with two main winners:
6.
    - Tansley Ward at the Hartington Unit for clinical area
    - Information management, Technology and Records for non-clinical areas

    I understand planning has already commenced for 2019 in some teams!

7. It was a real privilege on 6 December to be invited along with two other Chief Executives and Stacy Johnson from Nottingham University to talk to Chairs and Chief Executives at the NHS Providers Chairs and CEOs event about our experience of Reverse Mentoring. This vital topic was well received with several requests for information following the event. The point of note though was the overwhelming evidence that the project has had on the culture of organisations where it has been delivered. In particular it was noted the impact on 'speaking up' within organisations of having both a project such as reverse mentoring but also the impact of having vibrant and well supported networks.

8. On 12 December supported by Executive and Communication colleagues we held an open meeting for housing residents on the Kingsway site to come and talk to us about any issues they were having living in close proximity to our hospital but also to share information about our services and bust some myths about mental ill health.

    I was pleased with the number of residents who attended and their genuine interest in what we do as a Trust and how we can work together as 'good neighbours'. House builders Kier also attended to update residents on the next phases of their work and both Kier and ourselves agreed to take away some actions in support of creating a cleaner environment.

9. During December and January engagement visits have continued. As well as holding *Ifti on the Road* engagement sessions I have also continued my programme of attending clinical referral meetings and clinician shadowing. Key visits have included:

    - 'On the Road' session at Rivermead, Belper (CAMHS and CLDT)
    - Shadowed Dr Melchizadeck at his clinic at the Resource Centre.
    - 'On the Road' session at the Radbourne Unit
    - Attended Operations meeting at the Radbourne Unit
    - Visited all wards and inpatient units on Christmas Eve
    - Attended City Substance Misuse clinical Team meeting
    - 'On the Road' session at Bay Heath House Chesterfield

    The sessions were varied in their outcomes depending on the type of session however some of the key things I noted were:

    - The continued growth in complexity of people who are using our services including a shift in the magnitude of risks clinicians are dealing with on a daily basis
    - The importance of local decision making and devolving as much accountability

to individual teams as possible, included in this is the need for enhanced management and leadership training for team managers (underway and commencing in February)
- Worries about management of change programmes and the role commissioners play in supporting effective change management
- Importance of enabling colleagues to use newly developed skills quickly on return to their teams to preserve the skills and maintain personal motivation
- The real benefit of a structured clinical team meeting with respect to restorative supervision, clinical decision making and risk management – a worry that colleagues may not feel able to prioritise such meetings all the time due to capacity pressures.
- The importance of clinical system interoperability to support clinical safety
- How we support staff on extend leave periods eg maternity, career breaks etc to continue to feel part of the Trust
- Some of the tangible benefits of nurse led clinics and using all our professions as specialists in their own right to enhance outcomes.

All actions from these engagement sessions have been logged on our tracker by our Communications Team and where actions are required these have been shared with the relevant directors.

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

Assurances

- Our strategic thinking includes national issues that are not immediately in the health or care sector but that could be of high impact.
- The Board can take assurance that Trust level of engagement and influence is high in the health and social care community
- Feedback from staff and members of the public is being reported into the Board
- The Trust is compliant with EU Exit planning guidance issued by the Department for Health and Social Care
- Senior leaders are familiar with the NHS Long Term Plan and processes are underway for building requirements and expectations into the commissioning discussions associated with 2019//20 contracting round.

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

Within the report there are clear examples of where risks to inclusion are present. I remain seriously concerned about the pace of change evidenced in this year's Workforce Race Equality Standard report. The report evidences that the cultural change associated with inclusion is the area of the most lack of progress.

That said in our Trust we are developing some great examples of practice that help to ensure we provide care in an inclusive culture:

- The development of thriving inclusion Networks
- Development sessions bringing together inclusion Networks and Senior leaders
- Inclusion Network presentations at the Board
- Board development session facilitated by an expert in unconscious bias
- Adoption of Reverse Mentoring scheme about to be rolled out into phase 2 with core managers
- Attendance at Derbyshire community events such as Pride and Derby City Council BME Network
- Action planning being led by our inclusion networks

As we respond to the NHS 10 year plan and link those requirements into our commissioning discussions we must ensure any equality impact assessment carried out determines 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.

Where this assessment doesn't happen or if the assessment shows large detriment this will be escalated through the appropriate structures within our Trust.

Recommendations

The Board of Directors is requested to:

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

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

EU Exit Operational Readiness Action Tracker

Summary of actions for Providers

1. Undertake risk-assessment for the following 7 key areas by the end of January 2019;

Key Area identified nationally	Lead Director	Lead Manager	Completed (yes/no)	Comments and / or residual risk
Supply of medicines and vaccines	Mark Powell	Steve Jones	Yes	• No pharmacy department reliance on EU nationals • Government has responsibility for contingency planning of the UK medicines supply chain, NHS organisations are instructed not to stockpile medicines or provide larger prescriptions than usual • If supply shortages occur and cause short term disruption there may be a need for a temporary increase in pharmacy staff resources to dispense smaller quantities at an increased frequency and move stock around the organisation. This may result in delays in some provision of medicines if there is a need to confirm how essential a supply is. • Amounts of medication supplied may be reduced if stock difficulties occur, appropriate advice will be provided to frontline healthcare staff and for patients/carers. • Chief Executive will be informed of any effects on medicines supply that actually

Key Area identified nationally	Lead Director	Lead Manager	Completed (yes/no)	Comments and / or residual risk
				affect patient care to a significant degree. • Available on request: report of forward days' cover of each item on the pharmacy inventory
Supply of medical devices and clinical consumables	Gareth Harry	Richard Houghton	Yes	Evaluation submitted to DH and no residual risks identified.
Supply of non-clinical consumables, goods and services	Gareth Harry	Richard Houghton	Yes	Evaluation submitted to DH and no residual risks identified.
Workforce	Amanda Rawlings	Celestine Stafford	Yes	Risk is deemed minimal due to small amount of EU employees and no concentration of such employees in any particular department. 49 employees in total, although 20 of these are Irish so benefit from a pre-EU more favourable immigration agreement. Employees are not yet under any obligation to advise their employer if they have applied for and received their settled status, but 3 have so far submitted their claim to reclaim their fee.
Reciprocal healthcare	Claire Wright	Rachel Leyland	Yes	The current level of overseas visitors to the Trust is minimal. Current processes would capture any overseas visitors who are subject to payment for healthcare and then those procedures for any claims would be followed
Research and clinical trials	John Sykes	Rubina Reza	Yes	We currently have two Clinical Trials involving Investigational Medicinal Products with 6 patients enrolled in total. Both

Key Area identified nationally	Lead Director	Lead Manager	Completed (yes/no)	Comments and / or residual risk
				Sponsors for these two trials have confirmed via email in December 2018 that they do not expect any disruption to supply of the Investigational Medicinal Products (IMPs). As advised we will continue participating in and/or recruiting patients to clinical trials and investigations up to and from 29 March 2019 unless we receive information to the contrary from a trial Sponsor. A risk assessment has been completed in Datix. In the possible likelihood of there being a disruption to the IMPs, I have estimated this as a moderate clinical impact (risk rating of 9) as numbers are small and all clinical trials are designed to include early termination processes and safe transition back to standard clinical treatment following withdrawal from the IMP. We do not have any EU funded research grants currently.
Data sharing, processing and access	Mark Powell	Peter Charlton	Yes	With regard to Data sharing, processing and access, we do not currently have any routine data processing outside of the UK / EEA. We will also ensure that we consider the impact of Brexit when we have ad hoc requests to transfer patients' records overseas.

2. In addition, the following actions are also required to be completed;

	Lead Director	Lead Manager	Completed (yes/no)	Comments and / or residual risk
Organisational and system wide business continuity plans completed at the latest by the end of January 2019	Mark Powell	Karen Billyeald	No	KB to review BC plan in the next 2 weeks.
Test aforementioned plans by the end of February 2019	Mark Powell	Karen Billyeald	No	See above.
Ensure your board is sighted on EU Exit preparation and take steps to raise awareness amongst staff.	Sam Harrison	Anna Shaw	Current position on Brexit implications reported in CE Report to Trust Board December 2018.	Propose more formal report to Board in Feb 2019 providing assurance on actions underway. Communications to staff to outline work underway to follow guidance and ensure business continuity
Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019, but at this point there is no ask to reduce capacity or activity around this time.	Mark Powell	Kath Lane	No	First and second on call rotas reviewed, no residual risk. Ongoing review of Directors and senior manager's annual leave.
Confirm your organisation's Senior Responsible Officer for EU Exit preparation and identify them to your regional EU Exit team as soon as possible. This role should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting	Mark Powell	Ifti Majid	Yes	MP confirmed as SRO.

	Lead Director	Lead Manager	Completed (yes/no)	Comments and / or residual risk
emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential 'no deal' exit impacts. Organisations should also identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.				

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 February 2019

Integrated Performance Report (IPR) Month 9

Purpose of Report

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

Executive Summary

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

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

1. Regulatory Compliance dashboard

    - Seven day follow-up
    - Out of area placements
    - Sickness absence
    - Annual appraisals
    - Compulsory training

2. Strategy Performance dashboard

    - Control total and cost improvement programme
    - Neighbourhood waiting lists
    - CAMHS waiting list
    - Paediatric waiting list (see below)
    - Health Visitor caseloads

In addition to the areas identified above, Board members need to be appraised of the current situation regarding the Referral to Treatment (RTT)18 weeks standard for Paediatrics. Over the last two years there have been numerous discussions with commissioners about whether our service waits should be reported as part of the national 18 week RTT. Following a recent internal review, where it is clear that our service is a consultant led pathway, the Executive Team has decided that we should start to report this service as part of the 18 week RTT standard. This will affect the Trust's 18 week RTT performance as there are longer waits in this service. However, as part of the decision to begin to report this, the Trust has formally notified the CCG of our intent and requested that they provide the correct level of funding to support delivery of this standard. We await their response. In addition, the Trust has also informed NHSI of our decision and the implications for our RTT performance in the short to medium term. Reporting will be added to the IPR from next month.

There is a supplementary section that has been added to the end of this month's IPR. This extra section provides more detailed assurance on the actions that have been undertaken to improve urgent care services, particularly adult acute inpatient

areas.

In addition, the IPR is accompanied by a staffing report which provides information to inform a full Board discussion on specific issues affecting current and future staffing across the Trust.

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

Assurance

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

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

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

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

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

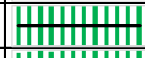
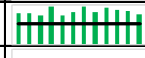
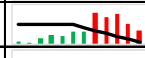
Recommendations

The Board of Directors is requested to;

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

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

1. Regulatory Dashboard

Category	Sub-set	Metric	Period	Plan	Actual	Variance	Trend	Last 12 Months	DQ
Finance	Finance Score	Finance Scorecard	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Capital Service Cover	YTD	2	2	G	→		
			Forecast	2	2	G	→		
		Liquidity	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure Margin	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Income and Expenditure variance to plan	YTD	1	1	G	→		
			Forecast	1	1	G	→		
		Agency variance to ceiling	YTD	1	1	G	→		
			Forecast	1	1	G	→		
	Single Oversight Framework	Agency costs as % of total pay costs	YTD	2.91%	2.87%	G	→		
			Forecast	2.87%	2.85%	G	→		
		NHS I Segment	YTD		2		→		
Quality and Operations	KPIs	CPA 7 Day Follow-up (M)	Dec, 2018	95.00%	90.63%	R	↓		
			Nov, 2018		97.33%	G			
		Data Quality Maturity Index (DQMI) - MHSDS Data Score (Q)	Dec, 2018	95.00%	96.38%	G	→		
			Nov, 2018		96.04%	G			
		IAPT RTT within 18 weeks (Q)	Dec, 2018	95.00%	100.00%	G	→		
			Nov, 2018		100.00%	G			
		IAPT RTT within 6 weeks (Q)	Dec, 2018	75.00%	98.28%	G	→		
			Nov, 2018		97.68%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Complete (Q)	Dec, 2018	53.00%	88.89%	G	↑		
			Nov, 2018		87.50%	G			
		Early Intervention in Psychosis RTT Within 14 Days - Incomplete (Q)	Dec, 2018	53.00%	76.47%	G	↓		
			Nov, 2018		84.62%	G			
		Patients Open to Trust In Employment (M)	Dec, 2018		10.21%	G	→		
			Nov, 2018		10.31%	G			
		Patients Open to Trust In Settled Accommodation (M)	Dec, 2018		57.78%	G	→		
			Nov, 2018		58.52%	G			
		Under 16 Admissions To Adult Inpatient Facilities (M)	Dec, 2018	0	0	G	→		
			Nov, 2018		0	G			
		IAPT People Completing Treatment Who Move To Recovery (Q)	Dec, 2018	50.00%	50.83%	G	↓		
			Nov, 2018		54.23%	G			
		Physical Health - Cardio-Metabolic - Inpatient (Q)							
		Physical Health - Cardio-Metabolic - EI (Q)							
		Physical Health - Cardio-Metabolic - on CPA (Community) (Q)							
		Out of Area - Number of Patients Non PICU (M)	Dec, 2018		13		↓		
			Nov, 2018		20				
		Out of Area - Number of Patients PICU (M)	Dec, 2018		17		→		
			Nov, 2018		17				
		Out of Area - Average Per Day Non PICU (M)	Dec, 2018	0.9	6.8	R	↓		
			Nov, 2018	2.4	10.0	R			
		Out of Area - Average Per Day PICU (M)	Dec, 2018	23.2	9.2	G	↑		
			Nov, 2018	24.1	7.7	G			
		Written complaints – rate (Q)	Q32018/19		0.03		→		
			Q22018/19		0.03				
		Staff Friends and Family Test % recommended – care (Q)	Q22018/19	81%	73%	R	↓		
			Q12018/19		74%	R			
		Occurrence of any Never Event (M)	Dec, 2018	0	0	G	→		
			Nov, 2018		0	G			
		Patient Safety Alerts not completed by deadline (M)	Dec, 2018		0		→		
			Nov, 2018		0				
		CQC community mental health survey (A)	2017		7.3/10		↑		
			2016		7.0/10				
		Mental health scores from Friends and Family Test – % positive (M)	Dec, 2018	81%	96%	G	↓		
			Nov, 2018		97%	G			
		Potential under-reporting of patient safety incidents per 1000 bed days(M)	Oct17-Mar18		36.10	G	↑		
			Jan-00		0.00	G			
Workforce and Engagement	KPIs	Turnover (annual)	Dec, 2018	10.00%	9.95%	G	↓		
			Nov, 2018		9.76%	G			
		Sickness Absence (monthly)	Dec, 2018	5.04%	6.49%	R	↑		
			Nov, 2018		6.85%	R			
		Sickness Absence (annual)	Dec, 2018	5.04%	5.66%	R	↑		
			Nov, 2018		5.68%	R			
		Vacancies (funded fte)	Dec, 2018		9.53%		↓		
			Nov, 2018		9.73%				
		Appraisals All Staff (number of employees who have received an appraisal in the previous 12 months)	Dec, 2018	90.00%	74.50%	R	↑		
			Nov, 2018		73.42%	R			
		Medical Appraisals (number of medical employees who have received an appraisal in the previous 12 months)	Dec, 2018	90.00%	94.00%	G	→		
			Nov, 2018		95.00%	G			
		Compulsory Training (staff in-date)	Dec, 2018	90.00%	84.44%	A	↑		
			Nov, 2018		83.94%	A			
		NHS Staff Survey (A)	Work		60.92%				
			Treatment		72.77%				

Key:

Period Current Month / Previous Month

Achieving target
Not achieving target
Within tolerance
No Target Set

Target

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

1.1 Finance Position

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

All metrics are forecast to achieve their planned outturn including the agency metric with agency expenditure forecast to be below the ceiling.

Comparing the actual expenditure on Agency to the ceiling, we are slightly below the ceiling value by £82k at the end of December. This generates '1' on this metric within the finance score. Agency expenditure is forecast to be below the ceiling by 3% which is generating a score of '1' which is as per the plan. Agency expenditure forecast includes contingency costs estimated at £75k.
The forecast agency expenditure equates to the plan of 2.9% of the pay budgets (2.9% last month). National NHSI benchmarking information from 2017/18 showed agency expenditure at 4.5% of pay budgets, with the Midlands and East region at 5.2%.

1.2 Seven day follow-up

The target was missed by 3 patients. There were 3 patients recalled to the Enhanced Care Ward (ECW) on Community Treatment Orders owing to non-compliance with treatment, in order to administer depot injections and then discharge. The requirement for 7 day follow-up was overlooked as part of this process. This issue has now been resolved.

1.3 Out of area adult placements (non-PICU)

The number of patients that the Trust admitted to out of area beds reduced for the 3rd month in a row, but is still higher than we would wish to see. The Trust continues to take part in the regional learning collaborative that is focused on supporting Trust's to reduce out of area placements.

1.4 Sickness Absence

Staff attendance remains a significant challenge to the Trust with an annual sickness absence rate of 6.6%.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Sickness Absence	4.7%	4.8%	5.3%	6.6%	6.5%	6.3%	7.4%	7.0%	6.6%
Business Improvement + Transformation	2.3%	0.9%	0.0%	5.8%	8.5%	1.4%	0.0%	0.4%	0.0%
Corporate Central	0.4%	0.0%	0.2%	0.4%	5.0%	3.9%	0.5%	3.7%	1.5%
Estates + Facilities	4.6%	4.4%	5.0%	5.8%	5.9%	6.2%	8.1%	6.9%	6.9%
Finance Services	3.0%	0.6%	0.7%	0.2%	1.1%	1.5%	2.8%	2.2%	4.9%
Med Education & CRD	1.8%	0.6%	0.5%	1.0%	0.6%	0.4%	2.9%	0.2%	0.8%
Nursing + Quality	6.8%	6.6%	6.5%	7.4%	9.2%	8.0%	12.4%	11.1%	7.3%
IT, Information Management + Patient Records	2.7%	3.2%	2.7%	1.2%	1.9%	3.0%	7.8%	5.0%	2.0%
Ops Management	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	8.4%	15.8%
Pharmacy	2.7%	0.1%	4.5%	5.6%	2.3%	2.3%	2.6%	2.9%	1.0%
People Services	24.0%	21.9%	N/A	N/A	N/A	N/A	0.0%	0.0%	0.0%
Campus	6.5%	7.6%	8.2%	11.1%	10.5%	9.5%	10.2%	8.4%	8.8%
Central Services	3.6%	3.9%	4.5%	4.4%	4.3%	3.8%	5.3%	6.0%	5.0%
Children's Services	3.3%	4.1%	3.9%	4.3%	4.9%	5.4%	7.2%	6.5%	6.5%
Clinical Serv Management	4.4%	0.3%	2.8%	3.2%	3.1%	1.9%	1.2%	1.7%	0.3%
Neighbourhood	5.2%	3.9%	4.7%	6.1%	5.8%	6.3%	6.7%	7.7%	6.7%

1.5 Appraisals

There has been a slight increase in appraisal completion, now running at 74.5% against a target of 90%.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Appraisal Completion	79.5%	79.1%	79.3%	79.5%	77.5%	74.6%	73.2%	73.4%	74.5%
Business Improvement + Transformation	63.6%	63.6%	45.5%	16.7%	16.7%	18.2%	18.2%	27.3%	36.4%
Corporate Central	40.0%	41.4%	36.7%	33.3%	36.7%	31.0%	16.7%	13.3%	27.6%
Estates + Facilities	86.2%	88.4%	90.7%	90.8%	80.5%	83.5%	84.7%	76.8%	75.6%
Finance Services	82.6%	72.7%	100.0%	95.5%	90.9%	100.0%	95.5%	95.5%	90.9%
Med Education & CRD	60.7%	60.7%	53.6%	50.0%	50.0%	34.5%	28.1%	25.0%	31.3%
Nursing + Quality	69.8%	63.5%	61.8%	66.0%	64.8%	61.5%	43.4%	43.4%	46.3%
IT, Information Management + Patient Records	97.1%	94.9%	92.3%	97.5%	95.0%	65.0%	89.7%	90.0%	95.1%
Ops Management	100.0%	100.0%	50.0%	40.0%	60.0%	60.0%	75.0%	80.0%	66.7%
Pharmacy	69.4%	66.7%	80.6%	82.4%	85.7%	72.2%	71.4%	72.7%	81.8%
People Services	100.0%	100.0%	N/A	N/A	100.0%	100.0%	50.0%	33.3%	0.0%
Nursing & Quality	100.0%	100.0%	100.0%	100.0%	N/A	N/A	N/A	N/A	N/A
Campus	85.3%	87.1%	85.7%	84.6%	82.8%	79.2%	73.6%	73.9%	74.6%
Central Services	76.1%	76.7%	76.9%	78.0%	78.1%	80.0%	80.6%	82.4%	83.1%
Children's Services	83.0%	78.1%	79.2%	78.1%	74.9%	72.1%	68.9%	68.9%	68.5%
Clinical Serv Management	56.7%	60.0%	60.0%	62.5%	58.1%	56.7%	54.8%	54.6%	53.1%
Neighbourhood	75.6%	74.8%	75.5%	77.9%	77.0%	71.8%	75.3%	77.2%	79.0%

1.6 Vacancies

The Trust vacancy rate includes funded FTE surplus for flexibility including sickness and annual leave cover and is currently running at 9.53%, a decrease of 3.65% compared to April 2018. During 2017/18 funded FTE vacancies reduced by 3.04%. In April 2018 the Trust funded fte vacancy rate increased significantly, however this was due to budgetary changes from 2017/18 to 2018/19. 2017/18 had a reduced budgeted establishment in relation to planned disinvestments and Cost Improvement Programmes, of which were not delivered to plan. The 2018/19 funded establishment includes new investment for several services.

During the period January 2018 to December 2018 252 employees have left the Trust and 330 people have joined the Trust through external recruitment. 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.

1.7 Training

Compulsory training compliance has increased slightly to 84.4% against a target of 85%. You will be aware of the national issues with the Electronic Staff Record (ESR) during December which prevented staff from completing e-learning, which will have an impact on compliance rates in early January 2019.

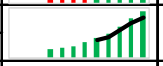
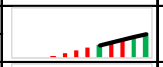
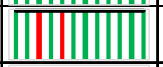
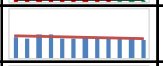
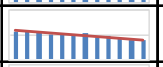
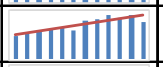
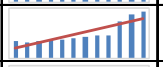
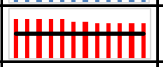
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Compulsory Training	85.8%	85.7%	82.4%	82.6%	82.9%	82.8%	83.3%	83.9%	84.4%
Business Improvement + Transformation	87.4%	93.7%	96.8%	90.3%	93.2%	93.6%	93.6%	93.6%	88.9%
Corporate Central	73.2%	72.7%	69.5%	71.8%	76.2%	76.9%	78.2%	79.6%	78.5%
Estates + Facilities	81.7%	81.9%	80.5%	80.6%	80.5%	77.8%	82.0%	81.9%	82.9%
Finance Services	97.6%	97.5%	98.0%	97.4%	99.5%	98.0%	99.0%	99.0%	97.5%
Med Education & CRD	77.1%	78.6%	77.2%	76.9%	72.5%	76.2%	79.6%	80.7%	80.0%
Nursing + Quality	85.0%	84.9%	82.7%	85.0%	86.6%	87.7%	86.4%	87.8%	86.8%
IT, Information Management + Patient Records	94.6%	97.7%	97.7%	95.2%	96.9%	95.2%	99.5%	98.6%	97.8%
Ops Management	91.7%	91.7%	86.1%	77.8%	77.8%	73.3%	73.5%	76.7%	79.6%
Pharmacy	87.4%	84.6%	77.2%	80.4%	83.5%	84.3%	84.6%	85.5%	89.6%
People Services	88.9%	88.9%	88.9%	66.7%	72.2%	72.2%	72.2%	51.9%	72.2%
Campus	87.3%	86.8%	83.4%	83.2%	82.6%	81.5%	81.5%	82.5%	83.5%
Central Services	86.0%	87.3%	83.3%	83.8%	84.2%	85.6%	85.8%	86.3%	86.2%
Children's Services	85.2%	83.3%	80.4%	80.3%	81.4%	82.2%	81.6%	82.3%	82.7%
Clinical Serv Management	68.0%	68.3%	61.2%	64.3%	66.4%	67.1%	70.5%	72.0%	74.0%
Neighbourhood	86.7%	86.9%	83.0%	83.8%	84.1%	83.8%	84.2%	85.0%	85.2%
Operations Support	96.3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

The table below provides Board members with an overview of key actions being undertaken to lower sickness absence rates and vacancies and improve rates of training and appraisals:

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

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

2. Strategy Delivery

Category	Metric	Period	Target	Actual	Variance	Trend	Last 12 Months	DQ
Finance Scorecard	Finance Scorecard	YTD	1	1	G	→		
		Forecast	1	1	G	→		
	Control Total position £000	YTD	1583	1841	G	↑		
		Forecast	2331	2331	G	↓		
	CIP achievement £m	YTD	3.609	3.366	R	↑		
		Forecast	4.871	4.584	R	↓		
		Recurrent	4.871	1.466	R	→		
	Agency £m	YTD	2.277	2.191	G	↑		
		Forecast	3.030	2.938	G	↓		
	Cash £m	YTD	23.015	27.997	G	↑		
		Forecast	21.608	22.915	G	→		
Quality and Operations Scorecard	RTT Incomplete Within 18 Weeks (%)	Dec, 2018	92%	92.1%	G	↓		
		Nov, 2018		94.4%	G			
	CPA Review in last 12 Months (on CPA > 12 Months)	Dec, 2018	95%	96.1%	G	→		
		Nov, 2018		96.0%	G			
	Delayed Transfers of Care (%)	Dec, 2018	0.8%	0.40%	G	→		
		Nov, 2018		0.29%	G			
	North Neighbourhood Average Wait (weeks)	Dec, 2018		7.4		↓		
		Nov, 2018		8.2				
	North Neighbourhood Current Waits (number)	Dec, 2018		1811		↑		
		Nov, 2018		1795				
	City Neighbourhood Average Wait (weeks)	Dec, 2018		8.3		↑		
		Nov, 2018		7.9				
	City Neighbourhood Current Waits (number)	Dec, 2018		1380		↓		
		Nov, 2018		1438				
	South Neighbourhood Average Wait (weeks)	Dec, 2018		9.3		↓		
		Nov, 2018		11.1				
	South Neighbourhood Current Waits (number)	Dec, 2018		1811		↑		
		Nov, 2018		1786				
	CAMHS Average Wait (weeks)	Dec, 2018		5.4		↑		
		Nov, 2018		5.1				
	CAMHS Current Waits (number)	Dec, 2018		927		↑		
		Nov, 2018		866				
	Community Paediatrics Average Wait (weeks)	Dec, 2018		20.4		↓		
		Nov, 2018		20.7				
	Community Paediatrics Current Waits (number)	Dec, 2018		760		↓		
		Nov, 2018		781				
	Number of Adult Acute Inpatients (Hartington and Radbourne) LoS > 50 Days	Dec, 2018		59		↓		
		Nov, 2018		67				
	Health Visiting 0-19 Caseload (based on 50.8 WTE)	Dec, 2018	250	348.41	R	↑		
		Nov, 2018		347.38	R			
Workforce and Engagement Scorecard	RETAIN - Staff engagement score	2017 Annual	To see an improvement in the staff engagement score	3.740	G	↑		
		2016 Annual		3.690				
		Q2 Sep 2018		74%	G	→		
		Q1 Jun 2018		74%				
	DEVELOP - Recruitment of preceptorship staff	2017/18	Number of students recruited into preceptorship	31	R	↓		
		2016/17		46				
	ATTRACT - Retention of preceptorship staff	2017 Annual	Number of students recruited into preceptorship who stay for at least one year	91%	G	→		
		2016 Annual		91%				
	LEADERSHIP & MANAGEMENT - Employee relations cases	Q3 Dec 2018	To see a reduction in the number of cases	34	G	→		
		Q2 Sep 2018		34	G			
		Q1 Jun 2018		40	G			
		Q4 Mar 2018		48				

Key:

Period Month / Previous Month

Achieving target / Not achieving target / No Target Set

Target / Trend

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

2.1 Control Total position

The surplus in the month of £285k was £59k above plan, so the year to date favourable variance has increased to £258k. The forecast remains to achieve the control total at the end of the financial year. We currently anticipate that in order to do so we will need to use all 'reserves'.

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

2.2 Cost Improvement Programme (CIP)

At the end of December £4.4m of CIP has been assured in the ledger with several schemes still to be actioned which are being forecast to deliver a further £165k of savings. This then leaves a gap to delivery of the full plan by £287k. Of the total forecast savings only 32% is to be saved recurrently.

2.3 Neighbourhood Waiting List

The number of referrals received has been steadily increasing over time. This is likely to continue in line with population growth. The recommendations set out below will be taken into the development of the clinical strategy for both working age and older adult community mental health services.

Agreed overarching recommendations:

- Reintroduction of distinct community mental health teams (CMHTs) for adults of working age and CMHTs for older adults and people with Dementia
- Delivery of pathways of care, largely based on care clusters
- Integrate the various community-based psychological therapy offers into CMHTs
- Design a tiered model of care enabling clinicians to work with people in ways that are consistent with their presenting need
- Ensure the Care Programme Approach (CPA) process and associated documentation reflect the tiered model of care and provide a distinguishable difference between CPA and non-CPA offers.
- Define the CMHT offers for diagnosed personality disorder, ADHD and ASD
- Establish service user co-production of services
- Define and Standardise the referral, triage, allocation and assessment function within CMHTs, identifying issues for prioritisation
- Confirm outcome measures to be utilised
- Establish the CMHT structure within PARIS and DATIX
- Define the core recovery and wellbeing offer
- Recruit and/or train Non-Medical Prescribers

2.4 CAMHS Waiting List

The CAMHS team and pathway structure has been revised and a significant piece of work has now been completed reassigning all the patients to the new teams. Following on from the pathway revision, work is now in progress to seek to reduce waiting times within the resources available. This includes clearly mapping interventions to specific pathways.

