Derbyshire Healthcare NHS Foundation Trust
Public Board of Directors

To be held digitally via MS Teams

10 May 2022 09:30 - 12:15

INDEX

Derbyshire Healthcare
NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY 10 MAY 2022 TO COMMENCE AT 9:30am
Following national guidance on keeping people safe during COVID-19 this will be a virtual meeting conducted via MS Teams

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks and apologies, declarations of interest - Register of Directors' Interests Annual Report 2021/22	Selina Ullah
2.	9:35	Patient Story	Carolyn Green
3.		Minutes of Board of Directors meeting held on 1 March 2022	Selina Ullah
4.		Matters arising – Actions Matrix	Selina Ullah
5.		Questions from members of the public	Selina Ullah
6.	10:00	Chair's update	Selina Ullah
7.	10:10	Chief Executive's update: - ICS Green Plan	Ifti Majid
STRATEGY, OPERATIONAL PERFORMANCE AND QUALITY ASSURANCE			
8.	10:25	Integrated Performance report	C Wright/J Lowe/ C Green/A Odunlade
9.	10:40	Workforce Standards Formal Submission 2022	C Green/J Sykes/ J Lowe
10.	10:50	Learning from Deaths and Mortality 2021/22 annual report	John Sykes
11:00 B R E A K			
11.	11:15	Staff Survey Results	Jaki Lowe
12.	11:25	Quality Position Statement "Caring"	Carolyn Green
GOVERNANCE			
13.	11:35	Board Assurance Framework 2022/23 Issue 1	Justine Fitzjohn
14.	11:45	Corporate Governance Report: - NHS Improvement Year-End Self-Certification - Annual approval of Modern Slavery Statement - Year-end governance reporting from Board Committees and approval of ToRs - Trust Sealings (six monthly report - for information)	Justine Fitzjohn
15.	11:55	Board Committee Assurance Summaries of meetings of Quality and Safeguarding, Mental Health Act, Finance and Performance, People and Culture and Audit and Risk Committees held during March and April 2022	Committee Chairs
CLOSING MATTERS			
16.	12:10	- Identification of any issues arising from the meeting for inclusion or updating in the Board Assurance Framework - Meeting effectiveness	Selina Ullah
FOR INFORMATION			
Summary Report from the Council of Governors meeting held 1 March 2022 Glossary of NHS Acronyms and 2022/23 Forward Plan			

Questions that are applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretary up to 48 hours prior to the meeting for a response provided by the Board at the meeting. Email: sue.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 July 2022. It is anticipated that this meeting will be held digitally via MS Teams
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

Our vision

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

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.

Our Trust values are:

People first – We focus on our colleagues, in the knowledge that a well-supported, engaged and empowered workforce results in good patient care.
Respect – We respect and value the diversity of our patients, colleagues and partners and support a respectful and inclusive environment.
Honesty – We are open and transparent in all we do.
Do your best – We work closely with our partners to achieve the best possible outcomes for people.

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 10 May 2021

Register of Directors' Interests

Purpose of Report

This report provides the Trust Board with the year-end 2021/22 Register of Directors' interests. This register will be published in the Annual Report for 2021/22. The register is updated with each new interest declared/removed and the revised version is then reported to each Public Board.

Executive Summary

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

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	x
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	x

Assurances

- Directors are asked to disclose to the meeting any changes to the Register of Directors' Interests during the course of the year
- When declaring any interest, each Board member affirmed their agreement to comply with the NHS Codes of Conduct and Accountability, and the Seven Principles of Public Life (Nolan), and to state whether there is any relevant audit information of which the Trust's Auditors are unaware.

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

There is no impact to those with protected characteristics arising from this report.

Recommendations

The Board of Directors is requested to approve and record the declarations of interest as disclosed. These are recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's Annual Report for 2021/22.

Report presented by: **Justine Fitzjohn**
Trust Secretary

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

DECLARATION OF INTERESTS REGISTER 2021/22		
NAME	**INTEREST DISCLOSED**	**TYPE**
Margaret Gildea Senior Independent Director	• Director, Organisation Change Solutions Limited • Coaching and organisation development with First Steps Eating Disorders • Director, Melbourne Assembly Rooms • Designated Independent Non-Executive Member, NHS Derby and Derbyshire Integrated Care Board	(a) (e) (d) (d)
Deborah Good Non-Executive Director	• Trustee of Artcore - Derby	(e)
Carolyn Green Director of Nursing and Patient Experience	• Midlands and East Regional Director, National Mental Health Nurse Directors Forum	(e)
Gareth Harry Director of Director of Business Improvement and Transformation	• Chair, Marehay Cricket Club • Member of the Labour Party • Non-Executive Trustee, Derbyshire Cricket Foundation	(e) (e) (e)
Ashiedu Joel Non-Executive Director	• Director, Ashioma Consults Ltd • Director, Peter Joel & Associates Ltd • Director, The Bridge East Midlands • Director, Together Leicester • Lay Member, University of Sheffield Governing Council • Fellow, Society for Leadership Fellows Windsor Castle	(a) (a) (a) (a) (a) (a)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Jaki Lowe Director of People and Inclusion	• General Medical Council Associate	(e)
Ifti Majid Chief Executive	• Co-Chair of NHS Confederation BME leaders Network • Chair of the NHS Confederation Mental Health Network • Trustee of the NHS Confederation • Spouse is Managing Director (North) Priory Healthcare	(d) (d) (d) (e)
Ade Odunlade Chief Operating Officer	• Trusteeship African Council for Nursing & Midwifery • Research Lead on Observations for Ox e-Health	(d) (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)
Selina Ullah Trust Chair	• Non-Executive Director, Solicitors Regulation Authority • Director/Trustee, Manchester Central Library Development Trust • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Non-Executive Director, Accent Housing Group • Director, Muslim Women's Council	(a) (e) (e) (e) (e) (e)
Richard Wright Deputy Trust Chair and Non-Executive Director	• Non-Executive Director (Chair) Sheffield UTC Multi Academy Educational Trust • Designated Independent Non-Executive Member, NHS Derby and Derbyshire Integrated Care Board	(a)