2.5 Paediatric Waiting List

Over the last 2 years there have been numerous discussions with commissioners about whether our service waits should be reported as part of the national 18 week RTT. Following a recent internal review, where it is clear that our service is a consultant led pathway, the Executive Team has decided that we should start to report this service as part of the 18 week RTT standard. This will affect the Trust's 18 weeks RTT performance as there are longer waits in this service. However, as part of the decision to begin to report this, the Trust has formally notified the CCG of our intent and requested that they provide the correct level of funding to support delivery of this standard. We await their response.

More practically, demand is exceeding capacity by 60 referrals per month. This has informed the request submitted to Commissioners to request additional funding to meet this demand and reduce the waiting list to an acceptable level, meeting the national RTT standard.

2.6 Health Visitor Caseloads

Health Visitor Caseloads are persistently high at around 348 children per Health Visitor. The Institute of Health Visiting recommends a maximum caseload of 250. Nationally 44% of health visitors have caseloads in excess of 400 children.

This poses a risk to our teams. A number of actions have been undertaken to seek to minimise this risk. These are;

- A review of the caseloads and staffing in all of the teams to ensure equity where possible
- Benchmarking against guidance as to what constitutes a caseload for a HV, and other organisations
- Over recruitment at band 4 to help alleviate some of the work, which will remain on a HV caseload, but interventions undertaken under the supervision of HV.
- Working with partner organisation Ripplez to review their allocations to ensure equity

Supplementary assurance report – Urgent Care improvements

1. Introduction

This part of the integrated performance report sets out the quality and performance improvements that have been delivered at the Radbourne Unit and across all urgent care services during the last 2 months.

During this time the CQC has undertaken 2 routine MHA (Mental Health Act) review visits. The feedback from these has been acted upon quickly. In addition, NHSI and CCG undertook a quality visit early January 2019.

During December and January there has been greater visibility of senior leaders at the Radbourne Unit to support implementation of key actions. This has proved to be very successful so far, with the steps taken, such as daily assurance processes, remaining in place.

2. Daily assurance of compliance with agreed Clinical Quality standards

Robust daily quality standards monitoring has been implemented across Radbourne and Hartington Units. A list of agreed standards have been reviewed on a daily basis by senior nurses, medics, managers and clinical leads with targeted focus on clinical compliance for Physical Health, Care Planning and Risk assessments.

This process has given a clear visual picture of hot spots and prompts action to be taken on a daily basis.

The level of compliance since the introduction of this process and reporting framework has improved. This process is now embedded and is delivered via the daily call that includes colleagues from across the Trust.

Care planning continues to form part of the daily monitoring reports, with focus on co-production and ensuring patients have copies of all their care plans where agreed. Targeted work on the quality of care planning will be rolled out to preceptorships to ensure newly qualified staff are aware of the standards required from when they commence their mental health nursing careers. This work has already commenced on ward 36 at the Radbourne Unit led by the Deputy Head of nursing.

In addition to compliance with quality standards, the daily assurance process also reviews safe staffing levels, training, supervision, recruitment and any estates issues.

3. Estates

A number of estates related issues have been identified in recent external inspections. A review of these issues, alongside a review of outstanding estates jobs at the acute units has been undertaken. As a result of this review, over 90% of all jobs (small and large) have been addressed, with agreed timeframes for all other jobs.

Two specific issues that have required further discussion have been ward blind spots and a temporary staff/patient safety solution until the nurse call system is fitted. In response to the issue of blind spots, it has been agreed that CCTV will be fitted across all wards. This order has been placed. Regarding a temporary nurse call solution, it has been agreed that a number of temporary alarms will be fitted that can be used by patients or staff. These will be fitted across all wards until the main system is fitted.

4. Staffing and Recruitment

Staffing remains one of the biggest issues across both acute and CRHT services. Through the daily assurance process it is very clear that providing the required number of staff each day to meet establishment and patient acuity levels is extremely challenging. This is driven by the number of vacancies and sickness levels. This in turn is compromising the ability of staff to undertake training and supervision in line with Trust policy. As things stand it isn't possible to meet policy so further discussions are required in order to mitigate the impact of this.

The acute wards have a high number of newly qualified staff and balancing the number of experienced and less experienced staff on a day to day basis is a key role of both daily assurance and the daily morning huddle. Safe staffing is quite often dependant on moving staff across wards every day to ensure cover for gaps and to balance experienced support for newly qualified staff.

5. CQC Actions – Acute and Crisis Resolution and Home Treatment (CRHT) services

Targeted work to deliver all CQC actions across urgent care continues. The table below provides the current status of each action across both acute and CRHT. Board members will note that a significant number of actions have been completed already.

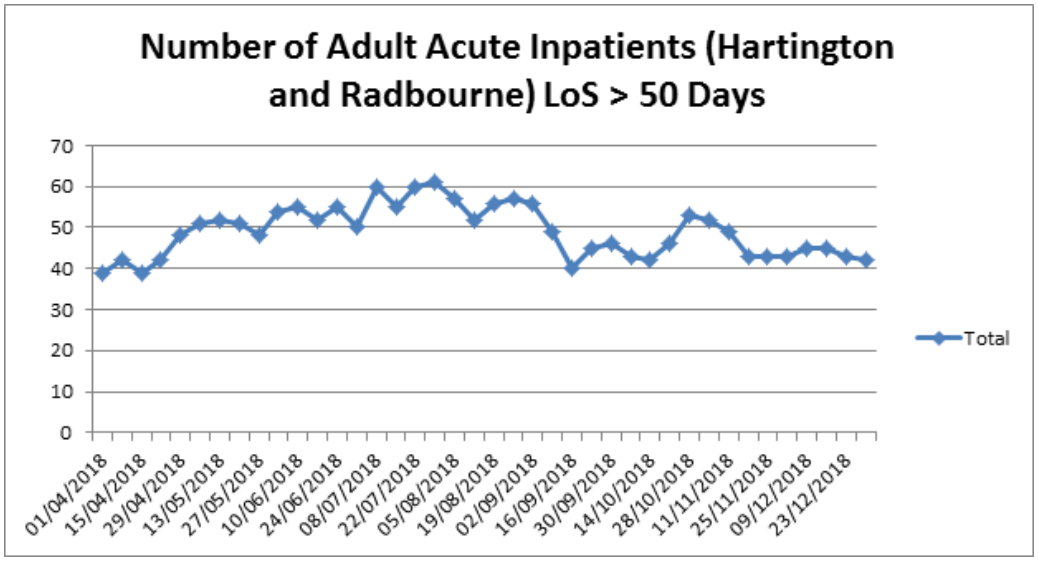
CAMPUS	TOTAL NO CQC ACTIONS – 59			
Service	**Number of Actions**	**Number of Actions in Progress**	**Complete Actions**	**Outstanding Actions**
Adult Acute	33	2	28	**5**
Crisis / HBPOS	15	0	11	**4**
Radbourne Unit	11	3	8	**3**

6. Urgent Care Key Performance Indicators

Clinical work continues to ensure length of hospital stay is for the right duration. Current numbers of patients with length of stay (LOS) 50+ days = 58 patients across Radbourne and Hartington. There is targeted work in place to focus on further reductions via Red2green and complex case reviews. A result of this has also been a reduction in the number of out or area placements.

The introduction of a new way of working introduced in the Crisis teams from 1 December 2018 focusing on purpose of admission, robust gatekeeping assessments and home treatment is anticipated to contribute to the reduction of hospital LOS. The crisis team will regularly attend clinical meetings across both units. Inpatient MDTs (Multi-Disciplinary Teams) can now make referrals for Home treatment for patients who are assessed as suitable for early discharge and home treatment.

The image below shows Current position on LOS.



7. Royal College of Psychiatry Inpatient Standards

We have introduced the Royal College Standards for Inpatient care to provide a framework for staff to base their practice on. This work is ongoing and staff are engaging well. Both units are now working on the same standards and Standards Champions have now been recruited to support implementation and sustain the improvements to care delivery.

The Practice Facilitators across both Units are also working with staff on the front line to embed the standards and their work will form part of the sustainability plan once we have joined AIMS (Accreditation for Inpatient Mental Health Services).

The following work has taken place as part of the standards implementation.

The following work has been undertaken to ensure we are meeting the required standards

- Operational Policy for Radbourne updated to include implementation of the standards.
- Portal to collect evidence has been created and being tested
- Champions identified for Radbourne and Hartington Units
- Recruitment of clinical Psychologists
- Recruitment of recreation workers at the Radbourne Unit
- Updating of the patients' information booklets across Radbourne and Hartington,
- Development of an Admission Checklist across Radbourne and Hartington,
- Review of the Observation Policy
- We made sure that the clinical audits mirror the standards requirements
- Workshop took place for Newly Qualified staff – revisiting in April to focus on care planning standards

8. NHSI and CCG quality visit to the Radbourne Unit

This quality visit was requested by NHSI and took place early January 2019. Overall, the visit went well. A follow on from this visit will take place in March. This was confirmed with NHSI at the Trust's last Performance Review meeting on 24 January.

Data Quality Kite Mark

Background

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

Approach

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

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

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

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

KPI Data Quality Reviews

A review will be undertaken every 6 months of 5 to 10 indicators to review their compliance with the defined indicators of quality. This will be done to complement any reviews undertaken by internal or external audit. The results will be shared with the Finance and Performance Committee together with any remedial action required.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 February 2019

Safe Staffing and Strategic workforce challenges
Supplementary report to the Integrated Performance Report

Purpose of Report

It is recognised that the arrangements around safe staffing levels and reducing agency spend are very challenging with the most efficient way to address these being through recruitment, filling of vacancies and planning ahead. However, it is widely acknowledged that recruitment in the NHS is extremely challenging with circa 100,000 vacancies at any one time.

The purpose of this report is to use available staffing information and information about national policy to enable the Board of Directors to engage in a discussion, both operational and strategic, about current and future workforce challenges.

Executive Summary

This report provides the Board of Directors with various strands of staffing information to support a deep dive discussion on safe staffing, recruitment and bank and agency use.

In addition, there are a small number of policy slides that have been included to provide a wider context to help ensure that discussions about 'today' are translated into action for the 'future'.

From the staffing information provided in this report the following can be summarised;

1. Areas where the Trust has made improvements or performs comparably well;

- The average time to recruit has reduced to 66 days
- Overall Trust wide vacancy rate is good
- Overall Trust bank fill rates are good
- Agency spend has reduced considerably over two years and is forecast to be under NHSI ceiling in 2018/19

2. Areas where further action continues to be taken to address ongoing risks;

- Staffing hotspots continue to be mainly in Inpatient areas for both registered and non-registered staff
- Vacancies across urgent care services remain higher than we would wish them to be
- Nurse and HCA Healthcare bank fill rates remain lower than target in a number of inpatient areas
- Medical recruitment has not improved with continued agency spend on medical locums
- Medical staffing risk areas remain the same – Working age Community

Mental Health, adult inpatient, CAMHS (Child and Adolescent Mental Health Services) and Paediatrics

- Due to their size some services are prone to having single points of failure, which in turn create safe staffing risks – e.g. eating disorders

On the whole, steady progress has taken place, with sustained effort still required in hotspot areas to ensure that 'today' we remain safe.

However, there is a need for the Board of Directors to take the current staffing position and begin to decide how this translates into a wider strategic workforce plan informed by the NHS Long Term Plan and aligned to developing clinical strategies and system wide working.

A small number of summary slides have been provided in order to stimulate this discussion.

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

Assurance

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

Consultation

This paper has not been considered elsewhere, however some content supporting the overview presented is regularly provided to various Committees.

Some slides have been taken from a strategic workforce planning day that the Trust held on 30 January 2019.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

The author has a responsibility to consider the equality impact and evidence on the nine protected characteristics (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation).	
There are no adverse effects on people with protected characteristics (REGARDS).	
There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.	X
Actions to Mitigate/Minimise Identified Risks	
This report reflects performance related to our whole staff and service receiver population and therefore includes members of those populations with protected characteristics in the REGARDS groups. Any specific impact on members of the REGARDS groups is described in the report itself.	

Recommendations

The Board of Directors is requested to use this information to;

1) Triangulate information contained within this report with other information from the IPR and Committee reports to seek assurance on safe staffing and any actions being taken to mitigate risks
2) Note the key areas of concern set out in the report – identified as hotspots
3) Discuss and agree action from this deep dive to influence and / or inform the Trust's strategic workforce plan

Report presented by:

Mark Powell
Chief Operating Officer

John Sykes
Medical Director

Amanda Rawlings
Director of People and Organisational Effectiveness

Carolyn Green
Director of Nursing and Patient Experience

Derbyshire Healthcare
NHS Foundation Trust

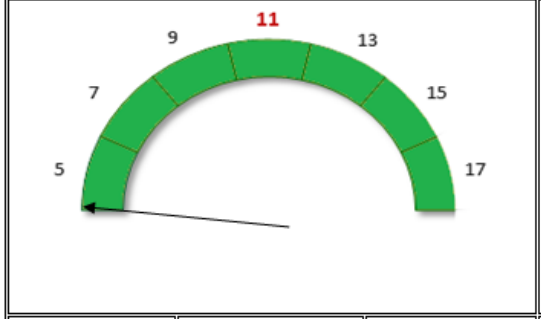
Current Staffing Position

Section 1 – Recruitment and Vacancy
Section 2 – Trust Bank
Section 3 – Agency

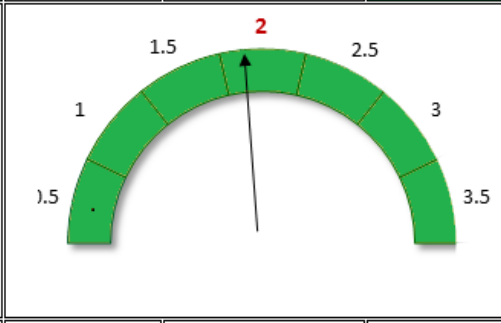
Making a positive difference

Section 1 – Recruitment and Vacancy time to recruit KPI
Trust wide vacancy position Dec 17 v Dec 18
Hotspots

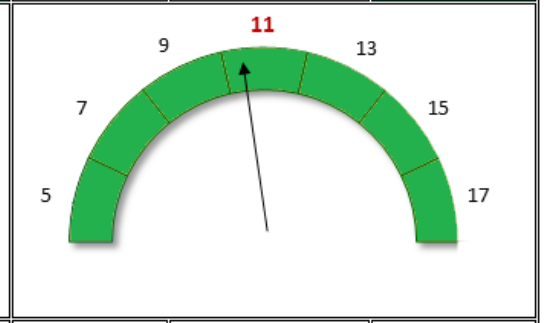
Authorisation start to final approval (T1a)	TARGET	ACTUAL
	10 working days	2.5



Approved to advertised (T1b)	TARGET	ACTUAL
	2 working days (PR)	1.9

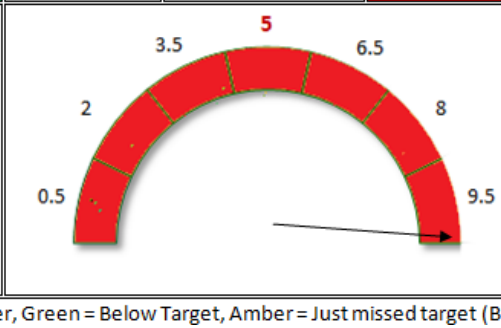


Vacancy is live on NHS Jobs/TRAC (T3)	TARGET	ACTUAL
	11 working days (PR)	10.8

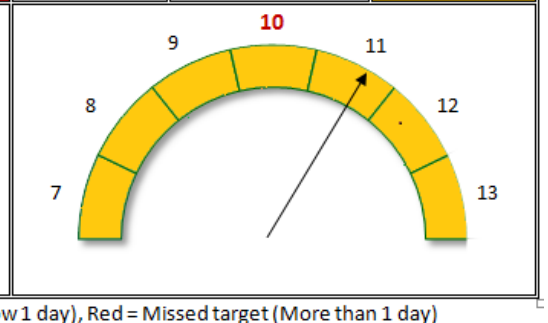


Applications forwarded to AO (T3a)	TARGET	ACTUAL
	2 working days after CD (PR)	1.7

Time to shortlist (T4)	TARGET	ACTUAL
	5 Working days after details are sent to AO (AO)	10.1

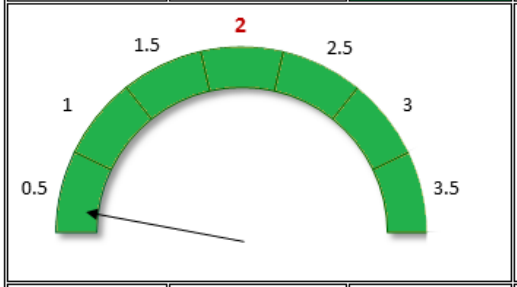


Notification given for Interview (T5a)	TARGET	ACTUAL
	Minimum of 10 working days after shortlisting has been returned (AO)	11.1

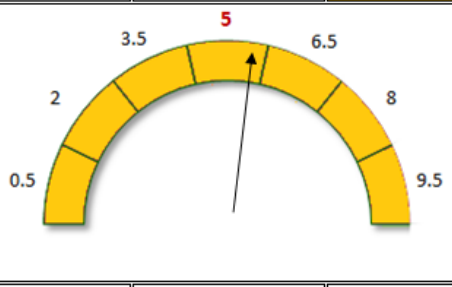


KEY: PR = People Resource Team, AO = Appointing Officer, Green = Below Target, Amber = Just missed target (Below 1 day), Red = Missed target (More than 1 day)

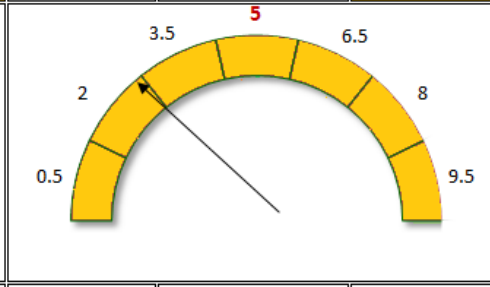
Interview invites sent out (T5)	TARGET	ACTUAL
	Maximum of 2 working days after details are returned. (PR)	0.4



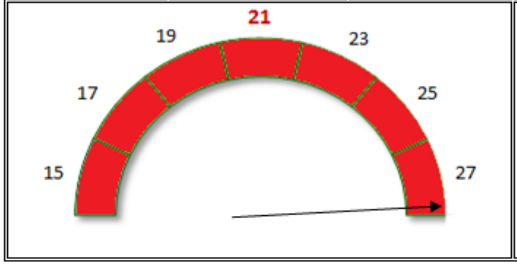
Outcome of the interviews notified to PRT (T5b)	TARGET	ACTUAL
	Maximum of 5 working days after the interview. (AO)	5.3



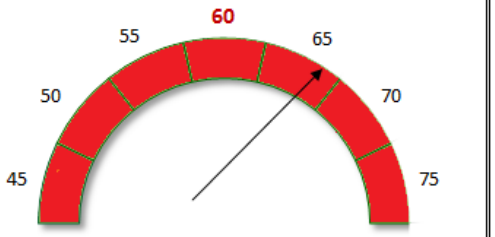
Offer sent to successful candidate(s) with request for pre-employment checks / regret letters sent (T6)	TARGET	ACTUAL
	Maximum of 2 working days (PR)	2.6



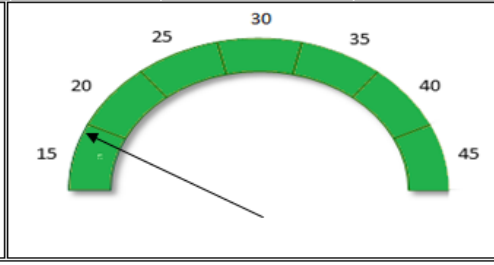
Pre-employment checks completed from date of offer being made (T15)	TARGET	ACTUAL
	Maximum of 21 working days. (PR)	33.1



Overall Average Length of Process (T14)	TARGET	ACTUAL
	60 working days. (PR)	66.3

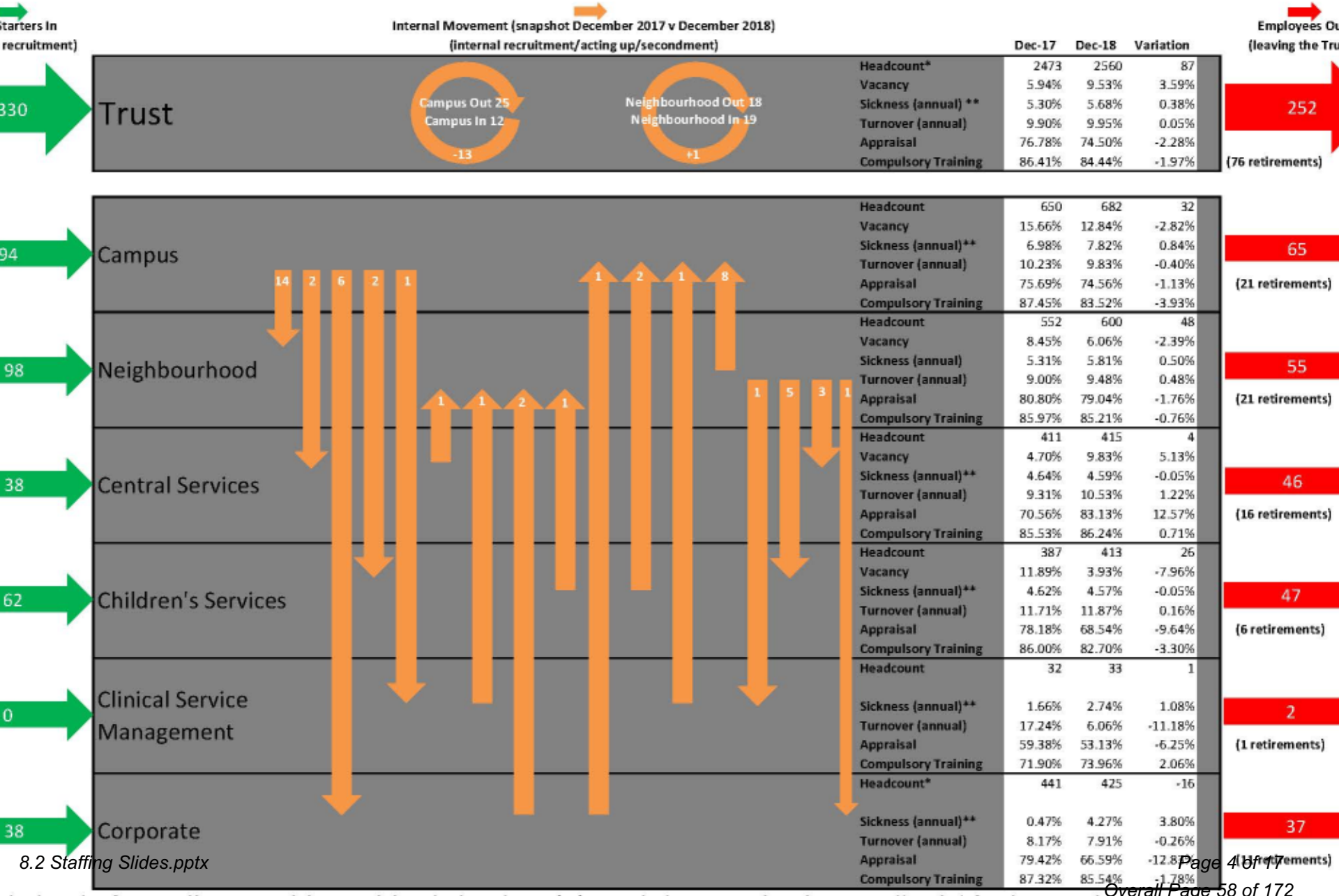


Average Length of time from offer of employment issued to applicant's start date (T16)	TARGET	ACTUAL
	40 working days (most trusts have 8 week notice period)	17.2



People Flow & Metrics

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



that the number of starters and leavers may not balance to variation on headcount due to 31/12/2018 terminations, movement in zero hours posts and 'snapshot' of people movement data.

*December 2017 headcount includes 28 'TUPE out' employees (excluded in the leavers figures)

**Latest available data for the annual sickness absence rate is November 2018

Starters In (recruitment)	Internal Movement (snapshot December 2017 v December 2018) - Campus Focus				Dec-17	Dec-18	Variation	Employees Ou (leaving the Tru
21	**Assessment Services Campus**	In 10: CAMHS 1; City Neighbourhood 1; County North Neighbourhood 1; County South Neighbourhood 1; Hartington Campus 1; Kingsway Campus 1; Radbourne Campus 4	Out 6: CAMHS 1; City Neighbourhood 1; County South Neighbourhood 1; Corporate 3	Headcount	144	152	8	14
				Vacancy	16.43%	13.73%	-2.70%	
				Sickness (annual)**	7.64%	7.19%	-0.45%	
				Turnover (annual)	8.70%	9.72%	1.02%	(5 retirements)
				Appraisal	77.78%	78.95%	1.17%	
				Compulsory Training	83.55%	84.28%	0.73%	
14	**Hartington Campus**	In 3: City Neighbourhood 1; County North Neighbourhood 1; Radbourne Campus 1	Out 5: Assessment Services 1; City Neighbourhood 1; Clinical Serv Management 1; County North Neighbourhood 1; Radbourne Campus 1	Headcount	100	106	6	12
				Vacancy	22.09%	14.74%	-7.35%	
				Sickness (annual)**	6.71%	6.37%	-0.34%	
				Turnover (annual)	15.53%	11.43%	-4.10%	(4 retirements)
				Appraisal	80.00%	69.81%	-10.19%	
				Compulsory Training	86.00%	79.87%	-6.13%	
37	**Kingsway Campus**	In 7: City Neighbourhood 1; County South Neighbourhood 1; Radbourne Campus 5	Out 9: Assessment Services 1; City Neighbourhood 3; County South Neighbourhood 1; Corporate 1; Learning Disability 1; Radbourne Campus 2	Headcount	224	232	8	24
				Vacancy	11.59%	10.95%	-0.64%	
				Sickness (annual)**	6.43%	7.21%	0.78%	
				Turnover (annual)	10.09%	10.62%	0.53%	(10 retirements)
				Appraisal	89.29%	81.03%	-8.26%	
				Compulsory Training	90.60%	87.54%	-3.06%	
22	**Radbourne Campus**	In 7: CAMHS 1; City Neighbourhood 1; Clinical Serv Management 1; Hartington Campus 1; Kingsway Campus 2; Nursing (N+Q) 1	Out 20: Assessment Services 4; CAMHS 1; City Neighbourhood 3; County South Neighbourhood 3; Hartington Campus 1; Corporate 2; Learning Disability 1; Kingsway Campus 5	Headcount	182	680	498	15
				Vacancy	16.11%	13.32%	-2.79%	
				Sickness (annual)**	7.28%	9.93%	2.65%	
				Turnover (annual)	8.52%	8.06%	-0.46%	
				Appraisal	54.95%	65.79%	10.84%	(2 retirements)
				Compulsory Training	87.42%	80.06%	-7.36%	

Liam Carrier - Assistant Head of Systems & Information/Project Ma

Katie Jordan - Workforce Analyst

itiatives to assist recruitment are in place and further developments planned.

uitment fairs
l advertising
k advertising
re and return scheme

- University link working encouraging students to commit to posts on completion of studies
- Enhanced Nurse placement support offered by practice facilitators
- Exploration of recruitment overseas
- Review of advertisements and "attractors"

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

n on the inpatient areas is clearly a key issue.
l scrutiny is being placed on the delivery of supervision and appraisal in those areas of poor performance .
management processes are in place.
n awareness amongst the leadership of the need for cultural change and positive leadership.
Nursing posts have recently been recruited to and an OT lead for Campus is a relatively new post.
rounds are embedded in practice.
gy drop in /consultation session have been established.
ar[illegible] work and the responses to staff survey and pulse checks action planning will further inform local actions.

Staffing hotspots

- Whilst overall the picture for the Trust is very good, there are services across the Trust that continue to operate with high levels of vacancy. In the main the biggest challenges are across both acute and CRHT services.

- Through the daily staffing assurance process it is very clear that providing the required number of staff each day to meet establishment and patient acuity levels is extremely challenging.

- This is driven by the number of vacancies and sickness levels. This in turn is compromising the ability of staff to undertake training and supervision in line with Trust policy. As things stand it isn't possible to meet some policies so further discussions are required in order to mitigate the impact of this.

- The acute wards have a high number of newly qualified staff and balancing the number of experienced and less experienced staff on a day to day basis is a key role of both daily assurance and the daily morning huddle. Safe staffing is quite often dependant on moving staff across wards every day to ensure cover for gaps and to balance experienced support for newly qualified staff.