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

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.
(e) Any connection with a voluntary or other organisation contracting for 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 VIRTUAL MEETING OF THE BOARD OF DIRECTORS TUESDAY 1 MARCH 2022

VIRTUAL MEETING VIA MS TEAMS

Commenced: 09.30 Closed: 12.27

PRESENT	Richard Wright	Deputy Trust Chair and Non-Executive Director
	Margaret Gildea	Senior Independent Director
	Geoff Lewins	Non-Executive Director
	Ashiedu Joel	Non-Executive Director
	Deborah Good	Non-Executive Director
	Ifti Majid	Chief Executive
	Claire Wright	Deputy Chief Executive and Director of Finance
	Carolyn Green	Director of Nursing and Patient Experience
	Gareth Harry	Director of Business Improvement and Transformation
	Jaki Lowe	Director of People and Inclusion
	Justine Fitzjohn	Trust Secretary
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications
	Lee Doyle	Deputy Director, Operational Performance
	Sue Turner	Board Secretary
DHCFT2022/00	Tamera Howard	Freedom to Speak Up Guardian
APOLOGIES	Selina Ullah	Trust Chair
	Dr Sheila Newport	Non-Executive Director
	Ade Odunlade	Chief Operating Officer
	Dr John Sykes	Medical Director
OBSERVERS*	Lynda Langley	Public Governor, Chesterfield and Lead Governor
	Andrew Beaumont	Public Governor, Erewash
	Julie Lowe	Public Governor, Derby City East
	Jo Foster	Staff Governor (Nursing)
	Richard Eaton	Communications Manager
	Denise Baxendale	Membership and Involvement Manager
	Ian Strange	Technical Analyst
	Rachel Leyland	Deputy Finance Director
	Natalie Day	Performance Analyst
	Samantha Shaw	Performance Office
	Jane Wall	Service Support Manager

The Board meetings are broadcast via a MS Teams Live event. The names of some observers might not be identifiable from email addresses and may not be recorded as attendees

DHCFT 2022/016	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Following national guidance on keeping people safe during the Covid pandemic this meeting was conducted via Microsoft and livestreamed to the public. Due to the number of infections in Derbyshire the Board of Directors will continue to meet virtually. In the absence of Trust Chair, Selina Ullah, Deputy Trust Chair, Richard Wright chaired the meeting and welcomed everyone. A special welcome was given to Deborah Good, who commenced in post today as a Non-Executive Director (NED) for the Trust. Richard reiterated the Board's thanks to colleagues for their ongoing support and contribution to the continued delivery of quality services within the Trust particularly during the recent peak of Omicron cases. Apologies were noted as listed. Deputy Director, Operational Performance, Lee Doyle deputised for Chief Operating Officer, Ade Odulade. The Register of Directors' Interest was noted and will be updated to list the appointment of Richard Wright, and Margaret Gildea as Designate Independent Non-Executive Members (NEMs), of the NHS Derby and Derbyshire Integrated Care Board (ICB) when the ICB takes effect from 1 July. In the spirit of openness and transparency, Director of Business and Improvement and Transformation, Gareth Harry announced that he will be taking up a post with NHS England and NHS Improvement (NHSEI) on 1 June. Gareth was congratulated on his new role which was not considered to be a conflict of interest or loyalty with today's agenda. **ACTION: Declarations of interests in respect of Richard Wright, Margaret Gildea to be transferred to the Register of Directors' Interests**
DHCFT 2022/017	**MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 2 NOVEMBER 2021** The minutes of the previous meeting held on 18 January 2022 were accepted as a correct record of the meeting.
DHCFT 2022/018	**ACTION MATRIX AND MATTERS ARISING** The Board agreed to close all completed actions. Updates were provided by members of the Board and noted on the action matrix.
DHCFT 2022/019	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been submitted for a response ahead of today's meeting.
DHCFT 2022/020	**OUTCOME OF PATIENT STORIES 2019 - 2021** Director of Nursing and Patient Experience, Carolyn Green presented an overview of the experience of service receivers from 2019 to 2021 and the commitments made by the Board. The Board was mindful that these stories have resulted in improvements and changes being made to the Trust strategy. They have also been used to identify continuous learning and development across the Trust's services. A short video was played of a conversation between a former patient and her GP concerning Premenstrual Dysphoric Disorder (PMDD) which demonstrated the connection between physical and mental healthcare and the learning that the GP developed for this condition. This video has been extensively used within the Trust and across the region to train staff in the treatment of PMDD. The report and video provided newly appointed Non-Executive Director, Deborah Good with powerful introduction to the Trust's services. Deborah was interested to know how