Radbourne Unit	**Funded WTE**	**Vacancies**	**Sickness absence**	**New staff due to start**
Band 7	5	1	0	1 shortlisting
Band 6	14	8 (+2 OT)	0	3 shortlisting
Band 5 RMN	85	23.24	3.6	9 appointed, 1 starting, 6 awaiting clearance, 3 Sept 19.
Band 5 WBOT	8	2	0	Interviews 17.01.19
Band 4	2	0	0	
HCA	45.8	0	0	6 awaiting clearance
Band 3 Admin	5	0	0	n/a
Band 8a Psychologist				Interviews 11.01.19
Hartington Unit	**Funded WTE**	**Vacancies**	**Sickness absence**	**New staff due to start**
Band 7	3	0	0	
Band 6	8.6	1	0	
Band 5 RMN	43.11	11.04	3.4	2 Sept 19, 1 Feb 19, 2 awaiting clearance
Band 5 MOT	1	0	0	
Band 5 WBOT	6	1	0	
HCA	22.85	18	2	

Section 2 – Trust Bank
Trust wide bank fill rate (monthly)
Inpatient fill rates
Reasons why bank staff are required
Bank and agency costs

Monthly shift fill rate by locality / area

Locality	Filled	Unfilled	Grand Total	Percentage
Admin & Clerical	**294**	**11**	**305**	96.4%
Corporate	5		5	100.0%
Nursing + Quality	7		7	100.0%
Operational Services	261	10	271	96.3%
Ops Support	11		11	100.0%
People Services	10	1	11	90.9%
Ancillary	**303**		**303**	100.0%
Estates and Facilities	303		303	100.0%
OT	**10**	**3**	**13**	76.9%
Operational Services	10	3	13	76.9%
Registered	**469**	**251**	**720**	65.1%
Corporate	17	2	19	89.5%
Operational Services	449	249	698	64.3%
People Services	3		3	100.0%
Unregistered	**1369**	**538**	**1907**	71.8%
Corporate	3	2	5	60.0%
Operational Services	1361	536	1897	71.7%
People Services	5		5	100.0%
Grand Total	**2445**	**803**	**3248**	75.3%

Monthly shift fill rate by skill

Skill	Filled	Un-Filled	Grand Total	Percentage
Admin & Clerical	294	11	305	96.4%
Ancillary	303		303	100.0%
OT	10	3	13	76.9%
Registered	469	251	720	65.1%
Unregistered	1369	538	1907	71.8%
Grand Total	**2445**	**803**	**3248**	75.3%

Inpatient Fill rates

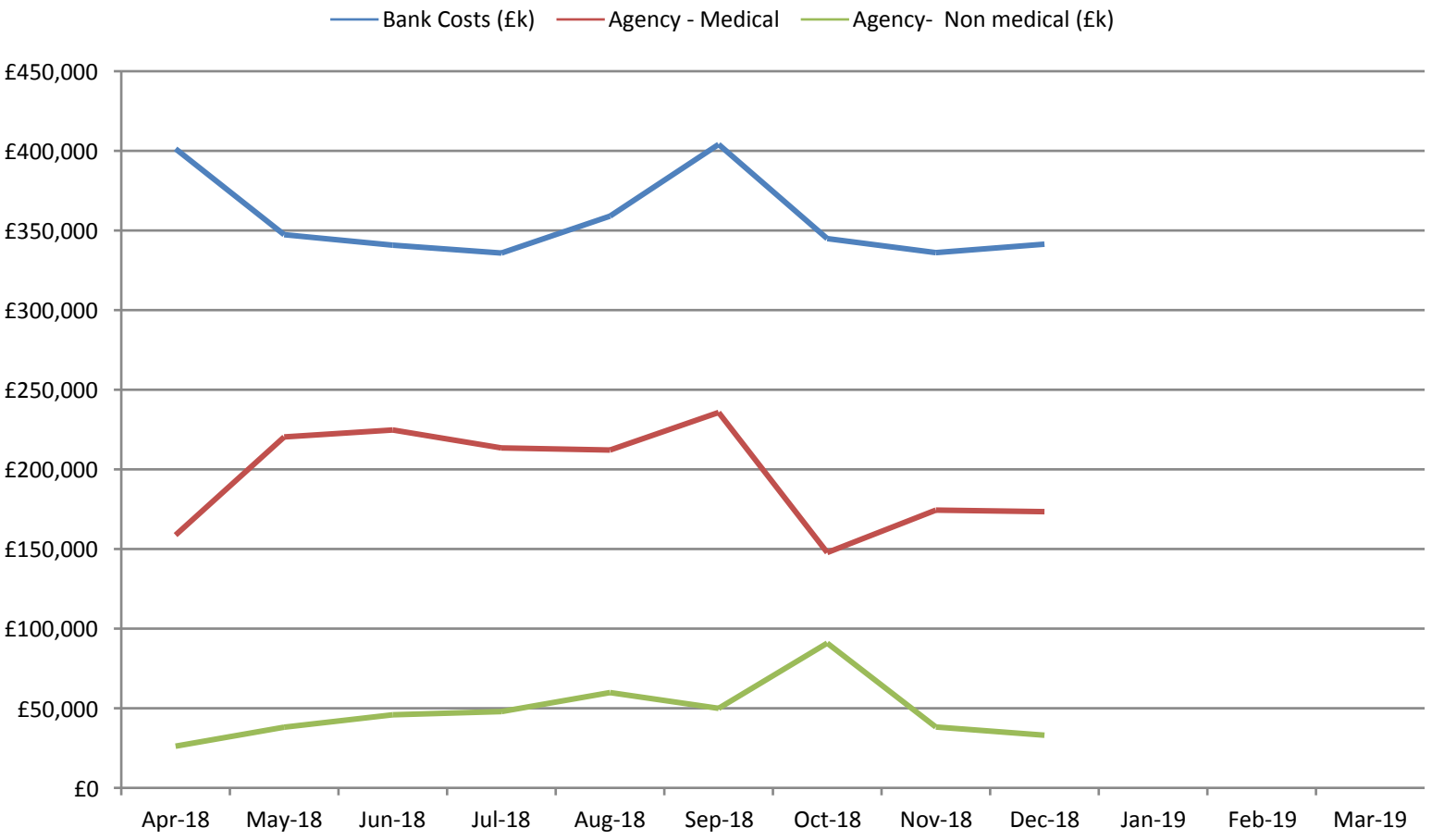
The table below gives an overview of bank shifts by Type and Unit, including fill rate and average request for shift in days (includes all staff groups and rostered units only). This shows that bank fill rates vary quite considerably, with inpatient areas having much lower fill rates than other services.

Unit	Day	Early	Late	Long Day	Night	Filled	Un-Filled	Grand Total	Fill Rate	Notice
383 City & County South CRHT (OSER)	52	12	91		2	105	52	157	66.9%	17.46
Cherry Tree Close		23	42	2	33	81	19	100	81.0%	6.76
County South MH Liaison Team	9					3	6	9	33.3%	6.78
Enhanced Care Ward (IP) (OSER)		44	62	12	96	156	58	214	72.9%	8.11
Hartington Unit Morton Ward Adult 'IP' (OSER)		25	38	15	36	83	31	114	72.8%	31.07
Hartington Unit Pleasley Ward Adult (IP) (OSER)		70	64	8	47	118	71	189	62.4%	33.16
Hartington Unit Tansley Ward Adult (IP) (OSER)	5	52	55	6	49	85	82	167	50.9%	12.69
Kedleston Low Secure Unit (IP) (OSER)	3	41	61	3	23	103	28	131	78.6%	9.12
Kingsway Audrey House		14	20		15	36	13	49	73.5%	5.41
Kingsway Cubley Court OP Female (IP) (OSER)	1	27	25	2	39	58	36	94	61.7%	9.32
Kingsway Cubley Court OP Male (IP) (OSER)		70	101	11	88	181	89	270	67.0%	14.89
LRCH Ward 1 OP 'IP' (OSER)		53	35	8	64	119	41	160	74.4%	25.79
Perinatal Psychiatry (Beeches) (OSER)	9	14	26		26	59	16	75	78.7%	12.19
RDH Ward 33 Adult Acute Inpatient 'IP' (OSER)	2	36	67	6	60	116	55	171	67.8%	23.70
RDH Ward 34 Adult Acute 'IP' (OSER)	3	31	52	10	53	112	37	149	75.2%	28.71
RDH Ward 35 Adult Acute Inpatient 'IP' (OSER)	12	38	51	15	89	141	64	205	68.8%	13.15
RDH Ward 36 Adult Acute Inpatient 'IP' (OSER)		65	79	5	116	178	87	265	67.2%	7.45
Grand Total	**96**	**615**	**869**	**103**	**836**	**1734**	**785**	**2519**	**68.8%**	16.49

Reasons for bank requests

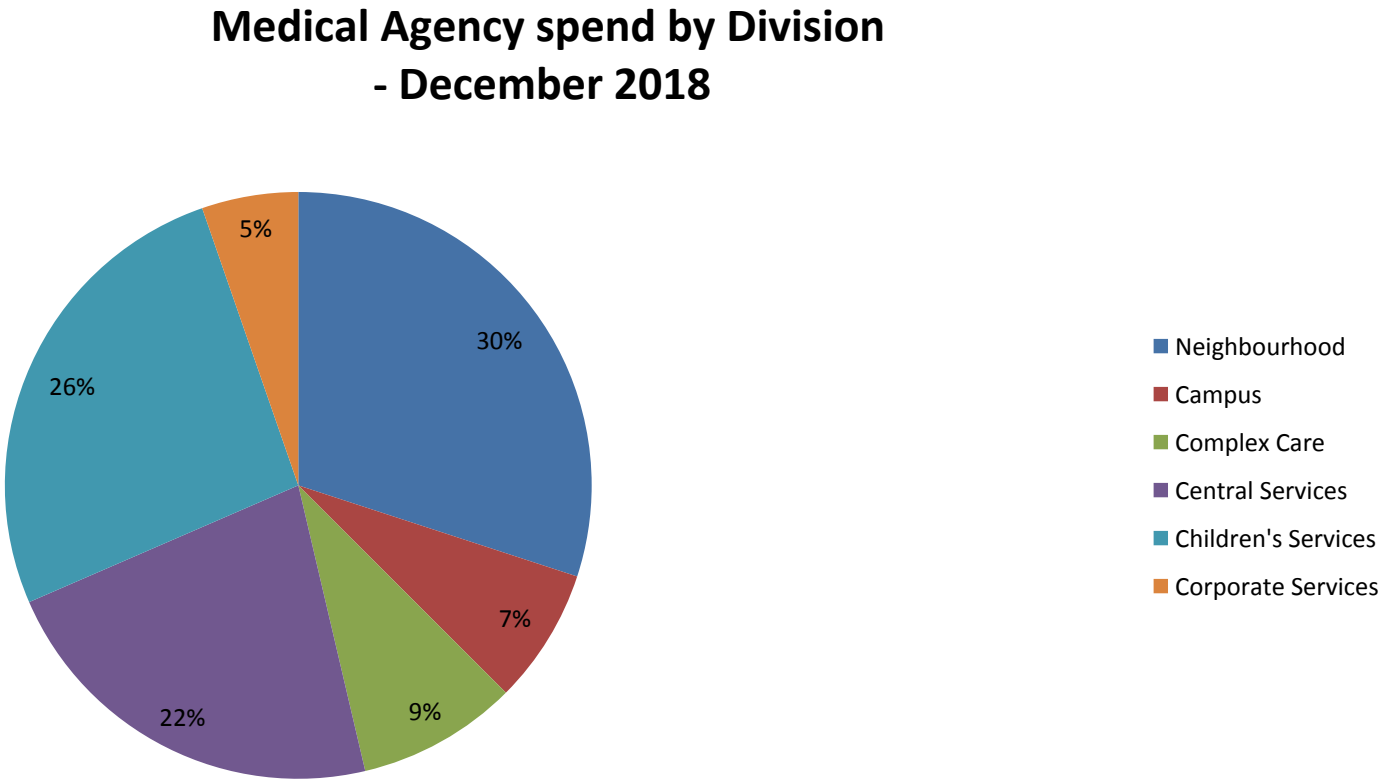
	Activity/ Winter Pressures	Direct Booking	Increased Obs	Maternity Leave	Sickness	Vacancy	Training /Study/In duction	Grand Total
383 City & County South CRHT (OSER)				25	105	27		157
Amber Valley Neighbourhood - Adult (OSER)				12				12
Bleep Hartington		1				4		5
Bleep Kingsway	1	2				1		4
CAMHS Admin				10				10
CfldCentral Neighbourhood - Adult (OSER)				7				7
Cherry Tree Close	19	4	29	2	29	15	2	100
Chesterfield CRHT (OSER)				27				27
County North Mental Health Liaison Team (UPCS)				2				2
County South MH Liaison Team	2				7			9
Dales North Older People CMHT (UPCS)				3				3
Derby City Older People CMHT (UPCS)				14				14
Derby Intgd Fam Health		18		3	2			23
Dist LD Medical (OSER)					15			15
Domestic Dovedale Day Hosp (FAC)				12				12
Domestic DRI Wards (E&F)				11		7		18
Domestic Kingsway (E&F)				36		36		72
Domestic Psychiatric Unit (E&F)				57		60		117
Domestic Ripley Resource (FAC)						19		19
Domestics MH Properties (E&F)				49		16		65
Education Commission Team (WODC)				10				10
Enhanced Care Ward (IP) (OSER)		2	43		29	140		214
Erewash Neighbourhood - Adult (OSER)				7				7
Erewash Neighbourhood - Older Adult (OSER)				13				13
Hartington Unit Admin (OSER)				6				6
Hartington Unit Morton Ward Adult 'IP' (OSER)	6	40	5		6	57		114
Hartington Unit Pleasley Ward Adult (IP) (OSER)	1		1		3	183	1	189
Hartington Unit Tansley Ward Adult (IP) (OSER)	1	41	3		10	112		167
Health & Safety (N&Q)				3				3
High Peak and Dales CRHT (OSER)				7				7
In Reach + Home Treatment OP (OSER)				5				5
Kedleston Low Secure Unit (IP) (OSER)		41			17	73		131
Kingsway Audrey House			11		34	3	1	49
Kingsway Cubley Court OP Female (IP) (OSER)		5	3	2	29	54	1	94
Kingsway Cubley Court OP Male (IP) (OSER)	17	35	36		75	107		270
Locality 1 + 5 (OSER)				13				13
LRCH Ward 1 OP 'IP' (OSER)	82		3	15	9	51		160
MAS (OSER)				7				7
Medical Secs (OSER)	57			11	56			124
MH Advice+Assessment Hub (OSER)				10				10
Operational Support Admin (OSER)						17		17
Paediatrics Admin Team (OSER)				9		7		16
Perinatal Psychiatry (Beeches) (OSER)	1		7	9	4	54		75
Pharmacy (OSUP)				11				11
RDH Ward 33 Adult Acute Inpatient 'IP' (OSER)	1		53		26	86	5	171
RDH Ward 34 Adult Acute 'IP' (OSER)	1	1	7		6	134		149
RDH Ward 35 Adult Acute Inpatient 'IP' (OSER)	50		24		6	125		205
RDH Ward 36 Adult Acute Inpatient 'IP' (OSER)	2		124		34	105		265
Single Post Bank (CORP)		18		11				29
Staffing Solutions (WODC)				9				9
Sth DD Neighbourhood - Adult (OSER)				4				4
The Lighthouse (DH) (OSER)				9				9
Volunteers (N&Q)				4				4
Grand Total	**241**	**208**	**349**	**445**	**502**	**1493**	**10**	**3248**

Bank and Agency Cost



Section 3 – Agency

- Proportion of Medical agency spend by Division
- Bank and agency spend by Division (comparator)



Bank and Agency spend by Division

Bank	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD
Neighbourhood	£12,280	£8,417	£9,791	£4,825	£9,155	10108.44	£19,593	-£3,745	£16,103				£86,527
Campus	£287,100	£243,517	£232,362	£239,366	£255,305	290674.9	£236,610	£241,560	£241,848				£2,268,343
Complex Care	£46,931	£40,081	£41,839	£42,973	£38,571	45090.71	£35,492	£33,214	£31,718				£355,909
Central Services	£27,428	£16,698	£21,608	£16,621	£22,302	24684.02	£22,932	£25,832	£24,776				£202,881
Children's Servic	£19,221	£12,982	£12,951	£12,251	£10,771	9556.78	£9,752	£5,868	£5,881				£99,234
Corporate Servic	£8,319	£25,671	£23,420	£19,804	£22,916	23958.28	£20,528	£33,370	£21,080				£199,065
Total Bank Spenc	**£401,280**	**£347,365**	**£341,971**	**£335,839**	**£359,019**	**£404,073**	**£344,907**	**£336,098**	**£341,407**				**£3,211,959**
Agency Medical	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD
Neighbourhood	£84,217	£95,169	£120,110	£108,741	£125,311	£117,014	£84,395	£74,960	£52,080				£861,997
Campus	£31,444	£65,279	£21,651	£47,543	£25,643	£39,079	£239	£10,260	£12,941				£254,078
Complex Care	£11,495	£8,767	£29,953	£24,904	£19,725	£17,535	£13,149	£17,533	£15,344				£158,405
Central Services	£16,947	£22,069	£27,023	£47,292	£19,150	£31,485	£8,769	£29,783	£38,423				£240,942
Children's Servic	£22,880	£29,514	£24,694	£13,029	£15,650	£29,789	£35,466	£37,181	£45,442				£253,645
Corporate Servic	-£8,234	-£431	£1,304	-£28,045	£6,665	£827	£5,754	£4,696	£9,216				-£8,248
Total Med Agen	**£158,749**	**£220,366**	**£224,734**	**£213,464**	**£212,144**	**£235,728**	**£147,772**	**£174,414**	**£173,447**				**£1,760,819**
Agency Non Med	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD
Neighbourhood	-£5,938	£11,263	£19,636	£19,262	£11,435	£6,596	£44,908	£22,632	£18,786				£148,580
Campus	£28,444	£21,174	£17,174	£8,940	£12,863	-£1,432	£38,400	-£768	£884				£125,680
Complex Care	£0	£0	£0	£0	£0	£0	£0	£0	£0				£0
Central Services	£0	£0	£0	£0	£568	£0	£0	£0	£0				£568
Children's Servic	£0	£3,240	£3,325	£2,299	£3,305	£156	£4,439	£2,296	£2,571				£21,630
Corporate Servic	£3,684	£2,442	£5,763	£17,415	£31,668	£44,624	£3,140	£14,069	£10,837				£133,642
Total Non med	**£26,189**	**£38,119**	**£45,898**	**£47,916**	**£59,839**	**£49,944**	**£90,887**	**£38,228**	**£33,079**				**£430,100**
Total bank and A	**£586,218**	**£605,851**	**£612,602**	**£597,220**	**£631,002**	**£689,746**	**£583,566**	**£548,741**	**£547,933**				**£5,402,878**

What does this all mean?

Strategic Workforce planning and opportunities

NHS Long Term Plan

NHS LONG TERM PLAN
JOIN UP AND IMPROVE

- Women's health, inc. mental health, maternity services (ante and post-natal), and children's services, inc. mental health and childhood obesity.
- Prevention and early diagnosis for cancer, heart attacks, strokes, depression and anxiety, and dementia.
- Community-based physical and mental care for patients with severe mental illness, autism and learning disabilities.
- Home-based care delivery, including rapid community response teams, for older people and their carers so they can live independently for longer, and underpin with personal budgets.
- Support for people living in care homes.

NHS LONG TERM PLAN
AGENCIES AND TIMESCALES

- **Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs)** are groups of local NHS organisations working with local councils and other partners to develop and implement local strategies to deliver the Plan.

Mental Health Workforce Transformation Projects - Regional

- Physical Health Competences for staff working in MH & LD settings
- Optimal staffing project
- MH awareness training
- New ways of working in MH pharmacy
- Core 24/Crisis response
- Development of integrated teams (place based care – physical and mental health staff working as part of MDTs)
- IAPT workforce models

National MH Projects (NW Skills Development Unit)

- Developing good practice in developing new workforce roles
- Enhancing the management of psychological stress and promoting systemic resilience
- Primary care mental health – understanding skills and the current training offer
- Supporting promotion of MH careers and developing psychology graduate career pathways
- Developing an NHS framework for harmful sexual behaviours in children
- Improving system leadership in children and young people's Learning Difficulty Services

National Approach to New Roles in MH

- Focus on roles to support new service models
- High level themes
  - Escalating the spread and adoption in MH
  - Maximising the potential of the workforce
  - Addressing shortage of supply
- Shared across 195 projects

Roles

- Nursing associates
- Psychological Therapies (including IAPT)
- Pharmacy
- Peer Support Workers
- Physician Associates
- Allied Health Professionals
- Nursing
- Social Workers

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 February 2019

Deep Dive - Quality Improvement Strategy and Continuous Improvement

Purpose of Report

To provide assurance on the work being undertaken in the Trust to implement its Quality Improvement Strategy and on the wider work to encourage a culture of continuous quality improvement across all teams and services.

Executive Summary

The paper outlines the approach agreed by the Trust in setting out its objectives for Quality Improvement and the use of Continuous Improvement methodologies. It provides examples of how continuous improvement has been put into practice since the strategy was agreed and how it has been implemented into business as usual processes. It summarises how Continuous Improvement methodologies have been at the heart of new approaches to Business and Operational Planning, identification of cost savings plans and the future development of Clinically-led Strategies. The paper also outlines the potential difficulties in balancing the need for urgent service improvements with long-term objectives and in identifying specific CIP plans from wider ranging improvement programmes.

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

Assurances

That the Trust Quality Improvement Strategic Objectives are being implemented through the Trust's approach to Continuous Improvement as outlined in the examples provided in the report.

Consultation

The report has been considered by the Executive Leadership Team (ELT)

Governance or Legal Issues

None

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

There is the potential for service improvements to be undertaken in a top-down fashion, where individuals' views are not respected and where individuals do not have the opportunity to influence change or the outcomes of the change. Individuals with protected characteristics are more likely to be impacted detrimentally when services improvements are undertaken in this way as it exacerbates existing power relationships. The objective of the Trust's Quality Improvement Strategy seeks to mitigate against this impact through the adoption of alternative methodologies and approaches.

Recommendations

The Board of Directors is requested to:

1) Note the report.
2) Discuss the potential risks to the delivery of its Quality Improvement Strategy objectives, when there are requirements for urgent service improvement schemes.
3) Consider any further opportunities to support and nurture a culture of continuous improvement in the Trust.
4) Consider the potential implications of failure to identify specific CIP schemes from wider Continuous Improvement Programmes.

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

Quality Improvement Strategy and Continuous Improvement

Summary

The paper outlines the approach agreed by the Trust in setting out its objectives for Quality Improvement and the use of Continuous Improvement methodologies. It provides examples of how continuous improvement has been put into practice since the strategy was agreed and how it has been implemented into business as usual processes. It summarises how Continuous Improvement methodologies have been at the heart of new approaches to Business and Operational Planning, identification of cost savings plans and the future development of Clinically-led Strategies. The paper also outlines the potential difficulties in balancing the need for urgent service improvements with long-term objectives and in identifying specific CIP plans from wider-ranging improvement programmes.

Trust Quality Improvement Strategy

The Trust's Quality Improvement Strategy was agreed in March 2018.

The strategy was developed with the underpinning philosophy of quality improvement resting on an understanding that those directly involved in giving and receiving a service are best placed to improve it, provided they are given the right tools and authority to do so. The strategy and focus of the approach was guided by an on-line questionnaire to staff, service users, carers and members of the public that generated over 170 responses and over 400 comments.

The strategy emphasised the importance of devolved leadership to enable quality improvement and that Trust systems should wrap around leaders to support quality improvement, with the focus on improvement being identified and clinically led within Divisions rather than centrally. The strategy described a number of Quality Improvement methodologies that would be made available to staff to use.

The strategy sought to create the right conditions for front line teams to feel empowered to develop and improve the services that they provide, in partnership with those in receipt of those services. It set objectives around culture, shared leadership, devolved leadership and the need for a shared commitment to a model of Continuous Quality Improvement.

The objectives of the Strategy are:

1. We will develop a culture where people in any role in the Trust feel that their ideas are welcome, considered, and can make a difference
2. Quality Improvement priorities and initiatives will be held at Divisional Level, and overseen through whichever mechanism each Division considers will give them the best chance of success
3. Local clinical leads and operational managers within divisions will feel supported to proceed with quality improvement initiatives, with access to clear quality improvement methodologies and additional support if required via the Project Assurance Board and the Nursing & Quality Team
4. Opportunities to share and showcase developments, either by planned events, social media or other means will be developed and supported, led by those on the front line
5. We will continue to nurture a culture of learning and tolerance in expectation of when initiatives might not go as planned
6. There will be a shared commitment to a model of continuous quality improvement between senior members of staff and front-line practitioners, both clinical and nonclinical.

Development of Quality Improvement Strategy Implementation Plan

In August 2018, the Trust Quality Committee agreed the Strategy Implementation Plan. It outlined how the Strategy would be implemented through the business as usual processes in the Trust.

Divisional COAT agendas have now included quality improvement as have Divisional Performance Review Meetings and Trust Medical Advisory Committee. Quality Improvement has also be built into Trust Wide events, such as the Trust Team Working Conference in September. The new Trust Website and Intranet site will include pages to communicate and encourage Quality Improvement methodologies and examples of good practice.

Continuous Improvement methodologies have influenced the Trusts approach to Business and Operational Planning for 2019/20 and to the identification of spend reduction initiatives in the emerging Cost Improvement Programme for the year ahead.

CQC Expectations on Quality Improvement

The Care Quality Commission publishes Brief Guides as a learning resource to assist inspection teams. The Brief Guide, *Assessing Quality Improvement in a Healthcare Provider*, published in March 2018, includes the following signs to look for in a mature quality improvement approach across an organization. As a comparator, also included in the table are the comments received by the Trust in our most recent inspection.

Signs of a mature quality improvement approach across an organisation	***Comments from most recent inspection***
Quality strategy available on website and intranet that explicitly mentions quality improvement and sets the organisation's quality improvement goals.	A quality strategy that mentions quality improvement.
Quality appears to be the priority at the Board from agenda and minutes, with a specific report on quality that is accessible publicly.	In place
The Board looks at data as time series analysis, and makes decisions based on an understanding of variation	In place
Clear and consistent improvement method for the organisation, and demonstrable across all areas/operations of the organisation.	Lack of a single quality improvement method and language across the organisation.
Presence of a central team dedicated to supporting quality improvement, with expertise in the improvement method and tools.	Presence of a central team that leads the provider's quality improvement approach.
Plan for building improvement skills at all levels of the organisation, with a large proportion of the organisation (and at all levels) having developed improvement skills.	A small proportion of people across the organisation have been trained in quality improvement methods but there remains a lack of learning options aimed at developing quality improvement skills at scale and pace at all levels of the workforce.
Structures in place to oversee quality improvement work, with multiple executive directors involved in regular provider-level overview.	In place
Robust, regular and local support in place across all areas of the organisation to support teams using QI to solve complex quality issues.	Minimal, distant or infrequent support available to teams using QI to solve a quality issue.

Signs of a mature quality improvement approach across an organisation	***Comments from most recent inspection***
Quality improvement work across the organisation demonstrates alignment – projects at team level align with strategic objectives for the organization.	No comments made
Demonstrable use of measurement on a routine basis to monitor progress of QI work against outcomes and ensure sustained improvement.	Evidence of a few teams or projects that have delivered sustainable improvement through the application of quality improvement, but these remain isolated hotspots.
All Executive team and clinical leaders are able to talk about their role in leading quality improvement, supporting teams in their quality improvement work	A small proportion of people across the organisation are able to describe the provider's quality improvement approach, their involvement in it or the difference it has made.
Data are presented as run or control charts, instead of bar graphs, pie charts or RAG rated. Narrative analysis describes system quality and performance using terminology of common cause and special cause variation.	No comments made

With one exception, the Brief Guide outlines the end points where the Quality Improvement Strategy and its Implementation Plan are working towards. The exception is the view that the organisation should select a single quality improvement methodology. To date, the trust has been supporting teams to adopt whichever methodology best fits their way of working and encouraging thinking on this to be driven by the operational teams themselves, rather than a top-down process. The Board may wish to keep this position under review.

Many of the comments made by the CQC are addressed in the Implementation Plan and in the work being undertaken in practice, this year, and in planning for the year ahead.

Continuous Improvement in practice in 2018/19

The Trust has developed a Leadership and Management Training and Development programme, starting in March and April. It will include a module on Continuous Improvement methodologies. Through this programme, aimed at leaders at team, service and divisional levels, the aim is to encourage the objectives of cultural change and to support local initiatives by leaders of every team.

The Transformation Team, under Joe Wileman, have expertise and knowledge of a number of continuous improvement methodologies, with which it can support initiatives by teams.

These include:

Lean management
Microsystem Coaching
Continuous Improvement
Productive ward
Red2Green,
PDSA (Plan, Do, Study, Act) and
SPC (Statistical Process Control)
Capacity and demand
Total Quality Management
Value stream mapping
Releasing time to care
Benchmarking / Carter / NHSI Model Hospital

In addition, resources are available from Research and Development and Public Health in terms of guidance and innovation related to our ongoing programme of work.

The team has been providing support to teams using these tools and techniques over the past year. For example, a community-based consultant and the neighbourhood team in

which they work wanted some specific SPC charts to enable them to assess the impact of some small changes they wanted to make to referral management processes. The Trust IMT&R team provided these reports on a monthly basis, allowing the team to assess the impact and then embed the improvements in their practice, which has reduced waiting times in their locality. The Consultant now plans to share this learning with colleagues through TMAC.

During the year, the Trust's Leadership Teams have had to respond with rapid service improvement initiatives, for instance in response to CQC visits at the Radbourne Unit and to the Cubley Wards. The rapid nature of the service improvements required have often meant that interventions have necessarily been more directive than the longer-term, bottom-up methodologies preferred under Continuous Improvement and prioritised under the Trust's strategy. There was a risk that top-down interventions might be counter-productive to longer-term improvements.

However, in both cases, the medium-term improvement plans for both areas are beginning to adopt approaches in line with the Trust Strategy. The Urgent Care Wards, based on the direct request and leadership of ward clinicians, are now working towards Royal College of Psychiatrists Accreditation Schemes and accessing their Quality Networks. This improvement programme is based in continuous improvement methodologies and the active engagement of teams in delivering identified improvements and quality standards. We are also looking at how we foster a culture of continuous improvement in our response to specific CQC actions more broadly, with a view to sustainability of the improvement approach to acute services beyond the time frame of the additional temporary leadership posts currently in place.

On the Kingsway Site, a technological solution was developed in conjunction with the Trust's IMT&R (Information Management Technology and Records) Team, developing and using an App to support real-time monitoring and recording of patient observations on handheld devices. This was formally piloted as part of a continuous improvement model, with ward based nurses and healthcare assistants contributing to its development. The rapid adoption of this tool in response to the CQC has now been embedded into practice on the Wards and is being rolled out into other units and wards across the Trust. We are continuing to embed a learning and review cycle, to ensure fitness for purpose across all our estate. This will involve further staff consultation and review, to ensure the continuation of a front line voice. In response to further requests from clinicians, the hand-held device is also now being developed to capture some physical healthcare interventions.

Continuous Quality Improvement in Operational and Business Planning for 2019/20

As part of the commitment to embed continuous improvement into how the Trust does business through its usual processes, the Trust has adopted a different approach to its Business and Operational Planning for 2019/20.

Whereas the business planning cycle for 18/19 was focussed on meeting governance and regulatory standards to support Trust compliance for key regulatory frameworks and consolidating performance, the process for 19/20 focuses on ambitions for the future with plans aiming to be more comprehensive and forward looking.

In response to feedback from teams, the plans will be termed "service delivery plans" rather than "business plans" or "plans on a page" in order that they are more engaging to clinical and operational teams. The plans themselves will deliver an overarching vision for the future direction of travel for services, which includes information to inform each division's service improvement and cost improvement plans for the forthcoming year.

Based on the learning from previous planning cycles, a more facilitative approach to the planning cycle has been adopted over the last three months. A suite of tools within an informal workbook has been used in one to one meetings with General Managers and heads

of departments to develop a final service delivery plan summary (previously a 'plan on a page').

The draft plans have been reviewed internally within divisions before the final draft plan is presented at a challenge and confirm, "Market Stall" event, planned for early February. The challenge and confirm event will provide an opportunity for scrutiny of plans, and to ensure that Trust wide supporting strategies align with objectives set within the plans. The Service Delivery Plans will then be finalised for agreement at the April meeting of the Trust Board.

The new approach adopted for the development of operational and service delivery plans supports a number of objectives in the Strategy: the plans are developed and held at a Divisional level and delivery will be overseen through Divisional Performance Review Meetings; local leaders are supported to proceed with plans and initiatives with support from central teams and it uses opportunities to showcase planned developments.

Continuous Improvement Programme and the identification of CIP

A similar approach has been taken to the development of the Trusts plans to reduce expenditure and the Cost Improvement Programme for 2019/20. This has been delivered in conjunction with the Trust Business Planning processes, above. A series of one to one meetings with General Managers and heads of Department is resulting in the identification of schemes and initiatives to improve quality, improve productivity and effectiveness of our staff and identify potential cost reductions. The recent paper received by the Board in November on Use of Resources and the opportunities identified within it, will drive this work.

As a reminder, the ten opportunities identified were:

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

The 2019/20 programme is increasingly informed by a continuous improvement approach, engaging with teams at task level and seeking and assisting with bottom up initiatives to reduce month on month and year on year operational running cost through improved quality, workforce processes and reduced waste. However, a challenge in taking this approach is the ability to identify specific cost-out budget reductions, as required by the Cost Improvement Programme reporting requirements to regulators. Whilst it is good to have a quality improvement and transformation programme that reduces organisational expenditure by an amount year on year as a by-product, the Trust will need to find ways in which these savings are appropriately reported and accounted.

Each of the Divisions and operational areas have been collating their plans in January to add to the schemes identified at an organisational level. This focus on divisional and operational identification of improvements and cost savings that can be attributed to them,

follows the objectives of the Trust's strategy. As with the approach to Business Planning, the plans are developed and held at a Divisional level and delivery will be overseen through Divisional Performance Review Meetings and local leaders are supported to proceed with plans and initiatives with support from the central team.

A potential challenge and risk to this approach will become apparent if this bottom-up process does not deliver the savings at the levels required for the Trust's financial planning purposes. The current indications from the planning processes, are that such a stretch will be required. When additional stretches to savings plans become required, then, as with the urgent service improvement actions noted above, short-term, top-down actions to pull a robust plan together in line with the planning timetable will need to be balanced with the engagement and ownership of the leaders who will be required to deliver the programme, in order that the Trust's Improvement Strategies are maintained.

On 27 March the Trust Chair, Chief Executive, Director of Finance and the Chairs of both Finance and Performance and Audit and Risk Committees, will scrutinise and approve, on behalf of the Trust Board, the 2019/20 Operating plan submission to NHSI.

Development of Clinically-Led Service Strategies

The Trust is launching a series of workshops for each of nine clinical pathways across the Trust's services, with the first sessions on the Older People Mental Health pathway being held on 31 January.

The sessions and the overarching process have been planned with Continuous Improvement methodologies at their heart. Engagement of clinical staff and patients has been embedded into the design and the sessions will deliver clinically led ideas for improvement, big and small, which will form plans for implementation into what will be new clinical models of care.

The design process has required some challenging balances to be made: balancing opportunities for "blue sky" thinking with the constraints of the reality of financial and operational delivery; of the desire for data driven solutions with the need for story-telling and compelling narratives for change.

The end product will be an agreed list of improvement ideas for each pathway and the reasons why the service should change: a strategy. Included within it will be an outline implementation plan of who will deliver the improvements, how and when. The methodology undertaken and designed into the process should mean that these plans are locally held, jointly by clinicians and managers together.

Recommendations

The Board of Directors is requested to:

1) Note the report
2) Discuss the potential risks to the delivery of its Quality Improvement Strategy objectives, when there are requirements for urgent service improvement schemes
3) Consider any further opportunities to support and nurture a culture of continuous improvement in the Trust
4) Consider the potential implications of failure to identify specific CIP schemes from wider Continuous Improvement Programmes.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 February 2019

Learning from Deaths - Mortality Report

Purpose of Report

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

Executive Summary

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - *'National Guidance on Learning from Deaths'*. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

Progress to date includes:

- Since April 2017 the Trust has received 4256 death notifications of patients who have been in contact with our service.
- From 1 April 2017 to 23 November 2018, 348 deaths were reported through the Trust incident reporting system (Datix). Of these, 342 were reviewed through the process of the Untoward Incident Reporting and Investigation Policy and Procedure of which 111 warranted a further investigation. 273 reported incidents were closed by the Serious Incident Group.
- The Trust has recorded 16 inpatient deaths, of all which have been reviewed under the Untoward Incident Reporting and Investigation Policy and Procedure.
- As a way to access a national database for cause of death, our application for NHS Digital continues and the Trust is currently awaiting an outcome. This continues to be a slow process to ensure that the Trust meets all of NHS Digital legal requirements. The Trust's Medical Director has escalated this to the Regional Medical Director, Midlands and East.
- 94 deaths have been reviewed through the Learning from Deaths Procedure
- 342 deaths have been reviewed under the Untoward Incident Reporting Policy and Procedure
- No inpatient deaths were found to be avoidable on review by the Medical Director

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

Challenges include:

- Undertaking a case note review of all deaths as outlined in the national guidance, within available time
- Delay in obtaining cause of death
- The sensitivity of our incident recording system means that the total numbers of deaths are potentially higher than comparable Trusts.

Availability of medic staff has improved following the consultants in the north of the county providing medic cover on a rota basis

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

Assurances

Our approach to ensuring that we're meeting the guidance supports Board Assurance risks. Failure to achieve the clinical quality standards required by our regulators with regards to learning from deaths may lead to harm to service users

This report provides assurance that the Trust is following recommendations outlined in the National Guidance on learning from Deaths – *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*

Consultation

Deputy Director of Nursing and Quality Governance and Medical Director.

Governance or Legal Issues

There are no legal issues arising from this Board report.

The Care Quality Commission Regulations this report provides assurance to are as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting Staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Regulation 20 Duty of Candour

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

The Trust is making an assertive effort to ensure that there is attendance from the multi-disciplinary team to attend Case Note Reviews to ensure quoracy. This is being monitored through the Mortality Review Group and Executive Serious Incident Group

Recommendations

The Board of Directors is requested to accept this Mortality Report as assurance of the Trust's approach and acknowledge that it has been published on the Trust's website together with the papers supporting the 5 February Board meeting agenda.

Report presented by: **John Sykes**
Medical Director

Report prepared by: **Rachel Williams**
Lead Professional for Patient Safety and Patient Experience

Louise Hamilton
Mortality Technician

Learning from Deaths - Mortality Report

1. Background

In line with the CQC's recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths[2]'. The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

The Guidance has outlined specific requirements in relation to reporting requirements. From April 2017, the Trust is required to collect and publish each quarter specified information on deaths. This is through a paper and Board item to a public Board meeting in each quarter, to set out the Trust's policy and approach (by end of Q2) 2017-2018 and publication of the data and learning points by Quarter 3 2017/18. The Trust should include the total number of inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subject to review, we are asked to consider how many of these deaths were judged more likely than not to have been due to problems in care.

The report presents the data so far from April 2017 incorporating new data for the periods September, October and November 2018.

2. Current Position and Progress

- As a way to access a national database for cause of death, our application for NHS Digital continues and the Trust is currently awaiting an outcome .This continues to be a slow process to ensure that the Trust meets all of NHS Digital legal requirements.

- The Mortality Review Group continues to undertake regular case note reviews and there have been improvements in medic availability since the implementation of a rota for attendance from the North consultants.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure.

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

3. Data Summary of all deaths

Month	2017-01-01	2017-02-01	2017-03-01	2017-04-01	2017-05-01	2017-06-01	2017-07-01	2017-08-01	2017-09-01	2017-10-01	2017-11-01	2017-12-01	2018-01-01	2018-02-01	2018-03-01	2018-04-01	2018-05-01	2018-06-01	2018-07-01	2018-08-01	2018-09-01	2018-10-01	2018-11-01
Total Deaths Per Month	285	205	215	182	201	213	173	183	182	169	154	205	231	196	203	165	185	139	183	134	135	189	129
Open inpatient referral deaths	0	0	1	0	2	0	4	0	1	0	1	1	1	3	1	1	0	2	1	1	0	1	0
LD Referral Deaths	2	2	2	1	0	1	2	3	2	0	3	5	4	3	3	2	5	0	5	4	1	5	0
Inpatient deaths	0	0	1	0	1	0	3	0	0	0	1	2	0	2	1	1	0	2	1	0	0	1	0

Correct as at 29 November 2018

Since the publication of the previous report clarification of the number of inpatient deaths has been undertaken .In previous notes the inpatient death figures were in relation to patients who at time of death had an open inpatient referral. The figure that has been reported was higher than the actual number of inpatient deaths.

Since April 2017 the Trust has received 4,256 death notifications of patients who have been in contact with our service. The figure elsewhere in this paper (4,560) is for all deaths from 1 January 2017. Initially, the Trust recorded all deaths of patients who had contact within the last 12 months but this was changed after discussion with Commissioners to contact within the last six months. This took effect from 20 October 2017.

4. Review of Deaths

Total number of Deaths from 1 April 2017 – 23 November 2018 reported on Datix?	348 (of which 257 are reported as "Unexpected deaths")
Number reviewed through the Serious Incident Group	342 (1 was not required to be reviewed by SI (Serious Incident) group as patient not open to service and 5 pending a review).
Number investigated by the Serious Incident Group	111 (232 did not require an investigation and 5 pending for a review)
Number of Serious Incidents closed by the Serious Incident Group?	273 (75 currently opened to SI group, as at 23/11/2018)

The Trust has recorded 16 inpatient deaths, of all which have been reviewed under the Untoward Incident Reporting and Investigation Policy and Procedure.
Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure*;

Any patient open to services within the last six months who has died and meets the following:

- Homicide – perpetrator or victim.
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHCFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family / carer / The Ombudsman, or where staff have raised a significant concern about the quality of care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death

- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not

5. Learning from Deaths Procedure

The Mortality Review Group has currently case reviewed 94 deaths. These reviews were undertaken by a multi-disciplinary team and it established that of the 94 deaths reviewed, 82 have been classed as unavoidable, 10 are on hold pending cause of death and 2 have been referred to the serious incident group.

The Mortality Review Group reviewed deaths of patients who fall under the following 'red flags', up to 31 October 2018:

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

The Mortality Group reviewed the deaths of patients who fall under the following 'red flags' from 1 November 2018:

- Patient referred to services, then assessed and, discharged without referral onto other mental health services (including liaison team)
- Patient diagnosed with a severe mental illness
- Patient only seen as an Outpatient
- Anti-psychotic medication

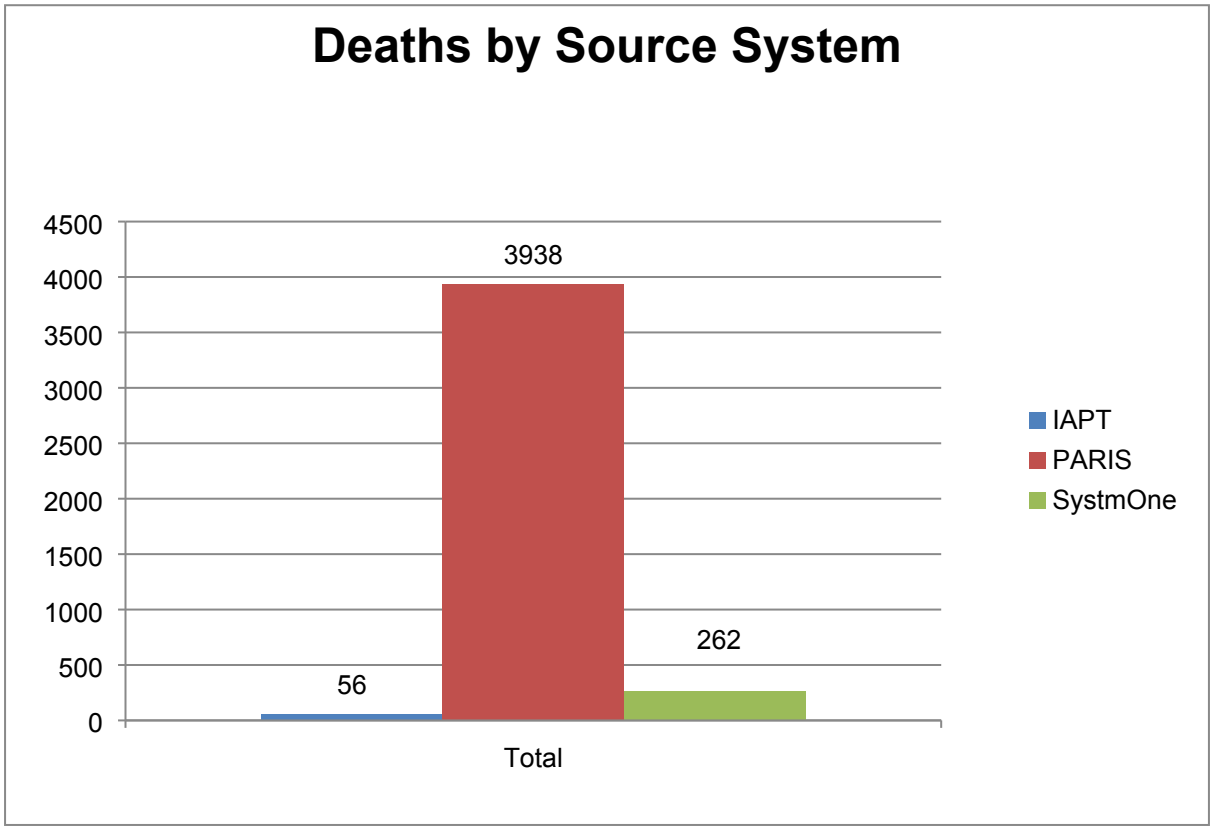
Initial analysis of death notification information shows the most prevalent causes of death are:

- Alzheimer's Dementia/ Vascular Dementia
- Old Age
- Ischaemic Heart Disease

Undertaking Case Note Reviews of deaths remains a challenge due to lack of medical colleague availability. This lack of availability has resulted in a 14 Case Note Review meetings being cancelled.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 January 2017

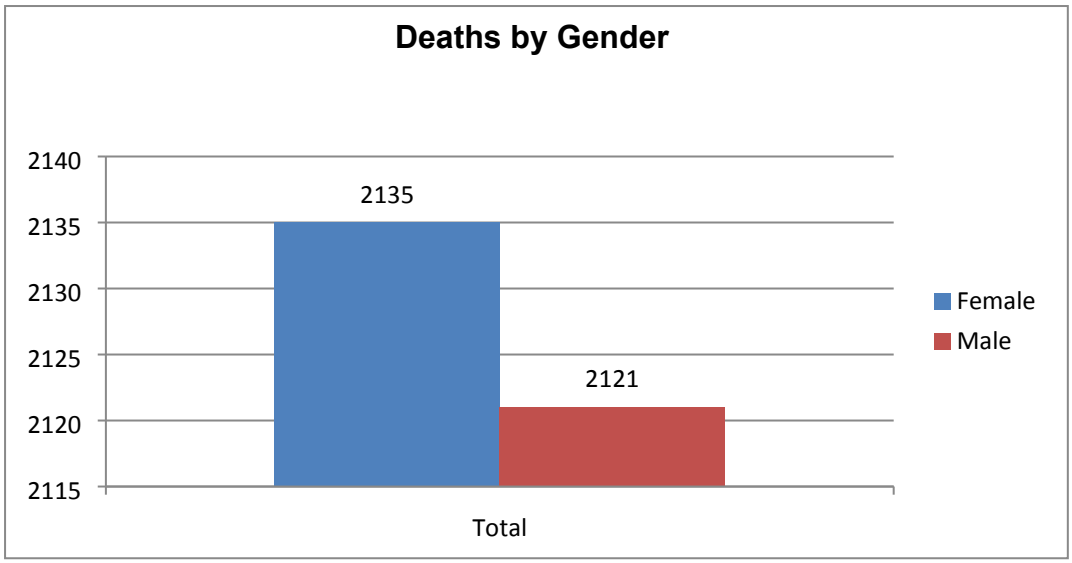


	IAPT	PARIS	SystmOne	Grand Total
Count of Source System	56	3938	262	4256

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS, as we would expect as this clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care. 262 death notifications were pulled from SystmOne and 56 from IAPT.

6.2 Deaths by Gender since 1 January 2017

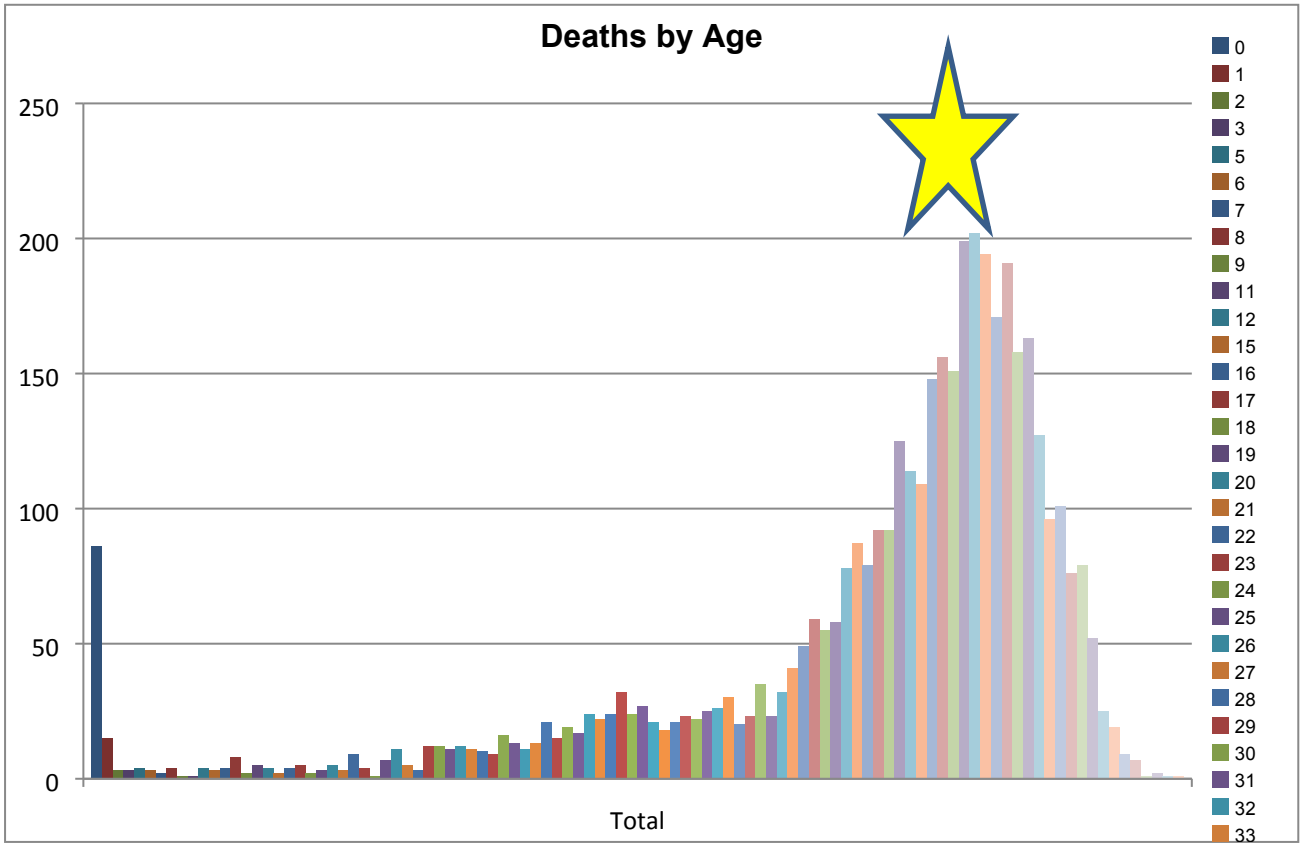
The data below shows the total number of deaths by gender since 1 January 2017. There is very little variation between male and female deaths; 2121 male deaths were reported compared to 2135 female.



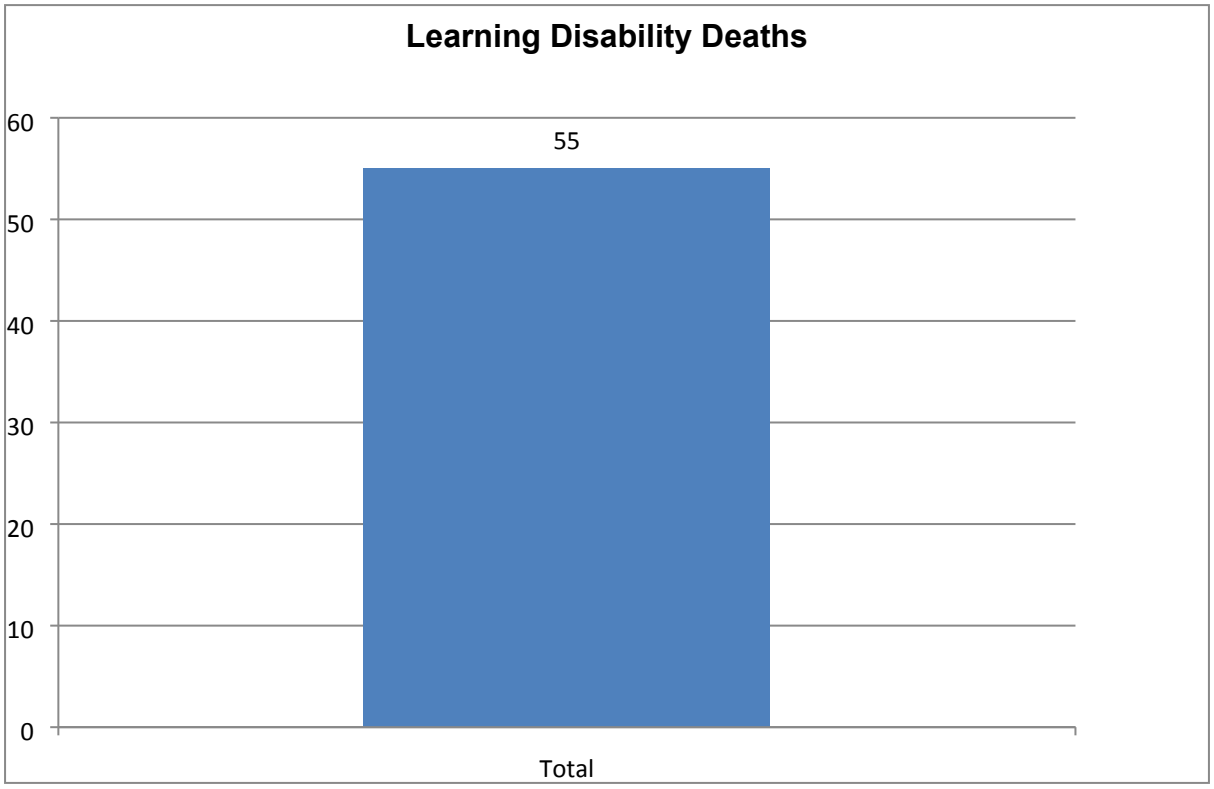
	Female	Male	Grand Total
Gender	2135	2121	4256

6.3 Death by age group since 1 January 2017

The youngest age was classed as 0 and the oldest age was 106 years. Most deaths occur within the 85-89 age groups (indicated by the star), in the last report most deaths occurred between 82-87 age group.



6.4 Learning Disability Deaths since 1 January 2017



The Trust reviews all Learning Disability deaths. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) Programme. However, we are unable to ascertain how many of these deaths have been reviewed through the LeDeR process as LeDeR only look at a sample of overall deaths. Currently the Lead Professional for Patient Safety and Experience is working closely with LeDeR so that the Trust can be involving moving forward in the review process and since the last report the Trust is now sharing relevant information with LeDeR which is used in their reviews.

6.5 Death by Ethnicity since 1 January 2017

White British is the highest recorded group with 3418 recorded deaths, 496 deaths had no recorded ethnicity assigned and 55 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Asian or Asian British - Any other Asian background	8
Asian or Asian British - Bangladeshi	2
Asian or Asian British - Indian	3
Asian or Asian British - Pakistani	10
Caribbean	26
Indian	27
Mixed - Any other mixed background	8
Mixed - White and Asian	2
Mixed - White and Black Caribbean	8
Not Known	496
Not stated	55
Other Ethnic Groups - Any other ethnic group	65
Other Ethnic Groups - Chinese	2
Pakistani	11
White - Any other White background	91
White - British	3418
White - Irish	24
Grand Total	**4256**

7. Recommendations and learning

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

7.1 Learning / Action Log

- Discuss the importance of using the analgesic ladder to manage pain in older people with dementia. Review use of pain management tools.
- The Eating Disorder team to facilitate a reflective session with the Neighbourhood teams in relation to managing Eating Disorder patients and timely referrals.
- To review the monitoring and communication process to patients with suicidal thoughts following the administration of medication where there are known suicidal side effects.
- Develop an operational policy that clarifies the roles and responsibilities of the organisation, teams and individuals in the delivery of care to forensic patients in the community.
- The development of a Trust infrastructure that supports staff in providing safe, effective care to community forensic patients.
- Clinical guidelines that reflect the specific needs of forensic patients in the community, including CPA (Care Plan Approach) and risk management.
- A programme of education and training that reflects the expertise required working with community forensic patients.
- A clinical supervision framework that ensures clinicians have routine access to professionals with clinical expertise in forensic care.
- To explore the development of Eating Disorder awareness training package to the relevant Trust teams.
- Eating Disorder Service to raise with MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa) Lead and Derby Hospitals Mental Health Steering Group the need to establish joint protocols for patients to be directed to appropriate support/ services, and joint clinics and / or regular review meetings for high
- Discuss with the multidisciplinary team the importance of adopting a broader approach to advanced decision making which is discussed in conjunction with DNAR (Do Not Attempt Resuscitation decisions.
- Where Social Care are involved with a client, an multi-disciplinary team and multi-agency meeting should be arranged once a year or more frequently if required due to significant change in accordance with CPA guidelines. CPA Review to be multi-disciplinary and multi-agency where relevant.
- The Trust requires an adequately commissioned community forensic team that addresses service the gaps identified within this report, so that community forensic care is safe and effective.
- Consideration should be given to whether S37/s. 41 patients discharged into the community should ever be transferred directly to non-forensic, generic

teams, or whether all such cases should at least initially be under the care of a forensic psychiatrist.

- Develop the role of end of life link workers or champions on the ward, to promote a culture of positive end of life care.
- To request commissioners to review contracts to include direction as to the expected level of discharge information and the timeliness of the communication from private providers.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 February 2019

Section 37/41 Briefing for the Board

Purpose of Report

To brief the Board on the consequences of a Supreme Court Ruling in December 2018 which concluded that forensic patients discharged into the community with restrictions (otherwise known as conditionally discharged patients or Section 42 patients) could not be deprived of their liberty through the conditions imposed on their Section by the Ministry of Justice or in the associated care plan.

Executive Summary

Some forensic patients pose a risk to others and one mitigation applied when they are discharged into the community has been to impose conditions on them either through their Section by the Ministry of Justice or in the associated care plan. These restrictions, for example, would limit their freedom of movement and/or insisting on a particular place of residence.

Following the Supreme Court judgement such conditions amounting to a Deprivation of Liberty would be unlawful.

On 11 January 2019 the Ministry of Justice issued guidance which can be summarised as follows:

1. Patients with capacity can be recalled to hospital either in person or virtually and then sent on long term Section 17 leave under the Mental Health Act for up to twelve months. Alternatively their cases could be referred to the High Court which retains an inherent power to answer any questions put before it and within that power has the ability to impose conditions relating to vulnerable people.

   Although the High Court has used inherent jurisdiction in certain cases these have generally involved consenting patients and the Court was the Court of the first instance and so the decisions may be appealed.

2. For patients without mental capacity to agree or otherwise with their conditions then they could be recalled to hospital and given Section 17 leave arrangements similar to the suggestion above, particularly if they are thought to be a risk to others. If the risks are not of that nature then a parallel Court application could be made to the Court of Protection to authorise a care plan amounting to a Deprivation of Liberty. This is likely to affect a significant number of patients with learning disability.

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

Assurances

There is a general assumption in provider organisations that protection of individual and the public should take precedence over the legal process and that reflex actions that would expose people to significant risk should be avoided. There will be patients in the community whose conditions under their Section 37/41 are technically unlawful but the legal risk is thought to be minimal as a technical breach does not attract a significant financial liability and this in any case may sit with Ministry of Justice and be a nominal £1.

There is a more severe risk however that potential discharges from secure hospitals may be slowed down or even stopped which, apart from affecting the individuals concerned, would potentially jeopardise the availability of forensic places.

The Ministry of Justice guidance may be substituting an impractical process for an unlawful one. Once a patient is recalled to hospital the hospital consultant becomes the Responsible Clinician who then needs to examine the patient and provide reports including those for Mental Health Act tribunals. It is difficult to see how this could reliably be done given the practical constraints that inpatient consultants already work under and the similar difficulty of recalling patients for examination to beds that may not be available and will certainly be sorely needed for urgent cases.

Consultation

The Trust led a Section 37/41 meeting on 25 January 2019 attended by high level representatives from the local authority and clinical commissioning groups. The meeting was chaired and led by Tracey Holtom, General Manager Complex Care. Andrew Coburn, Legal Services Manager, was in attendance, as was John Sykes and Chinwe Obinwa, Forensic Consultant Psychiatrist.

The issues were thoroughly rehearsed and the practical difficulties of following the Ministry of Justice guidance noted. There was a general assumption that we should proceed as a health community in a way that would not expose individuals or the public to unmitigated risk.

It was noted that if patients on the Sex Offenders' Register are recalled to hospital

then there is no legal compulsion for them to continue to sign on the Register in contrast to the present arrangements under Section 37/41.

Initial scoping has suggested that there may be 50 community cases involving patients who are mentally ill or disordered and up to 20 learning disability cases including five who are awaiting discharge.

The Trust already has a triage process established for Section 37/41 cases which has been agreed as appropriate but the Ministry of Justice and it was proposed that this is now expanded into a multi-agency panel that would consider the Section 37/41 cases in the community or awaiting imminent discharge. The panel would scrutinise existing Sections to:

1. Establish what the patient's likely capacity is judging from current records

2. To scrutinise the conditions and care plans to see if these would amount to a Deprivation of Liberty

3. To consider any risks posed to the public should these conditions be altered

It was also decided to consult further with the Ministry of Justice and NHS England on the matter.

Clinical information will be shared as required consistent with Caldicott principles.

It was decided that the scoping exercise will need to run until the end of May and further guidance may be forthcoming from the Ministry of Justice over this timescale.

Governance or Legal Issues

Conditions that are currently applied to Section 37/41 and their associated care plans may amount to an unlawful Deprivation of Liberty. The financial liability may lie with the Ministry of Justice but in any case is likely to be of a low order with nominal damages of £1 being awarded. The Trust has reacted very quickly to the situation and Derbyshire health community is probably as well placed as any other to assess the implication of this Supreme Court Judgement.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

The Mental Health Act and Mental Capacity Act represent Parliament's attempts to balance the right of the individual against that of protection of vulnerable people and

the general public. Balances and checks develop over time with case law.

Interestingly extended Section 17 leave as proposed by the Ministry of Justice as a legal fix for this critical conundrum has previously been criticised by court rulings which partly led to the instigation of Community Treatment Orders. It has since been established by case law that these themselves should not represent a Deprivation of Liberty!

A recently published review of the Mental Health Act suggested that CTOs are "the last chance saloon". Where all this now leaves Section 37/41s is difficult to predict at this stage.

Recommendations

The Board of Directors is requested to:

1) Note the implications of the recent Supreme Court Judgement
2) Decide on the level of risk that this poses to the Trust
3) Note and agree with the actions taken at the Section 37/41 meeting on 25 January 2019. Full notes from the meeting will be submitted to the Mental Health Act Committee on 7 March. There will be further discussion at the Mental Health Act Operational Group on 4 February.

Report presented by: **Dr John Sykes**
Medical Director

Report prepared by: **Dr John Sykes**
Medical Director

HM Prison & Probation Service

Mental Health Casework Section

Guidance:

Discharge conditions that amount to deprivation of liberty

January 2019

Any enquiries regarding this publication should be sent to us at: MHCSQACS@noms.gsi.gov.uk

1 Introduction

This document sets out the Secretary of State's position on the discharge of restricted patients on conditions that involve a deprivation of liberty, following the decision of the Supreme Court in *The Secretary of State for Justice v MM* [2018] UKSC 60 which was handed down on 28 November 2018.

The Supreme Court held that the Mental Health Act 1983 (MHA) does *not* permit either the First-tier Tribunal (Mental Health), the Mental Health Tribunal for Wales ("the Tribunal") or the Secretary of State to order a conditional discharge of a restricted patient subject to conditions which amount to detention or a deprivation of liberty.

The independent review of the MHA, published on 6 December 2018[1] included a recommendation (number 136) in relation to this issue as follows:

> "The Government should legislate to give the Tribunal the power to discharge patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards."

Relevant Government leads, including the Ministry of Justice and the Department of Health and Social Care are currently considering all recommendations in the MHA review's final report.

More immediately, the Justice Secretary will implement the following operational policy in relation to patients affected by the issue of discharge conditions that amount to a deprivation of liberty.

The aim of this operational policy is to ensure that, where appropriate, restricted patients do not need to remain in hospital beds and can continue their rehabilitation in a community-based setting, while on a long-term escorted leave of absence under section 17(3) MHA. This will ensure affected patients are managed safely, detained in an appropriate setting, detained in accordance with a procedure prescribed by law and are subject to the safeguards of a detained patient.

This document sets out the Secretary of State's view and guidance for his own officials. It is not intended as any kind of guidance for the Tribunal who, as an independent judicial body, will set their own guidance on the judgment.

2 Deprivation of liberty

Conditions objectively will give rise to a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights if the patient:

a) is not free to leave his placement; and
b) is subject to continuous supervision and control (per Baroness Hale in *P v Cheshire West & Chester Council* [2014] UKSC 19, [2014] AC 896 at § 49 and 54).

[1] https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

The deprivation of liberty will breach Article 5 if it is not authorised in accordance with a procedure prescribed by law.

The Secretary of State recognises that there are some patients already living in the community subject to conditions amounting to a deprivation of liberty and, therefore, unlawful conditions. Our policy on how we intend to deal with those patients is set out in section 5. There are also patients living in the community whose conditions of discharge in and of themselves are not unlawful, but who are subject to a care plan that includes arrangements that amount to a deprivation of liberty.

3 Patients with capacity

Where the patient has capacity to decide whether or not s/he should be accommodated at the relevant discharge placement with a care plan that includes arrangements that amount to a deprivation of liberty (DoL), the placement cannot be authorised under provisions of the Mental Capacity Act 2005 (the MCA), and the patient cannot validly consent to the arrangements. If a patient is being considered for discharge and the responsible clinician considers that they no longer require treatment in hospital, but are not yet suitable for discharge without constant supervision, the Secretary of State can consider providing his consent to a long-term escorted leave of absence, under section 17(3) MHA. Please refer to section 6 for further details.

The Secretary of State is aware of the case of *Hertfordshire County Council v AB [2018]* EWHC 3103 (Fam) where the High Court used its inherent jurisdiction to make an order authorising the DoL that arose from the patient's care plan. The Secretary of State does not consider that this is the correct approach. Where a patient continues to present such a risk to public protection, linked to his mental disorder, the Secretary of State considers that his treatment is best managed under the provisions of the MHA so that either the Secretary of State or the Tribunal can consider the public protection aspect of detention under the MHA. If further treatment and rehabilitation could be given in a community setting for such a patient, then a section 17(3) long term escorted leave approach would be more appropriate than to conditionally discharge with a care plan that required a DoL authorisation under the inherent jurisdiction of the High Court.

4 Patients lacking capacity

The earlier Court of Appeal decision in *MM* indicated that it could be appropriate for the Tribunal to defer conditional discharge of a patient who lacks capacity and whose discharge care plan would involve constant supervision. Such a deferred conditional discharge would enable the jurisdiction of the Court of Protection to be invoked to authorise the deprivation of liberty on discharge under section 16 of the MCA. At paragraph 27 of the *MM* judgment, the Supreme Court stated:

> "Whether the Court of Protection could authorise a future deprivation, once the (Tribunal) has granted a conditional discharge, and whether the (Tribunal) could defer its decision for this purpose, are not issues which it would be appropriate for this court to decide at this stage in these proceedings."

Where the Secretary of State or the Tribunal is considering discharge from detention in hospital for treatment under the MHA and considers that it is not satisfied that it is necessary for the health or safety of the patient or for the protection of other persons that s/he should receive such treatment, then a conditional discharge decision can usually be made.

The Secretary of State's view is that there are broadly two groups of patients lacking capacity who may be subject to a proposed discharge plan which would involve a deprivation of their liberty. The first set of patients are those who lack capacity and in their best interests, it is proposed that they live in a residential care home (or similar) as they are not able to look after themselves without the support such a placement would provide. In most of these cases, the need for such a care plan is due to the patient's inability to perform Activities of Daily Living or self-care without support that would involve an objective deprivation of their liberty.

The second set of patients are those who lack capacity and the argument is made that it is in their best interests for their care plan to involve constant supervision in order to prevent them from re-offending (i.e. it is in the best interests not to suffer the trauma of being prosecuted for an offence, or face physical threats from others should they re-offend). While it is recognised that there will be some cross-over between the first and second group, it is considered that there are a specific group of patients who, but for the risks they present to others, could live independently, without the need for constant supervision. Where a patient falls into this group, the Secretary of State considers caution should be exercised when considering whether to conditionally discharge such a patient with a care plan that would require a DoL authorisation under the MCA. (See section 4.2 below)

4.1 Patients lacking capacity – care plan that requires Deprivation of Liberty (DoL) to be authorised under the MCA

Where the care plan requires a Deprivation of Liberty (DoL) authorisation under the MCA, that is a separate consideration and the Secretary of State considers that the Tribunal can direct a deferred conditional discharge. Once conditional discharge is deferred, the necessary arrangements to put a DoL authorisation in place can be made and the patient discharged accordingly once the Tribunal has confirmed its decision. As the Secretary of State does not have the power to defer conditional discharge, in these circumstances, he can give an *indication* that he is minded to conditionally discharge on the basis that a DoL authorisation is put in place.

If, after a Tribunal decision to defer conditional discharge with a care plan that amounts to a DoL (or a Secretary of State indication that he would be minded to conditionally discharge), the Local Authority or the Court of Protection *declines* to issue a DoL authorisation, it is likely this would mean that the proposed placement is no longer available. In those circumstances, and where the responsible clinician can no longer support conditional discharge, he should inform the Tribunal and invite it to reconsider its deferred conditional discharge decision.

This procedure was set out in the case of R (on the application of H) v the Secretary of State for the Home Department [2003] UKHL 59, which upheld the Court of Appeal's decision where it summarised the following:

> "(i) The tribunal can, at the outset, adjourn the hearing to investigate the possibility of imposing conditions.
>
> (ii) The tribunal can make a provisional decision to make a conditional discharge on specified conditions, including submitting to psychiatric supervision, but defer directing a conditional discharge while the authorities responsible for after-care under section 117 of the Act make the necessary arrangements to enable the patient to meet those conditions.
>
> (iii) The tribunal should meet after an appropriate interval to monitor progress in making these arrangements if they have not by then been put in place.

(iv) Once the arrangements have been made, the tribunal can direct a conditional discharge without holding a further hearing.

(v) **If problems arise with making arrangements to meet the conditions, the tribunal has a number of options, depending upon the circumstances; (a) it can defer for a further period, perhaps with suggestions as to how any problems can be overcome; (b) it can amend or vary the proposed conditions to seek to overcome the difficulties that have been encountered; (c) it can order a conditional discharge without specific conditions, thereby making the patient subject to recall; (d) it can decide that the patient must remain detained in hospital for treatment.**

(vi) It will not normally be appropriate for a tribunal to direct a conditional discharge on conditions with which the patient will be unable to comply because it has not proved possible to make the necessary arrangements." (emphasis added)

4.2 Patients lacking capacity – care plan that requires Deprivation of Liberty to be authorised under the MCA where the best interests requirement under the MCA is primarily managing risk to the public

As noted above, the Secretary of State considers that there is a much smaller set of patients who lack capacity, and a care plan which amounts to a DoL is required on discharge in order to manage the risks they continue to pose to others. In those cases, the Secretary of State considers that conditional discharge would not be appropriate, but would be open to consideration of a s17(3) MHA long-term escorted leave of absence in the alternative (see section 6).

While the MCA does allow for a DoL where the best interests requirement is met on the basis of preventing the patient from re-offending, generally, the Secretary of State considers that such patients are best managed under the provisions of the MHA. This enables either the Secretary of State for Justice or the Tribunal to consider the public protection aspects of the criteria for detention under the MHA, rather than this important consideration being made under the provisions of the MCA. It also means that where such a patient can no longer be subject to a care plan with a DoL (for example if the DoL authorisation is not renewed), there is no immediate risk to the public, as the patient remains detained under the MHA.

While it is not easy to describe in general terms what characteristics such a case may have, a compelling factor will be what the care plan provides. For example, if the treatment set out in the care plan was analogous to that which would be delivered in an MHA setting (e.g. psychological/therapeutic interventions to reduce risk) and that appears to be the primary reason for the need for constant supervision, then it is likely that is the sort of patient who continues to meet the MHA detention criteria. If further treatment and rehabilitation could be given in a community setting for such a patient, then a section 17(3) long term escorted leave approach would be more appropriate than to conditionally discharge with a care plan that required a DoL authorisation under the MCA. The Secretary of State does not consider that there would be any requirement for a parallel authority under the MCA where a patient is subject to 17(3) long term escorted leave under the MHA.

5 Discharged patients on existing conditions

The Secretary of State is aware that there are a number of patients (both with and without capacity) who, prior to this decision, were discharged on conditions or a, which objectively amount to a deprivation of liberty. As

these cases are identified, the Secretary of State will consider their case in the light of the Supreme Court's judgment, and will have a number of options:

a. Exercise the Secretary of State's power to revoke or amend a condition to remove the illegality, if it is considered that the public would remain adequately protected without that condition (or with an amended condition);

b. Recall the patient to hospital on the grounds that the clarification of the law constitutes a material change of circumstance. **In these circumstances, the Secretary of State will at the same point consider granting immediate consent to the use of long term escorted leave of absence under section 17(3) MHA to enable the patient to remain in the community, where this appears to be in the patient's best interests and where any risk to the public can be safely managed during the patient's period of leave.** Where this option is appropriate, the Secretary of State will generally only give consent to long-term escorted leave of absence for up to 12 months and the recall will only be a technicality (i.e. the patient should not actually be physically returned to hospital). Both considerations and decisions will be made concurrently to enable the patient to remain where they are currently placed while a decision is made. The Secretary of State could extend consent to longer-term escorted leave of absence on the application of the responsible clinician after 12 months, but it will be necessary to review the continued appropriateness of such a leave of absence before extending it;

c. Absolutely discharge the patient, if it is considered that the public would remain adequately protected without restrictions (including the power to recall to hospital at a later date);

d. Refer the case to the Tribunal to consider amending or removing the relevant condition, or to consider absolute discharge.

In most cases, once the Mental Health Casework Section (MHCS) has identified that existing conditions are unlawful, the Secretary of State will initially ask the responsible clinician whether s/he considers that a restriction of the kind imposed by the unlawful condition remains necessary in order to protect the public. In some cases, MHCS will seek further information in order to decide the best approach, which might include a request for an updated risk assessment. On consideration of the case once this information is received, the Secretary of State will decide which of the above options to take. Where the Secretary of State considers that he is unable to take any of the first three options, he will refer the case to the Tribunal. It is anticipated that this will only be necessary in cases where closer examination of the issues by the independent Tribunal is required.

Where the discharged patient's conditions of discharge do not in their own right amount to a DoL, but where the care plan does, responsible clinicians should review the care plan to ascertain whether the arrangements remain necessary and proportionate. If they do, the responsible clinician should contact the MHCS and seek advice on whether any action is necessary. If such a patient lacks capacity and there is a DoL authorisation under the MCA in place, it is unlikely any action will be required.

If you are a professional responsible for the supervision of a restricted patient and consider that their conditions or implementation of their care plan may be unlawful, please contact the MHCS for advice:

https://www.gov.uk/guidance/noms-mental-health-casework-section-contact-list

6 Detained patients whose current discharge plans include a requirement for constant supervision in the community – long-term escorted leave of absence

As noted above, the Secretary of State will consent to the use of a long-term escorted leave of absence, under s17(3) MHA (i.e. leave for more than seven consecutive days) if it appears appropriate in an individual case.

The Secretary of State will always initially consider whether a restricted patient could be conditionally discharged rather than consenting to a long-term escorted leave of absence.

6.1 Where the patient lacks capacity, it may be possible for the Secretary of State to consent to the use of a long-term escorted leave of absence to test the suitability for a conditional discharge to a community placement if this is considered a necessary step. If the patient will need to live in a residential care home (for example) and as such their liberty would be severely restricted on discharge, the Secretary of State, at the appropriate time, would indicate his willingness to discharge to such a placement, on the basis that a DoL authorisation could be put in place under the MCA. While such a patient is on a long-term escorted leave of absence to the proposed discharge placement under s17(3) MHA, the Secretary of State considers that there is no need for an additional DoL authorisation under the MCA. A restricted patient on a long-term escorted leave of absence remains a detained patient and continues to have all the protections of the MHA, including the entitlement to apply to the Tribunal every 12 months. As paragraph 26 of the Supreme Court judgment in *MM* states, a restricted patient who is actually detained in hospital is ineligible for a DoL authorisation under the MCA. It is only at the point of conditional discharge that a DoL authorisation would be required.

6.2 Where the patient has capacity and the responsible clinician considers that s/he no longer needs treatment in hospital, but his risks are such that s/he could only be safely managed in the community with conditions that amount to a DoL (for example constant supervision while in the community), the Secretary of State (or the Tribunal) would not be able to conditionally discharge with such conditions.

The Secretary of State would consider consenting to a s17(3) long-term escorted leave of absence in these circumstances, with conditions that require constant supervision, if that would be a safe and appropriate way of enabling the patient to continue treatment and rehabilitation away from the hospital, while remaining a detained patient. Such a leave of absence would not be permanent, and the Secretary of State will generally only provide his consent for a maximum of 12 months at a time and would review the appropriateness of it continuing when the responsible clinician applies for an extension. Where there is a breach of leave conditions, or the responsible clinician is concerned that risks have increased, the responsible clinician may revoke the leave of absence and recall the patient to hospital without needing to apply for a recall warrant from the Secretary of State, as described in s17 MHA. Once the risks reduce such that constant supervision is no longer necessary, the responsible clinician can then apply for conditional discharge.

The Secretary of State will not generally agree to a long-term *unescorted* leave of absence in cases where the responsible clinician simply wishes to test a proposed discharge placement. Where there are no requirements for constant supervision and the application is simply consent for unescorted overnight leave prior to discharge, the Secretary of State's current policy of only granting up to 5 nights overnight leave remains in place. This is to ensure that s17 leave is not being used where conditional discharge is more appropriate.

MHCS INTERNAL GUIDANCE:

IN ALL CASES, WHERE THERE IS A KEY DECISION MADE, SUCH AS RECALL, LEAVE, CONDITIONAL DISCHARGE OR ABSOLUTE DISHARGE, PLEASE ENSURE THAT VICTIM ISSUES ARE CONSIDERED AND THE VLO INFORMED IN ACCORDANCE WITH EXISTING PROCEDURES AND GUIDANCE.

Section 1 - Conditionally discharged patients

Case Managers:
When reviewing CD reports, check the discharge conditions for any that could amount to a deprivation of liberty (e.g. "the patient must be escorted at all times"). If you think a condition might amount to a deprivation of liberty, refer the case to your Head of Team by creating a manual milestone allocated to the "B9 Discharge Requests and Decisions" list.

Senior Managers:
When reviewing unlawful conditions where the patient is already discharged:

Ascertain whether the patient lacks capacity.

1) **If the patient lacks capacity:**

a. Is there a DoL authorisation in place under the MCA? If there is an authorisation, consider whether removal of the unlawful discharge condition has any effect on the protection of the public.

b. Where a patient is subject to a DoL authorisation (and therefore his liberty has been lawfully deprived under the MCA), it is likely that you can remove the unlawful condition with no practical change to how the patient is being managed or any subsequent increase in risk to the public. It is important to note, however, that were circumstances to change in the future, and the patient no longer be subject to a DoL authorisation, consideration will need to be given to whether this increases their risk and, if so, how that can be safely and appropriately managed. In the majority of cases, however, the DoL authority under the MCA will not solely be in place due to public protection concerns and there will be other reasons in the patient's best interests that it was put in place.

c. If the conditions can be safely removed, create a "change of conditions review" in the usual way. Letters to the patient and RC should also include the following lines, to ensure MHCS is informed of any change to the DoL authorisation:

"Further, the responsible clinician is to notify the Secretary of State within twenty-four hours of any (i) imposition, removal or variation of a Deprivation of Liberty (DoL) Safeguard concerning your supervision in the community; (ii) any application for the imposition, removal or variation of such a DoL; and (iii) any forthcoming significant procedural step in respect of any such application."

d. You should also create a manual milestone to ensure that the case is reviewed when the DoL authorisation is due to be renewed (usually every 12 months).

e. If the patient lacks capacity, but there is no DoL authorisation in place, discuss with the clinical and social supervisors why there is no authorisation and whether it is possible to put one in place. If none can be imposed, then treat the case as though the patient has capacity.

2) If the patient has capacity:

a. Consider whether removal of the unlawful condition has any effect on the protection of the public or the safety of the patient.

b. Where, on the surface, it appears that the condition was imposed in order to manage a high risk of offending, you should contact the responsible clinician and social supervisor to seek their views on the current risk presented by the patient, should the condition be removed. It may be necessary to seek an up to date clinical assessment of risk.

c. Where the condition appears to have been imposed not to manage risk to others, but due to the patient's risk to himself, you should contact the responsible clinician and social supervisor to seek their views on the current risk presented to the patient, should the condition be removed. It may be appropriate to ascertain whether the patient has capacity; if not the most appropriate way forward may be to remove the condition while ensuring that a DoL authorisation is put in place under the MCA.

d. Where the patient has progressed such that removal of the unlawful condition would not mean the public is at risk and that the patient can be safely managed in the community, then it may be appropriate to remove it. If so, create a change of conditions review in the usual way.

e. Where it is clear that removing the condition would mean the risk to the public is elevated (or that the patient would be a danger to himself if not escorted in the community), it may be appropriate to recall the patient to hospital, on the basis that there has been a material change in circumstances. If so, create a recall review in the usual way. This step should first be discussed with the responsible clinician, together with the consideration for immediate leave of absence, set out at f. below. If you are able to agree to an immediate leave of absence as set out at f. below, then the recall will be a technicality and the patient should not actually be physically returned to hospital. Both considerations and decisions should be made concurrently to enable the patient to remain where they are currently placed while a decision is made.

f. If recall does appear to be necessary, consideration should always be given to immediate consent for a long-term escorted leave of absence under section 17(3) MHA. In order to maintain public protection, the Secretary of State's consent to leave may well involve imposing conditions on the leave of absence that amount to a deprivation of liberty, which would be lawful under the MHA, as the patient is now a detained patient, having been recalled. If recall, followed by immediate consent to leave of absence under the same conditions to the current placement is appropriate, you will still need to identify a hospital for the recall warrant. You should issue the recall warrant and the leave authority together. A long-term escorted leave review should be created at the same time as the recall review. Generally, the Secretary of State will only agree to a long-term escorted leave of absence up to a period of 12 months, at which point the responsible clinician will need to request the consent is extended for a further 12 month period (or they can apply for conditional discharge).

g. It should be noted that where the Secretary of State recalls a conditionally discharged patient (even with an immediate leave of absence) this means that:

i. the patient's legal status changes from being a conditionally discharged patient to a recalled detained patient;
ii. the patient's case will be immediately be referred to the Tribunal following recall;
iii. the patient thereafter has the right to apply to the Tribunal annually (and in the absence of such an application, the Secretary of State must refer the case every three years); and
iv. the indefinite leave of absence will only be consented to for a period of up to 12 months, which can be extended on the application of the responsible clinician.

h. In order to ensure the leave of absence is reviewed regularly, the senior manager should decide how often progress reports are required (minimum of every six months) and create a manual milestone for 11 months' time to remind the responsible clinician that the consent for long-term leave will shortly expire.

i. The senior manager should ensure that the Secretary of State's statement to the Tribunal makes it clear that while the patient has been recalled, due to the material change in circumstances, he is on a long-term escorted leave of absence. The statement should also explain why the Secretary of State considered that the unlawful condition could not be safely removed.

j. When reviewing these cases, the option of lifting the restrictions (absolute discharge) must always be considered. If none of the first three options set out in section 5 above appear appropriate, then it is likely you will need to make a discretionary referral to the Tribunal. In doing so, you should explain your reasons for making the referral and the Secretary of State's formal statement to the Tribunal should set out why he did not consider he could exercise his own powers within one of the first three options.

Section 2 - Detained patients

Tribunal proceedings

Case managers:

When reviewing tribunal discharge decisions or preparing tribunal statements:

Check whether the conditions imposed (or requested) could amount to a deprivation of liberty (e.g. "the patient must be escorted at all times"). If you think a condition might amount to a deprivation of liberty, refer the case to your Head of Team by creating a manual milestone allocated to the "B9 Discharge Requests and Decisions" list.

Senior Managers

When reviewing cases before the Tribunal where there is a clinical recommendation for discharge with conditions that objectively amount to a DoL:

1) Ascertain whether the patient lacks capacity;

2) If so, does the discharge plan include a DoL authorisation? If so, ensure that the Tribunal statement sets out the Secretary of State's position as above in Section 4, with regard to the imposition of conditions and potential for deferred CD to enable arrangements for a DoL authorisation. Bear in mind that where a DoL authorisation will be in place, any request for conditions that objectively amount to a DoL is likely to be superfluous (it would add nothing to the safeguard provided by the DoL authority) and such a condition would be unlawful;

3) If the patient has capacity, ensure that the Tribunal statement sets out the Secretary of State's position as above. You particularly need to consider what the implications are for public protection if a patient with capacity is discharged without such a restrictive condition, where the clinical assessment is that s/he needs constant supervision and whether it is appropriate for the Secretary of State to offer a view on suitability for discharge (e.g. in cases where the responsible clinician recommends discharge but has requested an unlawful condition which amounts to a DoL);

4) If the patient has capacity and the responsible clinician is requesting an unlawful condition, it may be appropriate to suggest that an alternative approach might be for him to seek consent for a long-term leave of absence.

5) If the unlawful conditions have already been imposed by the Tribunal (post the *MM* UKSC decision), seek legal advice on the best way to resolve the situation.

Applications for escorted overnight leave / long-term escorted leave of absence:

Case managers:

1) If the patient lacks capacity and the responsible clinician is requesting escorted overnight leave to a proposed discharge address, make sure it is clear whether eventual discharge is likely to involve a DoL authorisation. You may need to check with the responsible clinician. If so, escorted overnight leave is likely to be appropriate (and necessary). You should make your risk assessment as usual, but take into account the fact the overnight leave will be escorted. Bear in mind that the patient will not have had access to unescorted day leave. This is not an issue in these circumstances and not a barrier to escorted overnight leave.

2) Not all patients who lack capacity will need a long-term escorted leave of absence and may only require escorted overnight leave in the usual way (i.e. up to five nights per week). Ensure that the responsible clinician has clearly expressed what type of leave they are requesting and clarify with them if it is not clear.

3) If the patient does not lack capacity, but the responsible clinician is requesting an escorted leave of absence for the purposes of testing at a proposed discharge address, you should ask the responsible clinician to clarify why escorted overnight leave is being sought. It may be appropriate to consent to a leave of absence with restrictive conditions for detained patients in the same way it would be considered for those already in the community after recall (see below).

4) If in doubt, consult your Head or Deputy Head of Team for advice before completing your recommendation. Please note that a long-term leave of absence will generally only be considered if

such leave is to be escorted. Where the patient can take unescorted overnight leave, a long-term leave of absence will not generally be appropriate and the Secretary of State's policy remains that most patients will only require a period of testing on overnight leave for a maximum of five nights per week, prior to consideration of conditional discharge.

Senior managers:

1) Deputy Heads of Casework should ascertain whether the application is for a long-term escorted leave of absence. If so, the case should be referred to the Head of Team for a final decision. Please ensure that the correct review has been opened (i.e. the new "long term escorted leave" review) to enable MHCS to monitor volumes of such applications.

2) Where the application is for a long term leave of absence, please apply the following considerations:

a. Is the long-term leave of absence to be unescorted? If so, ascertain why the responsible clinician considers this step necessary. Generally, the Secretary of State will not agree to allow a long-term *unescorted* leave of absence and would prefer shorter periods of testing (up to five nights per week) and/or consideration of conditional discharge at the appropriate point.

b. Is the long-term leave of absence to be escorted? If so, ascertain why this is necessary. If the patient lacks capacity, is there a plan for eventual discharge that would require a DoL authority to be in place under the MCA? Is testing via a long-term escorted leave of absence necessary prior to consideration of conditional discharge?

c. You should always consider whether periods of overnight leave (up to five nights per week) or conditional discharge is more appropriate than a long-term leave of absence, before consenting to such a step.

Applications for conditional discharge where a responsible clinician has requested a condition that amounts to a deprivation of liberty

Senior managers:

1) Ascertain whether the patient lacks capacity;

2) If so, is there or will there be a DoL authorisation in place? If yes, consider whether you are content that, where relevant, the DoL authorisation is a sufficient safeguard to manage risks in the community on discharge. Bear in mind that the majority of DoL authorisations will be with regard to the patient's best interests with regard to assistance with daily living, rather than on the basis of management of risk to others. It is possible, however, to argue that a DoL authorisation is in the patient's best interests to prevent him causing harm to others due to the consequences of re-offending. If this is the case, you should satisfy yourself that it would be appropriate to conditionally discharge in these circumstances – does the patient still require treatment in hospital; can the risks be safely managed in the community? You should continue to consider the case like any other, bearing in mind that the patient will not be able to have been tested on unescorted leave. This is not a barrier to discharge. The fact the discharge plan will involve a lawful deprivation of liberty under the MCA will be relevant to your consideration, but may not be central to the decision;

3) If not, and the responsible clinician has requested a condition that objectively amounts to a deprivation of liberty, you should not, in any circumstances, impose such a condition. You should continue to consider the case like any other. It may be appropriate to consider a long-term escorted leave of absence (subject to the appropriate conditions), rather than discharge in these circumstances.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 February 2019

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

Purpose of Report

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

Executive Summary

- There continue to be eleven risks are currently identified in the BAF for 2018/19.
- Since Issue 3 of the BAF, the risk ratings for two of the risks have been revised:
    - Risk 18_19 3a. T*here is a risk that the Trust fails to deliver its financial plan*. Reduced from extreme to high risk due to a reduction in the gaps in controls in relation to reduced agency expenditure and delivery of firm plans for 2019/19 CIP with the decision by ELT (Executive Leadership Team) to reconcile the 2018/19 programme and move focus to the 2019/20 programme.
    - Risk 18_19 2a. *There is a risk that if the Trust doesn't engage our workforce and create an environment where they experience the aims and values of the Trust*. Reduced from high to moderate due to the significant amount of action undertaken to mitigate the risk and the further work planned to engage middle managers to improve engagement across the organisation.
- Two risks continue to be rated as extreme. These are: 18_19 4a Retention, development and attraction of staff and 18_19 4d Acute inpatient flow
- Discussion at the Quality Committee in December 2018, it was proposed to split the risk 18_19 4d *There is a risk that the Trust will not improve the acute inpatient flow of patients through our service,* to highlight the specific risks around acute inpatient care. Work is already underway to develop the 2019/20 BAF to include a specific focus on acute inpatient care and this will be completed for the Audit and Risk Committee in March 2019. In the interim risk 18_19 Risk 4d has been amended to include the focus on inpatient flow, rather than overall flow of patients through services.
- The Mental Health Act Committee agreed to retain risk 18_19 1b *There is a risk that the Trust will fail to provide full compliance with the Mental Health Act (1983) and Mental Capacity Act (2005)* as high, pending results of an audit around compliance with capacity assessment in the community which is due March 2019.
- The focus has continued on ensuring appropriate actions to mitigate risks are identified and to scrutinise, evaluate and challenge risk ratings. It continues to be the expectation that completion of identified actions will result in reduced risk ratings and we continue to work with Executive Leads to ensure appropriate mitigating actions are identified with timeframes and milestones for delivery.

- The recommendation (3) of the Deloitte phase 3 Well Led governance review to expand the BAF to include information on mitigating actions for all high and extreme rated operational risks has been agreed to be included in Issues 2 and 4 of the BAF, so is identified again in this version. Overall there are now 20 operational risks rated as high or extreme, two more than shown in Issue 2.

- The Deep Dive programme is on track. Executive Leads are using a standard template to ensure consistency of approach. We continue to reiterate the importance of following agreed consistent approach to Board Committee deep dive discussions.

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

Consideration of risks to populate the 2019/2020 BAF have commenced with ELT sessions during January 2019, and will be agreed at the Board development session planned for 20 February 2019. It is proposed by ELT that there will be fewer BAF risks overall, a smaller number of key gaps in controls and assurances and so and fewer more high level actions, and clear measurable metrics against which progress and movement of the risk rating can be assessed. The risks are proposed in relation to:

- Workforce safety and wellbeing
- Safety and quality of services
- Political environment, including the STP and BREXIT
- Financial sustainability
- Estates including single sex accommodation
- Information, including the EPR and cyber security

It is proposed that Executive Directors will take a more collective responsibility for updating and reviewing the BAF during 2019/20, with updates undertaken by the ELT as a whole. This will ensure updates to the BAF reflect the range of executive input to the risk and there is active challenge and shared responsibility to develop appropriate controls and assurances, with shared ownership for mitigation of the risk. Executive Leads for individual risks will remain.

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

Assurances

This paper provides an update on all Board Assurance risks and provides assurance on the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives.

Consultation

Executive Leadership Team: 10 December 2018

Executive Leadership Team – BAF focused sessions on: 7, 14 and 21 January 2019

Audit and Risk Committee: 15 January 2019

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Actions to Mitigate/Minimise Identified Risks

Specific elements within each BAF risk and associated actions are addressed by the relevant lead Executive Director in taking forward, for example clear policies and procedures are in place to ensure equality of access in all recruitment processes as outlined under Risk 18_19 4a (retain, develop and attract).

Recommendations

The Board of Directors is requested to:

1. Agree and approve this fourth issue BAF for 2018/19 and the significant assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2. Agree the amended risk rating, that is to decrease risk 3a (financial plan) from extreme to high risk and 2a (engagement) from high to moderate as proposed by the Executive Leadership Team and supported by the Audit and Risk Committee.
3. Receive the initial list of potential risks for inclusion in the 2019/20 BAF for discussion and agreement at the Board Development session on 20 February 2019.
4. Agree to receive the final version (v5) of the 2018/19 and first version (v1) of the 2019/20 BAF in April 2019.

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

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

Rachel Kempster
Risk and Assurance Manager

Board Assurance Framework
Fourth issue for 2018/19

The Board Assurance Framework (BAF) is a high level report which enables the Board of Directors to demonstrate how it has identified and met its assurance needs, focused on the delivery of its objectives and subsequent principal risks. The BAF provides a central basis to support the Board's disclosure requirements with regard to the Annual Governance Statement (AGS), which the Chief Executive signs on behalf of the Board of Directors, as part of the statutory accounts and annual report. This is the fourth formal presentation of the Board Assurance Framework to the Board for 2018/19.

1) Overview and movement of risks 2018/19

A summary of all risks currently identified in the 2018/19 BAF is shown below. This is added to as the year progresses

BAF ID	Risk title	Director Lead	Risk rating Issue 1	Risk rating Issue 2	Risk rating Issue 3	Risk rating Issue 4	Direction of movement
18_19 1a	Failure to provide safety and quality standards	Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	
18_19 1b	Failure to provide full compliance with the Mental Health Act (MHA) and the Mental Capacity Act (MCA)	Medical Director	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	
18_19 1c	Failure to develop systems and processes to deliver physical health care for patients	Medical Director	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	
18_19 1d	Failure to redesign the Care Programme Approach processes	Director of Nursing and Patient Experience	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	
18_19 2a	Risk that we do not engage our workforce to experience aims and values of the Trust	Director of People and Organisational Effectiveness	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	MOD (3x4)	
18_19 3a	Delivery of financial plan	Director of Finance	EXT (4x5)	EXT (4x5)	EXT (4x5)	HIGH (3x5)	
18_19 3b	Failure to influence Joined Up Care Derbyshire	Director of Business Improvement and Transformation	HIGH (4x4)	HIGH (4x4)	MOD (3x4)	MOD (3x4)	
18_19 4a	Unable to retain, develop and attract staff in specific teams	Director of People and Organisational Effectiveness	EXT (4x5)	EXT (4x5)	EXT (4x5)	EXT (4x5)	
18_19 4b	Failure to gain confidence of staff re the electronic patient record	Chief Operating Officer	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	
18_19 4c	Unable to introduce new workforce models and provide training to reskill staff	Director of People and Organisational Effectiveness	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	HIGH (4x4)	
18_19 4d	There is a risk that the Trust will not improve the inpatient flow of patients through our services	Chief Operating Officer	HIGH (4x4)	HIGH (4x4)	EXT (5x4)	EXT (5x4)	

2) Deep dives 2018/19

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

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

Risk ID	Subject of risk	Director Lead	Committee
18_19 1a	Safety and quality standards	Carolyn Green	Quality Committee July 2018 Completed
18_19 1b	MHA/MCA Compliance	Dr John Sykes	Mental Health Act Committee September 2018 Completed
18_19 1c	Physical healthcare compliance	Dr John Sykes	Quality Committee September 2018 Completed Further deep dive planned for January 2019 Completed
18_19 1d	CPA approach	Carolyn Green	Quality Committee November 2018 (deferred to February 2019)
18_19 2a	Staff engagement	Amanda Rawlings	People and Culture Committee October 2018 Completed
18_19 3a	Financial plan	Claire Wright	Finance and Performance Committee January 2019 Completed
18_19 3b	Influence 'Joined Up Care Derbyshire'	Gareth Harry	Finance and Performance Committee September 2018 Completed
18_19 4a	Staff retention, recruitment and development	Amanda Rawlings	Audit and Risk Committee (People and Culture Committee) July 2018 Completed
18_19 4b	Electronic Patient Record	Mark Powell	Quality Committee December 2018 Completed
18_19 4c	Workforce model and training to reskill staff	Amanda Rawlings	People and Culture Committee December 2018. Completed
18_19 4d	Improve flow of patients	Mark Powell	Audit and Risk Committee (Finance and Performance Committee) December 2018 Completed

Summary Board Assurance Framework Risks 2018/19. Issue 4.2

Ref	Principal risk	Director Lead	Current rating (Likelihood x Impact)
Strategic Objective 1. Quality Improvement			
18_19 1a	There is a risk that the Trust will fail to provide standards for safety and quality required by our Board, as set out in the Health and Social Care Act 2009 and measured through the CQC's regulatory process	Executive Director of Nursing and Patient Experience	HIGH (4x4)
18_19 1b	There is a risk that the Trust will fail to provide full compliance with the Mental Health Act (1983) and Mental Capacity Act (2005)	Medical Director	HIGH (4x4)
18_19 1c	There is a risk that the Trust will fail to develop systems and processes to deliver safe and effective physical health care for patients	Medical Director	HIGH (4x4)
18_18 1d	There is a risk that the Trust will fail to redesign the Care Programme Approach processes, which may impact upon the quality of care provided to patients and their carers	Executive Director of Nursing and Patient Experience	HIGH (4x4)
Strategic Objective 2. Engagement			
18_19 2a	There is a risk that if the Trust doesn't engage our workforce and create an environment where they experience the aims and values of the Trust, there will be a negative impact on the morale and health & wellbeing of staff which may affect the safety and quality of patient care	Director of People and Organisational Effectiveness	MODERATE (3x4) ↓
Strategic Objective 3. Financial Sustainability			
18_19 3a	There is a risk that the Trust fails to deliver its financial plans	Executive Director of Finance	HIGH (3x5) ↓
18_19 3b	There is a risk that the Trust fails to influence Joined Up Care Derbyshire (the 'system') to effectively engage in enhancing service models for children, and people with mental health problems, learning disabilities, or issues with substance misuse	Director of Business Improvement and Transformation	MODERATE (3x4)
Strategic Objective 4.Operational Delivery			
18_19 4a	There is a risk that the Trust will not be able to retain, develop and attract enough staff in specific teams to deliver high quality care	Director of People and Organisational Effectiveness	EXTREME (4x5)
18_19 4b	There is a risk that the Trust will fail to gain the confidence of staff to maintain a modern and effective electronic patient record system	Chief Operating Officer	HIGH (4x4)
18_19 4c	There is a risk that the Trust will be unable to meet the needs of patients by not introducing new workforce models and provide sufficient training to reskill staff.	Director of People and Organisational Effectiveness	HIGH (4x4)
18_19 4d	There is a risk that the Trust will not improve the acute inpatient flow of patients through our services	Chief Operating Officer	EXTREME (5x4)

Board Assurance Framework Risks 2018/19 v 4.2

Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

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

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

Assurances on Controls (internal):	Positive assurances on Controls (external):

Operational risk information extracted from Datix 05 12 18, updated 30 01 19

Board Assurance Framework Risks 2018/19 v 4.2

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Fully implemented quality priorities and Quality Improvement Strategy	Roll out of actions in relation to the current quality priorities and Quality Improvement Strategy including a training needs analysis and full implementation plan [ACTION OWNER: DBI&T]	28/02/2019	Quality priorities are required outcomes of quality visits, programme completed. Full training needs analysis in development. Quality Improvement ELearning now available. Implementation plan for Quality Improvement Strategy commenced.	Medium
Commissioner commitment to invest in mental health, children's services and learning disability services. Role of primary care models underdeveloped in Derbyshire.	Commissioner lobbying and provision of evidence to support need to increase funding or to provide an alternative strategic plan [ACTION OWNER DON]	28/02/2019	New mental health modelling national data shows Trust staffing is less than other Trusts and activity higher. This is the key information with benchmarking and other information for the bids for the National Mental Health investment standard	Low
Lack of effective forensic clinical service pathway following prison release. Release of IPP prisoners (indeterminate imprisonment for public protection) increases risks.	Recruit to and operationalise community forensic team, following funding settlement [ACTION OWNER:COO] Recruit to and operationalize additional investment in Neighbourhoods and Crisis service [ACTION OWNER:COO]	28/02/2019	Recruitment for nursing staff undertaken – to start Feb.2019. Psychology interviews planned for 17/12/18. 0.6 Forensic Psychiatrist in post. 1.00 Forensic Psychiatrist 3 times, no applications. Options appraisal re post to go to TMT for review 20/12/18	Low
Non commissioned services for Derbyshire based PICU beds and CAMHS Tier 4 beds	Improvement plan with commissioners in place for CAMHS Rise and HTT model [ACTION OWNER COO]	31/03/2019	Commissioners are to tender for PICU provision and provision of transport. The procurement aims to establish core contracts with PICU providers which should secure bed spaces for Derbyshire patients as close to Derbyshire as possible, reducing access, quality and transport issues relating to long journeys to hospitals.	Medium ⬇
Early warning signs of service failure and independent service modelling	Implement QUESTT. Explore and commission remodelling exercise of community mental health services and inpatient beds [ACTION OWNER DBI&T]	31/01/2019	Delayed due to other clinical IT priorities.	High
Fully embedded Clinical and Operational Assurance Teams	Embed CPD and complete development work for COATs [ACTION OWNER COO]	28/02/2019	Further review required of some COAT's to improve rigour and effectiveness	High
Gap in knowledge and competence in relation to treatment of autism and support in complex cases	Implement clinical quality improvements as identified in Schedules 4 and 6 in autism treatment during 2018/19 [ACTION OWNER DON]	28/02/2019	Learning disability and autism information and best practice standards refreshed on all in-patient areas. Autism boxes for distraction to be distributed to all services by Feb 2019. Autism awareness training increasing and remains on target. Autism training for frontline administration staff being rolled out in 2019 to supplement this work.	Low

Operational risk information extracted from Datix 05 12 18, updated 30 01 19

Lack of capacity for autism assessment services and non-compliance with the statuary autism act which recommends assessment within 12 weeks	Quality improvement mapping to understand referrals. Sharing this information with commissioners to undertake an equality impact assessment on commissioning decisions [ACTION OWNER DON]	28/02/2019	Shared with commissioners in the Nov 2018 QAG and accepted as a significant risk. Reissued on QAG risk and concerns log.	High
Clinical buy in to review NICE guidelines	To be evidenced through compliance with quality priorities assessed during Quality Visit programme [ACTION OWNER DON]	28/02/2019	Progress continues to be made with specific evidence of NICE guidelines being considered, this will require continued focus to ensure guidelines are embedded	Low
Full compliance with Trust strategy to be 'smoke free' .	Further develop improvement plan with ward teams to prevent smoking on inpatient wards to reduce risks of potential fire if smoking in undesignated areas [ACTION OWNER DON]	28/02/2019	E-burn implementation in place. Exploring pilot of E-cigs/vaping in NHS settings. Fire officer monitoring and maintaining fire checks and positive recommendations for improvement in design. Disinvestment by CCG in live well mental health smoking cessation programme.	High
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
2018 CQC comprehensive inspection has identified a deterioration in the safety domain across 3 service: adult acute, older people community and learning disability community	Extensive CQC action plan to be developed 'bottom up' with required evidence per area being established at the outset. [ACTION OWNER DON]	28/02/2019	The bottom up action planning has been successful, continued progress on ensuring actions are delivered on time. Significant progress but some areas are struggling with volume and pace, particularly the acute care setting	High
Effective plan to ensure ability to achieve quality priorities, CQUIN and Non CQUIN targets including 'Sign Up to Safety' and 'Always Events' campaigns	Implement CQUIN action plan for 2018/19, and action plans for 'Sign up to safety' and 'Always Event' campaigns [ACTION OWNER DON]	28/02/2019	Last CQUIN report to Quality Committee, all targets and milestones were met and achieved. The CQUIN at potential risk of failure is that required to deliver the national standard re the number of staff agreeing to receive the flu inoculation.	Low
Lack of clinical strategies with Divisional areas.	Develop new clinical strategies for recovery and enablement, substance misuse and Co- existing substance misuse and then Eating Disorders [ACTION OWNER DBI&T]	28/02/2019	New policy and clinical strategy development over- rides original plan. In design	Medium
Evidence to support sexual safety of patients is maintained across inpatient areas	Identify issues re sexual safety of patients in inpatient areas and develop a plan to improve where gaps are identified [ACTION OWNER DON]	28/02/2019	Sexual safety paper submitted to the Safeguarding Committee. Operational work continues in collaboration with SV2. Design of leaflet which has been co-produced. Recommendations on safety and gender to be included in clinical safety developments	Medium
Full compliance with safe use of medicines, with breaches still continuing to be identified.	Improvement plan in place to deliver compliance with medicines management code, including implementation of the Medicines Optimisation Strategy [ACTION OWNER MD]	Completed	Implementation plan for Medicines Optimisation Strategy approved by Quality Committee October 2018	Achieved
Achievement of required levels of compliance with mandatory and role specific training	Increase compliance with mandatory and role specific training requirements [ACTION OWNER COO]	28/02/2019	Some deterioration in performance and concerns re key safety training. Recommendation of additional monitoring at TMT	High
Timely completion of actions following serious incidents and complaints	Increase focus on completion of outstanding actions led by operational managers {ACTION: COO]	28/02/2019	Operational team capacity is impacting on this action. Risk based approach required	Medium
Evidence of compliance with recommendations from NHS Resolution in	Implement requirements from NHS Resolution reviews of suicide-related claims to	28/02/2019		Medium

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relation to suicide related claims	help prevent future harm. Implement recommendations and provide assurance [ACTION OWNER MD]			
Potential lack of continuity of psychotherapy services following CCG launch of consultation to fully decommission	Complete a Quality Impact Assessment process in line with any QUIPP scheme to disinvest from mental health services and respond to consultation. [ACTION OWNER DON and MD]	28/02/2019		High

Related operational high/extreme risks:

ID	Division	Title	Description	Controls in place	Mitigating actions	Date of next review
3385	Neighbourhood Services	Waiting Times for Psychological Assessment and Intervention	Long waits across areas of the neighbourhood for psychological assessments.	Use of waiting list policy and prioritisation of urgent cases. Use of a supervision/consultation model to reduce number of referrals Action from TMT to review number of individual contacts.	07/11/2018 update: Staff are using waiting list policy and will prioritise urgent cases. Where possible they are using a supervision/consultation model to reduce number of referrals and this is currently being evaluated, along with group work. Action from TMT to review number of individual contacts.	28/02/2019
21510	Campus Services	Poor levels of compliance with positive and proactive training in acute ward areas	Risks identified in relation to training compliance for positive and proactive training with respect to: - Overall compliance with positive and proactive training (as of Oct 2018) sits at around 50%. - Bank staff not accessing the training, despite an agreement would be funded once a member of bank staff had completed 26 shifts. The funding route for accessing the training is not clear, with no designated budget identified.	-Enough places for positive and proactive training are offered to ensure all staff requiring the training can access it - Local risk assessments, patient safety plans and care plans are in place	22/10/2018 update: 23 new starters, all have a confirmed place on course between Oct and Jan 2019. Deputy Director of Ops escalating though ASM to ensure bank staff requiring training are funded	30/11/2018
21585	Campus Services	Door system malfunctioning	On-going problem since 5/12/18 with electronic door system working intermittently. If these risks continue to remain we will have serious issues with business continuity.	Contingency plan is in place regarding access to doors - most doors can be manually overridden - apart from the treatment rooms, staff offices and secure reception - which is not manned 24 hours per day, request has been made for override boxes to be installed - however reported that this will not be imminent.	4/1/19 update: further faults identified on Scarsdale outer airlock door and Scarsdale staff base - readers changed. further 2 week monitoring period from 4/1/19 - 18/1/19	20/01/2019

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Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

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

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Improvement in practice and recording made in inpatient areas yet to be made in community settings	Focused workplan for improving compliance in community team with development of relevant guidance and documentation [ACTION OWNER MD]	28/02/2019	Re-audit completed. Reported to the MHA Operational Group Aug 2018 and MHAC Sept 2018. Improving compliance, plan to re-audit in 3-4 months.	Medium

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Comprehensive training to support application of MHA and DoLs	Develop and implement comprehensive training plan to support application of MHA and DoLs. [ACTION OWNER MD]	31/03/2019	Improved position. Review again at next MHAC March 2019.	Low
Real time feedback to clinicians following rapid tranquilisation	FSR to be developed to enable pharmacists to give clinicians 'real time' feedback following rapid tranquilisation to their patient. Pilot operation now on Enhanced Care Ward [ACTION OWNER MD]	28/02/2019	Monitoring of rapid tranquilisation improved due to developments in the FSR. Real time feedback to clinicians not possible without electronic prescribing. Regular reporting to MHA Operational Group. Electronic prescribing in procurement. Further national benchmarking and local audit results due Jan 2019.	Medium
Consistent approach to management of Associate Hospital Managers (AHM's)	Develop a plan to ensure a consistent approach is implemented with respect to recruitment, job descriptions, appraisal, offers of appointment and training for AHM's [ACTION OWNER MD]	28/02/2019	NED to lead discussion with AHM's re appraisal implementation Dec 2018. Mandatory training day arranged for March 2019, and law update to be confirmed later in 2019 to include changes expected to MH Act. Further update paper presented to MHAC Dec 2018.	Low
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Evidence of actions taken and embedded following CQC mental health act focused related visits	Action matrix to cover all actions from all units, and to highlight those overdue, to be in place by September 2018 as per KPMG recommendation [ACTION OWNER MD]	Complete	CQC portal functionality now being used to follow up actions. Approach and paper with current position agree at MHAC Sept 2018, Quarterly reporting to MHAC now included in forward plan, next update due Dec 2018..	Achieved
Potential breaches of Section 136 waiting times. (Due to reduction in length of time a person can be held in a S136 suite under the new Police and Crime Bill).	Raise at Board level with escalation to Commissioners [ACTION OWNER MD]	28/02/2018	This risk is impacted on by the difficulties accessing CAMHS/learning disability and PICU places. Issue escalated through ELT to Board.	Medium
Related operational high/extreme risks: None specifically identified				

Operational risk information extracted from Datix 05 12 18, updated 30 01 19

Board Assurance Framework Risks 2018/19 v 4.2

Strategic Outcome 1. Quality Improvement

Principal risk:

Risk: **There is a risk that the Trust will fail to develop systems and processes to deliver safe and effective physical health care for patients**

Impact: Morbidity and mortality for people with a serious mental illness (SMI) will continue to be worse than the national average, people will have longer stays in hospital and the CQUIN for physical healthcare will not be achieved

Root causes:

a) Known links between SMI and other co-morbidities e.g. diabetes, cardiac disease; respiratory disease
b) Increased risk factors in population e.g. obesity, smoking, alcohol and drug misuse and deprivation
c) Lack of secondary care infrastructure to monitor physical health impact of people with SMI
d) Lack of clear processes for communication between primary and secondary care with respect to physical health monitoring

BAF ref:	**Director Lead**: Dr John Sykes, Medical Director	**Responsible Committee**: Quality Committee	Datix ID:
18_19 1c			21289

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

Key controls:

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

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

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

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

Assurances on Controls (internal):	Positive assurances on Controls (external):
Programme of physical health care related audits and associated action plans	Safety Thermometer

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of single location on PARIS for recording and monitoring of physical health care	Develop a physical health care tile on PARIS to record in a single place all physical health care related information, initially focused on LESTER Tool compliance [ACTION OWNER MD]	31/03/2019	Early Intervention pilot data collection completed. Initial analysis / results identified significant improvement, with approximately 85% of compliance with physical health care checks. Tool requires development to be 'scaled up' for all relevant patients. Physical Health Care Committee to agree way forward Jan 2019. Compliance checks of inpatient proforma and 136 physical health	Medium

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			checks in place (paper based). Auditing framework in place.	
Trust led physical healthcare monitoring following initiation of medications	Expand Derby pilot of physical health care monitoring clinics to Chesterfield [ACTION OWNER MD]	Completed	Lead clinician and HCA's appointed. Training package developed, to roll out from Jan 2019, to deliver extension of Derby pilot, and new services in Chesterfield and Amber Valley, to ensure full compliance with LESTER monitoring in these areas.	Achieved
Uptake of intervention focused training re physical healthcare	Compliance reporting and monitoring of hotspots, to target in specific areas, including resuscitation training [ACTION OWNER MD/COO]	31/03/2019	Physical health in mental health e-learning (LESTER), in place for just over 12 months. As of December 2018, compliance is at 72%. Monitored through CQUIN delivery group. CRH providing some additional resuscitation training at Hartington Unit. Increase in ILS compliance, Exploring simulation training and RAMMPS. Trust is part of national learning set. .	Medium
Gaps in communication with GP practices re awareness of SMI cohort leading to potential gaps in physical healthcare monitoring	Continue to work with GP practices to ensure SMI databases are maintained and kept up to date [ACTION OWNER MD]	31/03/2019	Audit of SMI registers undertaken during Q4 17/18 demonstrated 91% compliance with required information shared with GP's. 2018/19 CQUIN requires defined process across Trust, workplan for Derbyshire agreed with Commissioners and public health. Quarterly meetings in place to monitor progress. Solution agreed with IT/IG for our access to primary care summary care records. To explore whether SCR can be uploaded onto Trust EPR systems as administrative routine.	High
Specific process and training to manage sepsis, in line with national guidance	Review the current infection control policies to ensure information around the identification and management of sepsis, and other high profile infections, are in line with current national guidance and best practice	28/02/2019	Sepsis policy in development with intention to roll out alongside NEWs2. This will replace existing DEWs framework	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Consistent monitoring and recording of physical healthcare standards across inpatient and community settings	Develop automated compliance checks and audits in PARIS [ACTION OWNER MD]	28/02/2019	Develop compliance report for key areas- 136 assessment, admission, community 1st contacts in addition to CQUIN requirements to be presented at TMT. Additional audits developed, used to inform developments to EPR.	High
Consistent implementation of the LESTER tool	Scope the implementation of a module in PARIS to enable local teams to receive early notification of patients commencing medication to enable monitoring to be put in place [ACTION OWNER MD]	28/02/2019	Trigger notifications to clinicians involved in a patient's care being developed based on diagnosis to instigate use of LESTER tool. Scoping of implementation of E-prescribing remains underway. Specification and interface issues being explored with development team and CIVICA. Medical director and EPR CRG chair working to identify if section in clinical letters can be subject to word search and this trigger alerts. Word search develops too many false positives. Further work required to develop trigger systems.	High

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ID	Division	Title	Description	Controls in place	Mitigating actions	Date of next review
21451	Campus Services	Chronic shortage of junior doctor cover leading to negative impact on physical healthcare	The Trust is currently experiencing and also anticipating further gaps in the trainee doctor on call rota, due to national chronic shortages of doctors in training for psychiatry. The new junior contract means that trusts cannot compel junior doctors to fill these gaps. If gaps can't be filled, registrars can act down but if no registrar is available then consultants are required to fill the role. However consultants lack the expertise in dealing with physical healthcare emergencies, resulting in patients potentially being attended to by doctors without the necessary skills. It is not feasible for consultants to acquire the necessary competencies and this may have a negative effect on recruitment and retention of senior medical staff.	Recruitment and retention initiatives for junior doctors.. Long terms plans, as part of the medical workforce plan, are underway to develop an integrated workforce to using advanced medical practitioners, however the pipeline will take 2-3 years to produce trained staff. Commencing discussions With Derbyshire Healthcare United to provide nursing home type cover to inpatient wards, so if there are gaps in the rota DHC United will then be able to respond to physical healthcare emergencies	19/11/2018. Repatriation of trainees from S Yorks/Humberside to EM Deanery presents extra risks - report requested for ELT.	31/12/2018
21471	Neighbourhood Services	Delivery of Physical health CQUIN	Implementation and full delivery of Physical Health in Mental Health initiative as detailed in 18/19 CQUIN is at risk. Full funding for delivery of initiative is not available and therefore reliant upon re-engineering current roles	Working with HR, staff side and workforce to facilitate implementation of service. However expected will only have limited cover and will not be able to deliver within all neighbourhoods initially. It is expected that the project will be rolled out neighbourhood by neighbourhood as resources permit. Therefore some neighbourhoods will be unable to provide a service that embraces the physical health in mental health principles.		01/04/2019

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Board Assurance Framework Risks 2018/19 v 4.2

Strategic Outcome 1. Quality Improvement

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

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

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	Complete revised V3 of CPA policy Design and redesign training methodology using experts by experience and carers[ACTION OWNER DON] Continual audit of compliance and outcomes., connecting to recovery and enablement strategy.[ACTION OWNER DON] Adopt a learning and scrutiny culture in supervision that reviews the adequacy and meaningfulness of CPA in supervision [ACTION OWNER DON] Embed CPA monitoring into COAT practice and include routinely on compliance and clinical audit programme.[ACTION OWNER COO]	Completed 28/02/2019 Completed 28/02/2019 28/02/2019	Policy revised and approved Operational implementation issues in design Redesign of PARIS CPA information required Findings from community audit of CPA and safety plan reviewed by COAT and reported to July 2018 Quality Committee. Completed Key component of the roll out of the revised CPA policy, the supervision and records audit already monitor these standards. Reports to COATs and summary report to QC has occurred, this approach will continue Findings from community audit of CPA and safety plan will be reviewed by COAT at regular intervals, and monitored at TMT. Performance monitoring against the code of practice standards in final agreed policy. Operational teams to develop implementation strategy, performance monitoring schedule and implement clinical standards.	
Compliance with revised policy	Develop and implement audit of compliance over an 18 month period [ACTION OWNER COO]	28/02/2019	This is in design, qualitative audits in place, automated audit based upon new CPA form is in design	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Delivery of improvement plan	Production of a 'deep dive' on the improvement plan with evidence of implementation and reporting structures in place [ACTION OWNER COO]	30/01/2019		Medium

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Strategic Outcome 2. Engagement

Principal risk:

Risk: **There is a risk that if the Trust doesn't engage our workforce and create an environment where they experience the aims and values of the Trust, there will be a negative impact on the morale and health & wellbeing of staff which may affect the safety and quality of patient care**

Impact: Negative impact on staff wellbeing which may lead to an impact on quality of care provided and overall staff retention

Root causes:

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

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

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

Key controls:

Preventative – Team Derbyshire leader's events to engage leaders. Ongoing wider engagement activities for all staff and staff communications which reinforces vision and values and staff communications which reinforces vision and values. Establishment of network groups i.e. BME, disability and health, and LGBT+. Ongoing dialogue with union representatives via formal and informal routes

Detective – Management and leadership questions from staff survey, staff survey engagement questions. 'Ifti on the Road' programme, programme/wider Board engagement feedback. Wider feedback including concerns raised as part of Freedom to Speak Up

Directive – Leadership development training supporting managers as part of a coordinated Leadership and Development Strategy. Refreshed Trust Strategy which outlines vision and values.

Corrective – Appraisal process (revision of documentation under consultation) and supervision processes. Organisational Development support to teams identified as low engagement or negative feedback

Assurances on Controls (internal):	Positive assurances on Controls (external):
Improvement from staff survey to pulse check evident during 2018. Consistent response rate from pulse checks	Positive CQC feedback on embedding of visions and values across a range of service
Report in Chief Executive report to Board and Weekend Note to staff highlighting staff engagement and feedback	Staff Survey results 2017 (limited assurance)
Positive Staff forum feedback ('You said: We did' infographic)	Staff Survey engagement 2018 – approx. 50%
Feedback from Quality Visits	

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Positive feedback from staff forum (limited response) Staff survey participation levels in comparison to peer group Positive feedback from network groups (BME Disability and Wellness LGBT+, reverse mentoring)		Pulse Checks Friends and Family Test		
Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of leadership development strategy	Develop leadership and management development strategy to include: management development; leadership development; coaching and mentoring, reverse mentoring. [ACTION OWNER DPOE]	28/02/2019	Leadership and Management Development Strategy agreed by ELT 26/11/2018 for January 2019 rollout. Action to close gap includes evaluation of programmes to assess impact.	Low
Further development to embed and coordinate wider engagement activity, including capturing feedback from all engagement activities	Range of activities are in place including Staff Forum, Team Derbyshire Healthcare Leaders events, team briefing, raising concerns, director/CE visits etc. to provide opportunity to engage with staff. Continuing implementation and evaluation of effectiveness to be undertaken including review of feedback captured from all engagement activities. [ACTION OWNER DPOE/DCA]	28/02/2019	Activities established in response to staff feedback following 'Working together feeling connected' survey in 2017. Paper for PCC in Oct 18 gave an update on areas of activity established including staff forum, leadership events, team brief, staff magazine, suggestion box, internal Facebook page, CE, Executive and NED engagement, staff conference - including development of staff promise. Action to close gap includes ongoing monitoring of engagement activity including analysis of feedback themes. Development of structured Director programme of engagement visits to teams from Jan 2019 and ongoing refinement of team brief and encouragement for delivery at team meetings.	Low 
Lack of response/analysis of feedback from staff	Broad oversight of feedback from all staff engagement to be coordinated and themes identified in order to address these. Ensure response to issues staff raise and promoting 'you said, we did' to encourage further engagement and feedback. [ACTION OWNER DPOE/DCA]	28/02/2019	Staff survey and pulse checks analysed. Plan in place to work with 10 least engaged teams by Sept 2018, to improve staff survey participation rates and overall engagement score. Analysis of staff survey, pulse check, Board engagement, team brief to demonstrate 'you said we did'. Increased staff participation in staff survey 2018.	Low
Staff awareness and ownership of Trust vision and values	Refreshed Trust strategy, vision and values to be cascaded through Trust and reinforced by staff communication, branding and role modelling from senior leaders. Promotion of examples of positive behaviours in practice to be disseminated and example of this happening in practice celebrated. Ensure staff are aware of what behaviours/practice is not acceptable and how to report this. [ACTION OWNER DPOE/DCA]	28/02/2019	Refreshed Trust Strategy, vision and values cascaded throughout Trust and reinforced through Team Brief, staff magazine and screen saver on Connect. Staff Forum up and running. Challenging and focusing on issues staff want to be discussed. Staff Conference Sept 2018 Work now underway to develop a set of expectations for staff whilst working in the Trust, led by HR and Communications managers. Work re bullying and harassment underway. Action to close gap: implement staff promise through core leaders launch sessions starting early 2019.	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Staff survey identifying issues with	Identify resources to implement leadership and	28/02/2019	Individual seconded to leadership and development manager post	Medium

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leadership and management.	management development programme which will help reiterate vision and values, behaviours, expectations for leaders and managers throughout the Trust. [ACTION OWNER DPOE]		from EMLA. Post is back out to substantive recruitment. Evaluation of feedback and longer terms impact on staff survey and wider factors relating to sickness, morale and wellbeing will provide assurance.	
Staff responses on morale and health and wellbeing questions in staff survey	Address hotspot areas and wider trust actions to address [ACTION OWNER DPOE]	28/02/2019	Hotspot areas have been focussed upon and success measured through improved staff survey feedback (level of feedback and positive response). Deep dive to PCC on 'hotspot areas' of sickness and absence in Dec 2018. Complete review of sickness/absence policy, processes and procedures, including support packages. Business case to ELT planned Jan 2019.	High
Coverage of engagement and collated staff feedback themes and evidence of actions to address	Refine team brief and encourage wider implementation, reinforced through Core Leaders programme	28/02/2019	Ongoing focus monthly on increasing participation and embeddedness of team brief process in organisation	Medium

Related operational high/extreme risks:

ID	Division	Title	Description	Controls in place	Mitigating actions	Date of next review
21278	Children's Services: CAMHS	Work related stress in team	Demand exceeding capacity, little control to manage this within current structure due to urgent and risky nature of clinical referrals and caseload. Difficulty in maintaining team approach and model of care due to small size of team and no resources can be accessed to cover for sickness and vacancies. The ED Pathway operates independently of early help and supported care pathways in CAMHS which leaves it vulnerable to isolation. Staff are identifying physical and emotional impact on well-being and health in individual supervision.	Clinical and operational supervision . Operational management of resources in team to respond and prioritise clinical needs. Agreement within team to reduce non-essential areas of activity where possible to reduce demands temporarily. Team stress risk assessment checklist completed. Issues raised with senior management and at CAMHS management meeting to complete individual stress risk assessments for staff where indicated.	Individual stress risk assessments. Continues to be high level of referrals often compromising available capacity. Cases having to be held in Eating Disorder team for lengthy periods of time awaiting transfer to other care pathways adding to workload in ED team and reducing capacity for new referrals. Secondments and temporary staffing arrangements affecting recruitment	01/03/2019
21467	Neighbourhood	Workplace Health, Safety and Welfare	DRRT staff may be at risk of various injuries due to the environment we work in at Newholme Hospital. The team is looking at expanding to out of hours work and at present we would be the only out of hours service in our current base. The office we are in is an 8 person office, however there are 14 members of the team which will continue to expand, the office is increasingly cramped with people and electronic items.	Work assessment checklist completed and attached. Drinking water available. Suitable toilet facilities with hot and cold water. Adequate lighting and ventilation Rubbish/recycling/confidential waste removed regularly	22/01/2019 update: Meeting with estates and ASM on 21/01/19. Possibility of the team occupying more space in Newholme with two options, DCHS estate manager contacted to advise of the options we are looking at. Date arranged on 20/02/19 to view part of Newholme that we may be able to occupy, until then it has been agreed we can overspill into CMHT space until something is arranged.	31/03/2019

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Strategic Outcome 3. Financial sustainability

Principal risk:

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

Impact: Trust becomes financially unsustainable.

Root causes:

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

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

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	3	5	↓	MODERATE	2	5			

Key controls:

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

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

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

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

Assurances on Controls (internal):	Positive assurances on Controls (external):
Financial performance reports to Trust Board and Finance and Performance Committee evidence the overall actual performance as well as the forecast performance. Includes several sections covering the efficacy of controls include: - CIP delivery achievement - Agency expenditure - Balance sheet cash value The Integrated Performance Report evidences delivery of services, workforce	- Internal Audits– significant assurance with minor learning opportunities for internal audits: 2017/18 Expenditure Data Analytics (3 medium, 1 low risk findings) and 2017/18 Payroll Data Analytics (1 medium, 2 low risk findings) - External Audits – strong record of high quality statutory reporting - Grant Thornton and KPMG audits show good benchmarking for key financial metrics (including liquidity) - NHSI Finance Rating Metrics – shows good performance - National Fraud Initiative – no areas of concern - Local Counterfraud work – Referrals show good counterfraud awareness and reporting

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information, quality information set against the financial performance evidencing whether we deliver services within our resources Use of Resources report to Trust Board meeting November 2018 evidences strategic approach to effective use of resources	in Trust and no material losses have been incurred - Deloitte Well Led review – positive affirmation of the effectiveness of the Finance and Performance Committee

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Agency approvals controls are failing to reduce agency expenditure to under the NHSI ceiling level	Executives continue to have regular meetings and take appropriate actions.[ACTION OWNER: COO] AIM: achieve average £250k per month agency spend (or less)	Completed	Agency controls have led to reduced total agency expenditure and better adherence to capped hourly rates, but ceiling not achieved. Agency spend reduced from c£5m in 1617 to c£4m in 17/18 Trust vision/priorities: Financial sustainability – the leading indicators chosen are achieving agency ceiling and recurrent CIP Reported position at end of month 4 (31/7/18) is that we are under agency ceiling. Action closed, to be reopened if required.	Achieved
Cost control/Cost improvement – requirement for firm plans for full 18/19 CIP programme (and longer term pipeline of cost and quality improvement)	QIPP and CIP incorporated into the mental health STP workstream [ACTION OWNER DBI] Increased CIP meetings and project scrutiny, management action via PAB {ACTION OWNER – CEO] AIM: full CIP programme, quality assured. Updated PMO and associated structures with new Director Business Improvement and Transformation in place	Completed	CIP and QIPP continue to be part of Mental Health STP Workstream. New Programme Delivery approach planned. Gap remains: full assured programme for 18/19 required. Further action: ELT decided to reconcile 2018/19 programme which left a c £300K gap and to move focus to 2019/20 programme. PAB had been re-instated, chaired by CEO . PAB now replaced by updated TMT/ELT and Programme Office approach in order to urgently shift the full focus to 2019/20 planning and delivery. Continuous cost and quality improvement remains a key deliverable in the new Director of Business Improvement and Transformation role Efficiency focus for 2019/20 and beyond is informed by the ten main improvement areas described in the Use of Resources paper presented to November 2018 Trust Board The Trust has also engaged with Midlands and East Productivity team regarding opportunities for increased productivity as shown by Model Mental Health Hospital benchmarking	Achieved

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Strategic Outcome 3. Financial sustainability

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

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

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of capacity and cohesion across clinical pathways	Transform clinical pathways to provide more joined up care (internal focus)[ACTION OWNER DBI&T]	28/02/2019	Trust attended at each of eight PLACE alliance meetings in Jul and Aug 2018. Trust representation at identified at	Medium ↓

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			organisational development workshops through Autumn.	
Delivery of 'Five Year Forward View'	Develop new clinical models for service delivery via Mental Health System Board (external focus). Work with commissioners to deliver Mental Health Investment Standard in developing new pathways and services [ACTION OWNER DBI&T]	28/02/2019	Work on rehabilitation pathway continues, including analysis of cohort in locked rehab beds. Scoping of use of public health well-being hubs as alternative to clinical interventions. Agreement with Commissioners on system wide savings to deliver mental health element of the CCG QIPP target.	Medium
Level of influence on system wide children's and urgent care QIPP schemes	Ensure Trust is actively participating in workstreams for children and urgent care [ACTION OWNER DBI&T]	28/02/2019	COO attendance at Urgent Care Strategy Board meetings. Meeting scheduled in Oct 2018 with children's commissioners to discuss system approach.	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery.
Compliance with Mental Health Investment Standard	NHS England monitoring of CCG's compliance with investment standard [ACTION OWNER DBI&T]	Ongoing monthly	Agreement with CCG on the reset MHIS in July 2018. Delivering system wide savings.	Low
Agreed contract with commissioners for 2019/2020	To agree a contract with commissioners which delivers investment in our priority areas and core services, and meets the requirements of the Mental Health investment Standard	31/03/2019	Contract negotiations underway. Trusts executive's directors in process of agreeing priorities for investment. Contract meetings diarised until end of March 2019	Medium
Agreed contractual income results in the need for a cost improvement programme with a very high risk to delivery.	Agreement with commissioners of a contact which delivers core services and priority areas	31/03/2019	Actions as above	High

Related operational high/extreme risks:

ID	Division	Title	Description	Controls in place	Mitigating actions	Date of next review
867	Neighbourhood Services	Commissioned Care Co-ordination Capacity within Neighbourhood Teams	Commissioning Gap. Insufficient care co-ordination capacity. Risk applies to all neighbourhood teams. Identified gap in resource requirement has led to significant pressure on care co-ordination capacity. Demand for service over the past 12 months has increased by 16% which has also led to pressure on capacity and waits for care coordination	Shortfall in care co-ordination resource has been raised with the commissioners. Each team has a waiting list management procedure this is implemented as far as is possible. Each team has a duty system to respond to those on the waiting list, and to try and manage their needs and ensure flexible approach to needs led allocation in a timely manner. Waiting lists are reviewed by service managers.	18/06/2018 update: Commissioners have provided funding for an additional 7 Care Co-ordinators for neighbourhood services. The funding can draw down as recruitment takes place.	01/04/2019
21189	Central Services: Mental Health: Eating Disorders Service (Adults)	Admission criteria to Eating Disorders Service	Service currently has BMI admission to service criteria. Concerns there are significant people with eating disorders who cannot access specialist therapeutic services. Possible risk of impact on increasing prevalence and chronicity of eating	Voluntary services exist to offer supportive non clinical interventions. Currently working on proposals to broaden the admission criteria to the ED Service in consultation with Commissioners. Clinical and Operational Leads to meet to devise new access criteria (including implications on capacity/waiting	03/12/2018 update: Further funding remains unavailable via CCG. Plan to propose possibilities around 'big ticket' wins for both CCG and ED service. Including shared care proposal relating to blood testing. Existing BMI access criteria to remain in place (inc. rapidly reducing BMI.	03/04/2019

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			disorders across Derbyshire without early and timely clinical intervention.	times) and new service specification for commissioners.		
21223	Central Services: Learning Disability: Erewash CLD Team	Exceeded waiting times for dysphagia referrals	SLT LD currently accepts referrals for dysphagia classed as routine and urgent Due to only 1.3 therapists currently available to provide this service, there are 52 people waiting for a service following a telephone screen, with 14 classed as urgent. Recent ISMR's and LeDeR reviews have shown that people who are on the waiting list for this service, have died from aspiration pneumonia whilst awaiting an assessment.	Detailed option appraisal attached to risk assessment.	25/01/2019 update: Due to 2.7 resignations and the impact of this on the waiting list targets, the risk cannot be mitigated as these therapists are all dysphagia trained, with one being the expert dysphagia practitioner 12 on the waiting list currently Meeting arranged on 6/02/2019 with ASM to discuss options	28/03/2019
21184	Children's Services: Universal and Specialist Community	Commissioning intentions - The Lighthouse	The Lighthouse is currently provided under a Section 75 agreement with the local authority. There is currently work being undertaken to review the delivery model of the service. Some of the early indications are a change to the clinical input we provide which may lead to an alteration to our ability to deliver to key clinical standards and patient safety needs	ASM, GM and Contracts manager engaged in the local authority led workshops (monthly). Review of clinical standards and QIA of current provision, evidence base and standards to inform decisions. Horizon scan of other models underway.	20/11/2018 Update: Staff consultation process commenced on 05/11/18. Meeting with LA and CCG (public meeting with parents 19/11/18). No clear model produced, CCG advise they will undertake a procurement exercise. Reference to a social care model. Unclear health component as yet. LA / CCG to produce model and contingency for parents by mid Dec'18. Internal support continues for staff.	21/12/2018
21503	Campus	Non-commissioned Older adults Crisis service	The Crisis Resolution and Home Treatment (CRHT) Team in North Derbyshire was established and became operational 24 hours/ day in 2005. There is currently no equivalent service for adults aged 65 and over. The Older Adult (OA) Consultant Psychiatrists and CMHTs deal with urgent referrals in this age group without the support of a CRHT.	As the DRRT only see patients with an organic illness such as Dementia, any patient over the age of 65 with a functional illness is managed by the Older Adult CMHT and if there risks escalate beyond this services ability to manage they are referred for an inpatient admission to maintain their safety.	07/01/2019 update: No further progress at present although the crisis team do continue to support older adult services and review referrals on a case by case basis if the patient is close to working age or if the presentation is primarily functional.	30/03/2019
21586	Neighbourhood	Wait times breaching CCG contract	Due to increasing MAS referrals against original costings and clinical provision MAS are currently breaching the 12 week wait from referral to diagnosis. There are current projections to 2800 referrals across the Derbyshire MAS patch and clinical provision for 2200. This does not include the MAS 24 work.	Staff are booking maximum clinical appointments daily and training is being paired back to minimum mandatory. Considering cancelling attendance at staff forum as this loses 2 clinic slots a month with planning group and staff travelling.	New risk added 12/12/2018	31/03/2019

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Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Lack of available staff in hotspot areas	Increase availability of staff in hotspot areas [ACTION OWNER MD/DPOE	28/02/2019	Focused work being undertaken via ELT and PCC on hotspot areas. Actions being taken to address the availability of staff through: reduction of sickness absences, increasing fill rate to vacancies, and increasing bank and agency fill rates where appropriate.	High
Workforce plan to include alternative workforce models both medical and	Work in partnership with clinical pathway work programme to develop workforce models for each	28/02/2019	Interim report to PCC in Dec 2018 on current position with medical workforce and alternatives available. Full report to emerge from	High

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nursing	pathway with an MDT approach. [ACTION OWNER MD/DPOE]		clinical pathway workforce modelling. Expected by end Feb 2019. LBR and Levy funding will be aligned to new emerging workforce models.	
Appeal of the trust as a place to work	Further develop multigenerational offer to attract staff for key national occupational shortages, and for development and retention of staff in key areas [ACTION OWNER DPOE] Develop an 'itchy feet' programme and also consider rotational opportunities across inpatient and community services in order to proactively manage the flow of workforce across these areas [ACTION OWNER DPOE/COO]	28/02/2019 28/02/2019	Work commencing between people services and operations. Development of a business case to give assurance around the gaps Flexible working offer needs further promotion, in-house bank being expanded. Rotation programme deferred due to high demand for recruitment and operational capacity	Medium
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
National funding sources to develop our workforce	Gain funding streams from Learning Beyond Registration (LBR), Apprenticeship Levy and STP funding for Mental Health [ACTION OWNER DPOE]	28/02/2019	LBR funding reduced for 18/19 by over 50%. Identifying offset against the levy and bids made into STP workforce to see how to support staff development. Update to PCC planned for Dec 2018.	High

Related operational high/extreme risks:

ID	Division	Title	Description	Controls in place	Mitigating actions	Date of next review
2772	Children's Services: CAMHS	Insufficient resources CAMHS workforce	Insufficient CAMHS workforce leading to a lack of care coordination within new pathway model resulting in increased reliance on medical team. Reliance on locum and agency usage.	Active recruitment to Consultant vacancies and short term locum cover. Patients who only require only medication management have been transferred to health hub (nurse prescriber)	20/11/18 update: Recruitment for Complex health post open, with ND recruitment to begin. Paper submitted to TMT/ ELT proposal to cease out of hours on call. To be agreed. Further agency cover 10pa approved, now sourcing. Await decision on on-call rota, final cover options being explored with COO. Remains at same level of risk. Meeting with Consultants 06/12/18.	21/12/2018

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20993	Children's Services: Universal and Specialist Community Services	Staff shortage Children and Therapies	Currently without one full time Band 5 therapist and a half time Band 6 OT this situation has lasted longer than anticipated due to difficulties recruiting to the Band 6 post. Patients affected adversely by forthcoming breaches in waiting times (over 18 weeks). Children known to service already having to wait for reviews – some with physical disabilities may experience harm from lack of timely special equipment reviews.	Identifying children open and inactive to services and discharging some Caseload reviewed to ensure waiting times can be addressed with capacity for throughput. Additional support secured for service engineering facilitated sessions with transformational lead. ASM to monitor the situation and feedback the risks and consequences to senior management.	04/12/18 update: Recruited 2 band 5's on permanent contracts following permission to over-recruit. There will be training and development required for these posts which will impact mainly on the band 6's and 7's. There is a risk of increasing internal waits for input for children already on caseload - this is being monitored. An operational lead is being recruited which will enable clinical leads to make changes to pathways and forge ahead with positive changes. We will remain in crisis status until this can be completed.	31/01/2019
3262	Community Paediatrics Teams	Long waiting lists following reduction in paediatrician staffing levels	Children and young people and their families are not being seen and assessed within a timely and appropriate manner.	Attempts at recruitment are ongoing. Follow up caseload to be transferred to ND Team and there are longer term plans for transformation in some of the areas however this will have an impact in the longer term rather than in the short term. Suitable locum cover has been difficult to obtain and only covers the less specialised aspects of the roles.	02/11/18 update: Refer to TMT Report re RTT 18 weeks (attached to this risk). Additionally staffing is to full establish and the ND Co-ordinator has commenced in post. This should start to have an impact on the future referrals waiting for assessment. A locum is currently being deployed to support the waits for ADHD assessment.	31/01/2019
21447	Neighbourhood Services	Minimum staffing levels for a 7 day per week service	Low levels of staffing in IRHTT. The team currently comprises of 13 members of staff. From 03/06/18 the team has been providing a 7 day per week service, 9am to 5pm, with skeleton staffing levels at the weekend. There is the potential that staff sickness levels may increase due to the stress that the IRHTT is currently under functioning with low levels of staffing.	Wherever possible there is always a minimum number of 4 staff on duty, 2 qualified nurses/OT.	The IRHTT remains a developing service and the possibility of it merging with the DRRT is being explored. If this was to occur it would improve the clinical staffing levels.	11/03/2019
21534	Central Services	Lack of clinical staff within psychodynamic psychotherapy service	CCG currently has a public consultation into continued funding for Psychodynamic Psychotherapy with a plan to decommission. Service currently has 3 WTE vacancies due to therapists leaving and/or reducing hours.	Vacant posts out to advert after no previous shortlistable applicants Existing staff offered additional hours Request with Psychology for either secondment or additional hours within the service. Consideration of bank/agency therapists Authorisation of paid A/L excess (if untaken by April)due to cover of service.	14/11/2018 update: Shortlisting of 3 individuals for B7 therapist post Authorisation of paid A/L excess (if untaken by April) due to cover of service. Request to People Resources to look at bank/agency therapist options. O/H referrals completed for staff off sick.	31/12/2018

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21207	Campus	Staffing issues	Note: MHTH is based at Police Head Quarters in Ripley Due to a current lack of staff the service is struggling to provide the commissioned service to police, EMAS, Out of hours GP's, and Social care. Furthermore on some days no service can be provided. Minimum staffing levels should be 2 clinicians per shift. At present there is often only one staff member by themselves.	Staff are offered additional hours including overtime to help cover the deficit. Emergency services have been made aware that they can contact services within DCHFT and DCC for information and advice regarding services users under their care. (crisis team, liaison team, Inpatient wards and AMHP's) Recruitment underway and 2 staff awaiting start dates.	09/01/2019: There is no current change from the last progress review in terms of staffing, however this has been raised to the MH Commissioners and social care managers by ASM	04/03/2019

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Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

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

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Clear specification for improvements	Develop clear specification of improvements required	28/02/2019	Second scoping exercise completed, resulting in now three task and	Low

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required	to PARIS, with project plan, and timeline to meet agreed scope. FSR CRG to develop plan and report back to the Finance and Performance Committee [ACTION OWNER COO]		finish groups. Two groups have finalised their specification. Physical healthcare specification delayed, to be completed by Jan 2019. Clerking in sign off to be completed early in new year.	⬇
Confidence of staff in using the FSR to enhance patient care	-Ongoing support and review from Clinical systems lead -Involve clinicians in the FSR CRG to seek opinion and advice. -Ensure focus is maintained on reducing complexity and number of templates and time taken to complete by staff [ACTION OWNER COO] -Identify medical clinical information officer to develop clinical involvement in PARIS [ACTION:MD]	Ongoing Completed 28/02/2019 Completed	Additional training sessions continue to be delivered in locations across the organisation. Increased number of clinicians now attending the FSR CRG (5) Task and finish groups outlined above have been developed in response to areas of highest concern from clinicians and requiring the greatest simplification and redesign. Clinical lead well embedded and responding to individual and team requests, and developing staff confidence in system. Resulting in reduction in number of queries re functionality of system. Job description approved by ELT. In process of recruitment.	Low ⬇
Fragmented recording of physical healthcare information on PARIS	Remapping of physical healthcare health care recording and monitoring on PARIS [ACTION OWNER MD]	31/03/2019	Being progressed by task and finish group for physical health care as outlined above. Final specification due Jan 2019, to be rolled out of by end of March 2019.	Medium
Limited staff engagement with safety planning process	Developing the safety plan framework on PARIS in line with commissioner feedback to include a stepped approach to safety planning and review of the existing form [ACTION OWNER MD]	Completed	Safety plan development is on track. Developers have the new specifications and these are being built. Teams in place to test new form	Achieved
Too many locations on PARIS to record same information	-Rationalisation and reduction of clinical documents held on PARIS -Conversation of 'forms' to 'locations' to centralise similar clinical information in one place. -Increasing auto population of forms where relevant -Development of tiles to improve access to key information (Care planning/ physical health care/ safety planning [ACTION OWNER COO]	28/02/2019	The FSR CRG review the enhancement log at each meeting, rationalise actions and reviewed more complex actions with the staff proposing to clarify request. Number of actions aligned with actions identified through scoping exercise, so these will be subsumed in task and finish group work plans. New developments are paused to create capacity to develop the above. Around half of forms on enhancement log have now been rejected or amalgamated thus reducing the number of forms available to staff. Audit of little used forms in place, and these are removed when assessed as not required.	Medium ⬇
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Oversight of other Trust development of FSR's	Continue to develop supporting arrangements with other Trusts using PARIS and other EPR's to support learning and development [ACTION OWNER COO]	Completed	Trust colleagues have visited another trust that uses Civica to establish what learning can be transferred to our own trust. Any positive learning is being reviewed at the CRG meeting. Trust actively engages with the wider user network on an ongoing basis as required.	Achieved
Related operational high/extreme risks:				

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ID	Division	Title	Description	Controls in place	Mitigating actions	Date of next review
21473	Corporate Services	Data Accuracy	There is evidence to support that electronic clinical data is inaccurate in terms of discharge and that there are gaps in the electronic record in relation to REGARDS This is a clinical risk in terms of the accuracy of the patient care record but also serves to skew performance reporting and requires constant cleansing resolutions	Robust reinforcement of accurate discharge process to be monitored over the next 6 months and reinforced across all areas. IM&T are creating patient registration forms that are pre-populated with data already held on the patient record. These are currently being piloted. Once this work is complete, the intention is that patients will be asked to check and update the information on the form while awaiting their appointment.	10/12/2019 update: Work on going re exception report development and patient update	31/01/2019

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Strategic Outcome 4. Operational Delivery

Principal risk:

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

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

Root causes:

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

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

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

Key controls:

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

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

Gaps in control:	Actions to close gaps in control:	Review due:	Progress on action:	Risk to delivery:
Workforce plan: Oversight of delivery via fully functioning strategic workforce groups. Leadership ownership of the plan with sponsors for introducing new roles	Reshape the strategic workforce group and education group membership. [ACTION OWNER DPOE]	Completed	Year 2 workforce plan has been agreed. Investment into key roles such as Nursing Associates, Nursing Apprentices and ACP's agreed. ELT and PCC to track progress. New strategic workforce and education group in place.	Achieved
Funding: Ownership across the leadership team to transform current gaps in supply to new posts. Trust and HEEM funding availability	Executive oversight at ELT to delivery and transformation. HEEM funding – bid for every available work stream [ACTION OWNER DPOE]	28/02/2019	Medical Director working with workforce planning lead and chief nurse to present a paper to PCC for Dec 2018 and a revised workforce model per clinical pathway to emerge from clinical pathway work (due Feb 2019)	High

Operational risk information extracted from Datix 05 12 18, updated 30 01 19

Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Lack of regular review at ELT and strategic workforce group of workforce plan delivery	Increase the focus on the ELT and Strategic workforce groups quarterly [ACTION OWNER DPOE]	Completed	Strategic Workforce Group now meets monthly and engages across all parts of the organisation and has a balanced agenda between strategic and operational issues.	Achieved

Operational risk information extracted from Datix 05 12 18, updated 30 01 19

Strategic Outcome 4. Operational Delivery

Principal risk:

Risk: **There is a risk that the Trust will not improve the acute inpatient flow of patients through our services**

Impact: This may lead to: poor patient experience and outcomes due to increased length of treatment or stay; increased placements outside of local area; inefficient use of resources; reduced access to services; increased waiting times; financial penalties

Root causes:

a. Average length of stay is above national average
b. Lack of alternative care options
c. System wide resourcing issues

BAF ref:	**Director Lead**: Mark Powell, Chief Operating Officer	**Responsible Committee:** Finance and Performance Committee	Datix ID:
18_19 4d			21297

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

Key controls:

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

Directive – 'LEAN' based approaches to service change; Recruitment to key leadership posts in acute care i.e. Urgent Care Improvement Lead, Clinical Lead, 136. – Clinical Lead, General Manager secondment, Clinical Director. Coaching support by Programme Assurance Office and Head of Programme Delivery. Introduction of Royal College of Psychiatry Standards to provide service with a framework to inform practice

Corrective – Board reporting on Trust Strategy; Dementia Rapid Response Teams; In-reach to Ward 1; CAMHS home treatment model; Ongoing engagement with urgent care staff

Assurances on Controls (internal):	Positive assurances on Controls (external):
Bed status dashboard Red2Green weekly tracker Monthly Integrated Performance Report to Board	CMHT Community Service Survey CQC 2018 comprehensive review (gaps in assurance)

Gaps in control:	Actions to close gaps in control:	Review due	Progress on action:	Risk to delivery:
Lack of clear Urgent and Emergency Care clinical model	Deliver 100 day plan. Plan focuses on delivering improvements to: clinical standards and re-energising clinical practice; improving clinical and operational leadership and staff engagement; redesigning and transforming service model; delivering and supporting staff; improving the	Completed	100 day plan delivered and closed, longer term actions being implemented. All identified posts recruited to. Leadership and management review completed and recommendations being implemented. PARIS app launched to enter data from a hand held device. Community Clozapine Initiation clinic developed to take pressure off inpatient beds. Bank fill rates above 80%. Royal College	Achieved

Operational risk information extracted from Datix 05 12 18, updated 30 01 19

	physical environment. [ACTION OWNER COO]		of Psychiatry Standards introduced, self-review completed. Increased support for clinical leaders to monitor and manage absences. 25 new starters to Radbourne and Hartington Units.	
Lack of clearly defined clinical pathways	Agree and implement clearly defined clinical pathways to ensure people are cared for by the right staff with the right skills for the right length of stay [ACTION OWNER COO]	28/02/2019	First two meetings taken place to identify need for a Trauma informed or Personality Disorder Pathway. Challenge due to sufficient community resources required to support inpatient discharges.	High
High numbers of patients with length of stay over 50 days	Identify causes of delayed discharges and review practice to ensure discharge process starts at point of admission in order to reduce length of stay. Work more closely with stakeholders such as social care to support reduction in length of stay. [ACTION OWNER COO]	28/02/2019	No of patients with length of stay above 50 days is decreasing, delayed discharge continues due to housing or suitable placement availability. Bed occupancy demand continues leading to increase use of out of area beds. CHTT new model planned from 1/12/18, expecting positive impact on patient flow. Continued monitoring of Red2Green.	High
High vacancy rates and and high levels of sickness absence in urgent care services	Deliver bank fill rate of 80% for Radbourne Unit and CRHT [ACTION OWNER COO]	28/02/2019	25 new staff with increased visibility of practice facilitators to support. Clinical leads continue to be supported to monitor absences.	Medium ⇩
Increased use of health services by some high risk individuals	Improve packages for high intensity users of health services through projects supporting the acute care pathway [ACTION OWNER COO]	28/02/2019	High intensity users project (JET -Joint Intensity Team) team commenced. Training commenced and working through cohort of patients identified.	Medium
Delayed discharges above specified lengths of stay	Bed optimisation project, including 'Red2Green' project implementation to increase flow in inpatient areas [ACTION OWNER COO]	28/02/2019	Red2Green continues to be undertaken across all wards, data being collated to evaluate impact. Improvement plan being delivered which will include a focus on further reducing lengths of stay. Continued escalation focus on patients who have stayed in hospital over 50 days, evidence of impact.	High
High caseloads and long waiting lists in community based mental health teams	Complete Neighbourhood review, to ensure services are meeting commissioned needs in line with 'Joined Up Care Derbyshire' approach [ACTION OWNER COO]	31/03/2019	Current Phase of the review has been completed. Paper produced outlining proposal and plan for future development of Neighbourhood Services. Awaiting authorisation from Board that able to proceed.	Medium ⇩
Gaps in assurances:	Actions to close gaps in assurances:	Review due:	Progress on action:	Risk to delivery
Continued high use of out of area beds resulting in reduced patient experience and financial impact	Actions outlined above to be implemented, with an expectation that they will reduce demand on beds but will not reduce to levels sufficient to impact on risk rating i.e. consistent low level usage of out of area beds, of around 1-2 patients. [ACTION OWNER COO]	28/02/2019	As outlined above. Going forward overall strategic review required, aligned to estates strategy and risk 1a of the BAF relating to patient safety and experience.	High

Operational risk information extracted from Datix 05 12 18, updated 30 01 19

Board Assurance Framework Risks 2018/19 v 4.2

Risk Assessment Matrix

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

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

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

Operational risk information extracted from Datix 05 12 18, updated 30 01 19

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Summary Report to Trust Board
Mental Health Act Committee (MHAC) - meeting held 7 December 2018

Key items discussed:

- **Revised MHA Operational Group Terms of Reference:** accepted with the proviso that an addition be made to Section 4 – Duties and Responsibilities – to reflect the dynamic nature of work undertaken – horizon scanning/innovation/quality improvement – to be agreed by Chair's action.

- **Minutes of MHAC Operational Group and Actions Matrix:** reflected a picture of acute inpatient units under intense clinical pressure with an increase in restrictive practices in the first two quarters of this year following a downward trajectory prior to this. The Radbourne Unit particularly has been affected and a dramatic increase in MHA assessments in Derby Royal's ED was also noted.

- **Review of BAF risks:** No significant change to levels of assurance but further quality improvement work underway.

- **MHA Manager's Quarterly Report:** the quality and usefulness of the report were acknowledged as it enables trends and variation to be tracked over a rolling 12 month period. It had already been reviewed at the Ops meeting. Further data/information regarding rapid tranquillisation and 136 suite activity will be available at the next meeting. It was decided to challenge commissioners regarding the policy of independent PICUs (Psychiatric Intensive Care Unit) to decline admission of patients recalled under CTOs (Community Treatment Order).

- **Consultation with Derby Royal Hospital** (results of CAMHS on call): the level of CAMHS consultant vacancies is threatening the viability of their on call rota and proposals have been put forward to reduce their availability to 9am-5pm on week days and 24 hours at weekends supplemented by the nurse RISE team after hours. Alternative proposals have been put forward and will be explored. The Medical Director is working with commissioners to develop alternative approaches to S12 MHA assessments utilising least restrictive principles.

- **Associate Hospital Managers Update:** backlog of 20+ uncontested Managers' Hearings has been cleared. The problem of late reports due to medical vacancies has been tackled. There are 6 outstanding hearings.

  The proposals to replace Managers' Hearings with more Tribunals as part of the MHA review was noted. AHM vacancies are not being recruited to pending the outcome of the MHA review proposals.

  It was decided to scope with resource implications of the proposed new legislation relating to the MHA and MCA.

- **Update report on appraisals of Associate Hospital Managers:**
  Standard DBS checks would be adequate rather than enhanced. Anne Wright and Sam Harrison to decide which should be our Policy.

  Further discussion is required to agree an approach to appraisal.

- **Monitoring of Compliance with MHA related CQC Actions:** themed approach is being

taken to the Big (5) issues and other themes identified in the 2018 inspection. The Director of Nursing guaranteed resolution of these matters if the acute units achieve Royal College accreditation standards. Progress on the action plans following visits to Ward 35 and the Beeches was noted.

- **Training Compliance Report:** "slow crawl" to achieve compliance targets was noted with high DNA (Did Not Attend) rates. A vicious spiral is developing. Wards that are under pressure cannot release staff and low training (and supervision) rates are associated with poor outcomes including restrictive practice. Agency staff may need to be used to release staff.

  The People & Culture Committee will be asked to consider innovative approaches to training. The general dissatisfaction and lack of evidence of effectiveness with e-learning was noted in contrast to the popularity and evidence base for simulation training.

- **Seclusion Report:** summary produced by the Assistant Director of Clinical Professional Practice, the Head of Nursing and the Lead for Restrictive Interventions was welcomed but the associated reports were not as they were too detailed and difficult to navigate. They will be replaced with high level summaries as part of standing items at future meetings. The Director of Nursing confirmed a recent increase in restrictive practices following a downward trajectory over the last 5 years. Hot spots include ECW (Enhanced Care Ward) (to be expected) but also Tansley Ward and Ward 34 (male only). This correlated with high vacancy rates and low levels of training and supervision. The approach to quality improvement was noted but only limited assurance is possible at this time.

- **Re-written Policy on After Care for Detained Patients under S117:** ratified.

Assurance/lack of assurance obtained

- Significant assurance on the process of reporting in the Mental Health Act Manager's quarterly report; limited assurance in terms of the progress made in addressing some of the challenges recognised in the report around seclusion, rapid tranquilisation and restricted practises in particular.
- Limited assurance on the monitoring of compliance with MHA related CQC actions
- Significant assurance that training programmes are in place; limited assurance on compliance with the training requirements.
- Limited assurance on clinical practice around restrictive practices.

Key risks identified

- BAF risk considered and no changes made as insufficient progress made in terms of training compliance; risks around clinical practices and CQC compliance already adequately captured in the BAF,

Decisions made

- Scope with resource implications the proposed new legislation relating to the MHA and MCA.
- Re-written Policy on After Care for Detained Patients under S117 ratified
- Agreed not to recruit any additional AHMs, as 8 is sufficient for current needs, and pending MHA review outcomes.
- Summarise the external peer review of consultant caseloads for the Quality Committee – *Action: JRS*
- Chair to sign off revised ToR for Operational Group - *Action: AW*
- Challenge commissioners around the practice of independent PICUs declining CTO recall admissions - *Action: GH*
- AW/SH to decide on the policy regarding level of DBS checks for AHMs - *Action: AW/SH*

- Inpatient consultants to routinely check on availability of care plans for patients at multidisciplinary team meetings -
  Action: JRS to brief clinical directors
- People & Culture Committee to consider innovative approaches to training -
  Action: MG
- High level summaries regarding restrictive practices to be a standing item at future meetings -
  Action: CG

Escalations to Board or other Committee

- Review of approach to training transferred to the People & Culture Committee and innovation encouraged. The feeling is that even with improved performance management (eg challenging serial DNAs) we will only achieve modest outcomes with the current approach.

Committee Chair:	**Executive Lead:**
Caroline Maley (for Anne Wright)	**John Sykes, Medical Director**

Derbyshire Healthcare NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
People & Culture Committee – Meeting held 18 December 2018

Key items discussed

- Staff Story received excellent feedback – this was about patient care and experience and the initiative taken to bring the seaside and summer holidays to Cubley Court which provided a source of contentment for patients.
- Deep Dive BAF Risk 4c - Clinical Workforce Strategy – Interim paper was presented as a deep dive to the current position with the workforce now. Strategy to follow the clinical pathway work programme in April 2019. A report setting out the proposed mitigations for reducing this risk rating is to be submitted to the next meeting in February.
- Deep Dive BAF Risk 2a – Staff Engagement – Further discussion regarding the risk profile. Agreed to leave as is at this point in time until the results of the staff survey are released
- Approach for improving training compliance rates – Discussed e-learning and ESR, how staff can have their training transferred when joining DHCFT, what are we doing about compliance and how to get staff released. Recommended that the Committee oversees all training compliance
- Strategic Workforce Report – Received feedback on the Bullying and Harassment workshop and the early insights.
- Progress report on achievement of the People Strategy was noted
- Sickness absence management and appraisal rates – Committee received a deep dive into hot spots and was updated of actions and progress
- Quarterly Workforce Equality and Diversity Report / Equalities Update – progress was noted
- No escalations were received from the Committee's sub-groups:
  - BME Network
  - JNCC
  - Strategic Workforce Group
- Workforce Supply Progress and Hotspot Areas – Progress of recruitment was noted and congratulated, work continues
- Acting Up Internal Audit Report – Actions noted
- Apprentice Levy Update Report – Progress was noted
- Management and Leadership implementation plan – Committee to seek future assurance on the evaluation process post training interventions
- Items escalated to the Board or other Committees – none
- Identified risks arising from the meeting for inclusion or updating in the BAF – none

Assurance/lack of assurance obtained

- Review of BAF Risks
- Deep Dive BAF Risk 4c - Clinical Workforce Strategy – rurther information to follow in April 2019
- Deep Dive BAF Risk 2a – Staff Engagement – risk remains as is, review again on receipt of staff survey results
- Approach for improving training compliance rates – limited assurance with a requirement to change the way we deliver training
- Progress report on achievement of the People Strategy – significant assurance
- Sickness absence management and Appraisal rates - deep dive into Hot Spots and update of actions and progress, limited assurance to review again in February 2019
- Quarterly Workforce Equality and Diversity Report / Equalities Update – Significant assurance on the mechanisms in place though limited assurance to when we will see the results
- Escalation Summary reports from the Committee's sub-groups – significant assurance taken:
  - BME Network
  - JNCC
  - Strategic Workforce Group
- Workforce Supply Progress and Hotspot Areas – significant assurance
- Feedback from Acting Up Internal Audit Report – significant assurance
- Apprentice Levy Update Report – full assurance taken and note work being taken to embed apprenticeships in our workforce
- Management and Leadership implementation plan

Key risks identified

- No further risks identified

Decisions made

- Review again staff attendance and appraisal completion in February 2019

Escalations to Board or other committee

- None

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

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
Quality Committee Meeting held 8 January 2019

Key items discussed

- **Summary of Board Assurance Framework (BAF)** risks for Quality Committee. This was reviewed and debated with regard to capacity and demand.

- **Deep Dive BAF Risk 1c Physical Healthcare -** review and compliance of risk 1c. Of the current compliance and performance of physical healthcare, there is no business case submitted to fully comply with required clinical standards to fully implement a Physical Healthcare strategy. A partial solution is in place. There is a requirement for the executive lead to review the development of a business case to implement all required standards. A business case timescale is required be received by ELT, to assure Non-Executive Directors that physical healthcare investment will meet standards at pace. Reviewed the risk and recatergorisation the level of risk. The lead executive will come back with implementation plan in conjunction with the Gareth Harry. Limited assurance.

- **Quality Dashboard -** overall stability in the indicators. Completion of CQC actions were challenged to ensure divisions remain on target and outcomes are met - there are some overdue actions. Emphasised the need to receive evidence of completion of all actions against the required standard.

- **Acute Care Briefing –** Committee briefed on the **s**tabilisation of current acute performance. Medium term support is in place to take a longer term action.

- **Addendum to Mortality Report** - not submitted to the Committee but will be included in the report submitted to the 5 February Board meeting to show mortality rates in inpatient care settings.

- **Annual Review of Recovery Outcomes -** Significant assurance that this is the correct strategy for recovery and re-ablement. Some evidence of progress. Limited assurance obtained as strategy will take up to three months to be implemented and that it is a three year journey. Six monthly reporting will be made to the Committee on implementation and progress on outcome measures.

- **Neighbourhood Delivery Model** (verbal update) **-** progress report on implementation will be submitted to the Committee in March 2019. Date of workshops for neighbourhood review to be reported to the Committee April/ May,

- **Supportive Observations Report** – completed. Significant assurance.

- **Positive and Safe Annual Report** - significant improvement, additional investment in reducing violence strategies. Limited assurance received with the need to improve recording of specific data in the incident reporting system DATIX.

- **Peer Review Summary –** report covered overarching peer review findings to implement standards for accreditation and implement any learning and recommendations. The key recommended outcomes were endorsed. The new forensic service and continued audit of Section 37/41 is to be undertaken. Limited assurance.

- **Update on the effectiveness of COATs** - a verbal report was provided about the divisional governance audit and review. This will be reviewed and presented to the Quality Committee

and included in forward plan. • Meeting effectiveness- a review of the meeting, and how we are influencing the strategy.	
Assurance/Lack of Assurance Obtained • Improving outcomes and considering review of outcomes and or success criteria for all papers with limited assurance	
Meeting Effectiveness • A different Quality Committee and scrutiny, and exploration of the strategic influences. • Well chaired from the interim chair.	
Decisions made • BAF risk 1c Physical Healthcare to be increased from high to extreme.	
Escalations to Board or other committee • To review the strategic direction of the Trust in connection to the capacity and demand and the Board policy on strategic influence on the use of resources in Derbyshire.	
Committee Chair: Margaret Gildea	**Executive Lead: Carolyn Green, Director of Nursing & Patient Experience**

Derbyshire Healthcare NHS Foundation Trust

Board Committee Summary Report to Trust Board
Audit & Risk Committee – Meeting held 15 January 2019

Key items discussed

- Board Assurance Framework (BAF) Issue 4 reviewed including long list of BAF risks for 2019/20.
- Six month review of Raising Concerns and Whistleblowing arrangements. Planned future developments highlight aim for continuous improvement in embedding Speaking Up Culture.
- Freedom to Speak Up Self Review Report showing progress with agreed development actions.
- Implementation of internal and external audit recommendations progress report
- Quarter 3 Data Security and Protection Report
- Deloitte Phase 3 Recommendation – Data Quality - with recommendation to approve as complete and embed in business as usual.
- Interim report on progress with 2018/19 Audit & Risk Committee Objectives including outstanding areas for discussion
- Standing Financial Instructions Waiver Report for the period 1 April 2018 to 31 December 2018 including extract from statutory register and analysis of activity
- Revisions to Accounting Standards/Policies for 2018/19 Annual Accounts as per the GAM were presented
- Year-end Timetable and Plans update with key deadlines and approval dates.
- External Audit Plan 2018/19
- 2018/19 360 Assurance Internal Audit Plan 1 December – 31 March 2018.
- Internal Audit Progress Report including update on completed Data Security and Protection audit.
- KMPG Internal Audit report on PARIS implementation and governance, including management response, provided for information (received in draft at 4 December 2018 meeting)
- Counter Fraud, bribery and corruption report tabled including updated Counter Fraud, Bribery and Corruption policy.

Assurance/lack of assurance obtained

- Significant assurance received on robust processes in terms of ongoing management of the BAF, and that risks presented had been scrutinised by individual Executive Directors, the Executive Leadership Team and relevant Committees.
- Significant assurance on the framework set in place to support Raising Concerns/Speaking up

at Work including commitment by the Trust demonstrated through funding four day per week permanent role from 1 April 2019.

- Significant assurance on progress with actions to address development areas arising from the Freedom to Speak Up self-review
- Significant assurance on follow up of internal and external audit and counter fraud recommendations. No outstanding actions were breaching agreed timescales for delivery.
- Significant assurance received on continued work towards completion of the 2018/19 Data Security and Protection Toolkit and Data security work plan. Positive progress around cyber security measures and planned assurance reporting noted.
- Significant assurance received through blue form report that Deloitte recommendation 10 is complete, with ongoing assurance agreed through embeddedness in business and usual reporting
- Significant assurance received on progress with Committee objectives. Final report to be included in year-end Committee report.
- Full assurance received on process followed to approve and record waivers.
- Full assurance received on the project management arrangements planned to deliver the 2018/19 Annual Report and Accounts including Quality Account to meet internal and statutory deadlines.
- Significant assurance opinion received on Data Security and Protection internal audit undertaken December 2018. Significant assurance received on overall plan and implementation.

Key risks identified

- BAF – reduced risk for risks 3a (Financial Plan) and 2a (Engagement) due to mitigations as outlined
- Data Security and Protection Report – The Committee acknowledged the risk for 2018/19 to the organisation of failing to meet the requirements of the new Data Security & Protection Toolkit (new IG Toolkit) particularly with regards to the mandatory data security training requirement. Ongoing risk of cyber security noted – to be included in 2018/19 BAF.

Decisions made

- BAF – agreed reduced risk for risk 3a (Financial Plan) from extreme to high and 2a (Engagement) from high to moderate
- Further reporting on the Freedom to Speak Up self review development actions to the July Committee meeting to include timescales for completion
- Reporting on Data quality, as raised through Deloitte recommendation 10, to Committee on six monthly basis (added to forward plan).
- Outstanding action areas for Committee objectives 2018/19 - agreed method for performance review of internal and external auditors through reporting against indicators in their respective reports. Agreed to sharing assurance on third parties contractors with Committee members.
- Revisions to Accounting Standards/Policies for 2018/19 Annual Accounts as per the GAM were approved.

• 2018/19 External Audit Plan agreed. • 360 Assurance internal audit plan to 31 March 2019 agreed. • Approved updated Counter Fraud, Bribery and Corruption policy and agreed dissemination to staff in next Policy Bulletin. Report from People Services relating to historic recommendations from counter fraud cases to March Committee meeting.	
Escalations to Board or other Committee • None	
Committee Chair: Geoff Lewins **Non-Executive Director**	**Executive Lead: Sam Harrison** **Director of Corporate Affairs**

Derbyshire Healthcare
NHS Foundation Trust

Board Committee Assurance Summary Report to Trust Board
Finance & Performance Committee – Meeting held 22 January 2019

Key items discussed

- Board Assurance Framework – F&P risks for consideration

  Discussed the flow risk in particular and how it might evolve into 2019/20 BAF.

- Deep dive for Finance Plan delivery risk

  Agreed as described. Discussed range of 2019/20 financial risks and contracting, clinical and operational risks that have a financial impact. Discussed wider continuous improvement focus and communication thereof. Also discussed MHIS as it relates to income and cost pressures

- Commissioning Interface and Contract Update (QIPP/contract levers/penalties/CQUIN) including future contracting and commissioning issues

  Discussed planning guidance, commissioning and contracting discussions and progress with budget setting and size of gap. Verbal confirmation of recently issued 2019/20 control total. Discussed system planning progress and risks

- Operational Performance and KPI Achievement

  18 week RTT (Referral to Treatment) performance highlighted as growing concern. Cancellations: 24% of them are appointments being brought forward. REGARDS data capture has significant number of blanks. BME recording- high BME representation in patients as recorded compared to Derby City/County population. Cultural and wider issues to address mixed response across protected characteristics. Discussion to take place at ELT (Executive Leadership Team) on how best to address wider issues and messaging on importance.

  Discussed performance more generally highlighting performance measures under pressure and recent capacity issues.

  Future target setting – discussed ability to meet as set.

- CIP Delivery and Continuous (Quality) Improvement Delivery Programme

  Significant gap between amounts identified and amount required for 2019/20. (2018/19 concluded.)

  Spend reduction versus budget reduction discussions. Discussed governance arrangements for 2019/20. Emphasised the requirement for recurrent delivery.

  Additional extraordinary F&P meeting to be called on 20 February to discuss continuous improvement and CIP progress within the context of an update on the overall financial plan and contracting progress and draft plan submission.

- Financial Performance and Planning Update

  2018/19 some improvement in forecast costs. Discussed year end, cash and trade receivables.

Discussed likelihood of achieving control total. Discussed Out of Areas and Agency. Much financial discussion had taken place during meeting as set against other agenda subjects that drive financial performance and risks.

- Reference Costs

  Published Reference Cost Index of 0.92. Well received. Discussed variability within that overall total and areas for data improvements related to clustering especially during assessment phase. Overall RCI is also reflective of increased demand.

- Draft Estates Strategy

  Acknowledged as a work in progress. Explicit link to clinical strategy development. Discussed aspirations and intent as being clear. Focus on colleagues and efficiency opportunities to be enhanced. Summary of estate very useful. Discussed dormitories as described in draft and need to have further consideration. Short, medium, long term priorities to be further clarified in implementation programme. Equalities impacts need to be included in next iteration. Discussed governance of sign off for final estate strategy. Committee to review/recommend to go to Board for full sign off in Easter/early summer depending on clinical strategy development.

- Preparation for 2018/19 year-end effectiveness reporting and arrangements for year-end qualitative survey and review of Committee's Terms of Reference

  Discussed some updates to terms of reference. Medical Director to be taken out of main membership and attend as and when for specifics. Include reference to continuous improvement *including CIP* not just CIP.

  Discussed process for collating year-end report including members' qualitative views in survey. Committee agreed the 2019/20 forward plan to be prepared along same lines as 2018/19 version.

- Deloitte Phase 3 Well Led Framework progress review

  Discussed embeddedness into business as usual for comment 11 learning and continuous improvement and comment 12 staff views on data – both agreed as green. (Rec 2 annual planning had already been agreed as green in previous meeting).

- Treasury Management Policy and Procedure - Approved

Assurance/lack of assurance obtained

- BAF risk deep dive - Significant assurance
- Commissioning Interface and Contract Update (QIPP/contract levers/penalties/CQUIN) including future contracting and commissioning issues – Limited assurance
- Operational Performance and KPI Achievement – Limited assurance
- CIP Delivery and Continuous (Quality) Improvement Delivery Programme – Limited assurance
- Financial Performance and Planning Update – Significant assurance for 2018/19. Evolving position for 2019/20
- Draft Estates Strategy – assurance rating not applicable due to being in draft

Key risks identified

- Level of cost recurrent reduction required for 2019/20 with limited progress to date compared to current gap
- System contracting risks
- Lack of sight on MHIS (Mental Health Investment Standard) and other contract values

Decisions made

- Refer equality monitoring to ELT to discuss how best to improve REGARDS data capture and wider cultural factors affecting current capture and given its importance
- Additional F&P meeting required to discuss CIP/contract/financial planning progress in the round
- Medical director to me removed from main membership and attend as and when required
- Treasury management policy approved as presented
- Deloitte actions progress - agreed as green

Escalations to Board or other committee

- None specifically to Board (ELT to discuss REGARDS equality monitoring)

Committee Chair: Richard Wright	**Executive Lead: Claire Wright, Deputy Chief Executive and Director of Finance**

2018-19 Board Annual Forward Plan

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 5 February 2019

Report from the Council of Governors Meeting Held on Wednesday 9 January 2019

The Council of Governors met on Wednesday 9 January 2019 at the Centre for Research and Development, Kingsway Hospital site, Derby. The meeting was attended by 16 governors.

Report from Governors Nominations and Remuneration Committee

Sam Harrison presented the report on the Governors Nominations and Remuneration Committee meeting held on 1 November 2018. The council approved the proposed amendment of the Terms of Reference to reflect that an equal number of public governors to other governors was satisfactory for quorum purposes. This supports the principle that public governors should not be in the minority for any decision making required.

Questions arising from the Chief Executive Report – December 2018

In response to a query as to what measures had been taken by the Trust in preparation for Brexit, it was noted that Mark Powell, Chief Operating Officer, is the designated Senior Responsible Officer for the Trust and is overseeing business continuity planning. The Trust's Chief Pharmacist, Steve Jones, has looked in detail at the supply of medicines and is monitoring this in line with national guidance. A staff message outlining the Trust's current position is to be prepared for the week beginning 14 January and will be circulated to governors for information.

Non-Executive Director deep dive

Margarete Gildea, Non-Executive Director and Chair of the People and Culture Meeting gave an update on the work of the Committee, highlighting her role in holding Executive Directors to account. Her role as Lead NED for Freedom to Speak Up was also outlined.

Integrated Performance Report

The Integrated Performance Report was presented to the Council of Governors to provide an overview of performance as at the end of December 2018. The Non-Executive Director Board Committee Chairs reported on how the report had been used to hold Executive Directors to account in their respective Board Committees for areas with regards to workforce, finance, operational delivery and quality performance.

Governance Committee Report

Carole Riley, Interim Chair of the Governance Committee presented a report of the meeting held on 11 December 2018. Kelly Sims and Christine Williamson expressed an interest in the roles of Chair and Deputy Chair of the Governance Committee and will meet with Carole Riley and Denise Baxendale outside the meeting to take forwards.

Update on the Current Staff and Public Governor Elections

Denise Baxendale gave an update on preparations for the current staff governor and public governor elections and to provide assurance on the process being taken. Governors noted the timeline for the elections, the range of actions underway to

promote the vacancies and support the activities underway. Posters have been circulated and external parties have been contacted.

Care Planning Update
Carolyn Green presented a report on the current information surrounding care planning and the work of the Trust to improve this core requirement.

Co-production and Service User Involvement/Experts by Experience
Carolyn Green provided an update on a project relating to co-production and service user involvement /experts by experience on which she is preparing a proposal paper. Carolyn confirmed that she will be the lead executive and Roger Kerry has agreed to take on the role as independent chair for the project. Carolyn also confirmed that Gareth Harry will be involved in order to connect with STP developments. The project will run as a six month pilot scheme and the first meeting will take place on the 14 January 2019, which will be given over to planning.

Derbyshire Healthcare
NHS Foundation Trust

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST TERMS

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

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

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

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

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