	stories were selected to be heard by the Board and how individuals were prepared so they could tell their stories and whether they covered the entire range of services across the Trust. Carolyn assured Deborah that stories are selected from all of the Trust's services and are often the result of a patient's complaint or are based on an individual's negative impression of the service they are under. Patients are supported so they can feel safe while telling their stories despite them often being very difficult stories to share. Deputy Chief Executive and Director of Finance, Claire Wright highlighted that these patients' experiences and the video were perfect examples of their perspectives of the Trust's care and treatment that illustrated the reality of caring and treating the whole person. Although the report evidenced common themes of continuity of care and how patients feel they are falling through the gaps, it is hoped that the Service Delivery Board will create opportunities to reduce these gaps and prevent people falling between physical and mental healthcare. Carolyn added that the Trust strategy is focussing on amplifying the voices of service users by using their experience to increase quality improvement. The Trust's peer support workers are also supporting the Trust to improve the experience of patients and the outcomes of our services. Carolyn hoped that Richard Wright and Margaret Gildea as designated NEDs of the ICB will help to develop a clinically driven Integrated Care System (ICS) co-led with experts by experience and include this within the ICB terms of reference. This challenge was supported by the Board and by Richard and Margaret who undertook to ensure this becomes an objective of the ICB's terms of reference. Gareth Harry would also take continuity of care forward through his role within NHSEI. The Board acknowledged the importance of embedding the learning from patient stories to make improvements and changes to the Trust's services. The Board was mindful that this was the third report it had received on the outcomes of patient stories and agreed that the report will be scheduled again two years' time. **ACTION: Outcome of patient stories to feature every two years in the Board forward plan** **RESOLVED: The Board of Directors supported the recommendations for clinical driven practice improvements to be taken through the Integrated Care Board and NHSEI.**
DHCFT 2022/021	**<u>CHAIR'S UPDATE</u>** Selina Ullah's report summarising her activity in her role as Trust Chair since the previous meeting held on 18 January was noted in her absence. The report included details of service visits, staff engagement and included conversations with the staff networks. **RESOLVED: The Board of Directors noted the content of the Chair's update.**
DHCFT 2022/022	**<u>CHIEF EXECUTIVE'S REPORT</u>** Ifti Majid's CEO report provided the Board with an update on local and national developments within the national and local Derbyshire health and social care sector over the last two months. Ifti referred to the government's health and social care integration white paper on joining up care for people, places and populations deals with the mechanism for increasing integration and the ambition for each Place-Based Care for enhancing outcomes for local people. Prior to the pandemic a significant amount of work took place in Derbyshire in relation to local outcomes. Ifti reported that a national set of priority local outcomes will be added to each local Place ready to go live from April 2023. More detail will emerge where these issues will be discussed within the Derby and Derbyshire Integrated Care Partnership (ICP).

Information on the alliances the Trust is currently part of were appended to Ifti's report. The common Board paper contained in Appendix 1 provided an update on the work of the East Midlands Alliance for Mental Health and Learning Disabilities for the period October 2021 to February 2022 and covered the work that the Trust is undertaking with other trusts within the East Midlands. Ifti outlined how this work has moved towards taking action and developing investment for support workers especially in areas that the Trust finds it difficult to recruit to. Planned joint board development sessions with other trusts within the alliance were cancelled due to COVID but will be reintroduced over coming months.

The updated draft Trust Strategy outlining priorities for the Trust, including partnership working was shared in Appendix 2. There are still some areas to be populated after wider consultation with colleagues, key groups in the Trust and external partners. Feedback received so far from colleagues has been very positive especially with regard to the Trust's vision and values.

Ifti referred to the work of the Derby and Derbyshire Integrated Care Partnership (ICP) progressing within a phased development. Phase 1 between now and September 2022 will continue with the emphasis being principally related to Health (including the NHS), Public Health and Social Care. Phase 2 will focus on establishing the role of the Derby and Derbyshire ICP and its relationship with the Health and Wellbeing Boards and delivery of the agreed future model. Ifti attended the first meeting of the ICP on 28 February as the Trust's CEO and also as the Lead CEO for the Anchor and Provider Collaborative.

Other documents relating to the provider collaboratives were appended to Ifti's report. The establishment of a "Provider Leadership Board" i.e. an aligned decision making board structure that will be known as the Provider Collaborative Leadership Board (PCLB) which was discussed and agreed previously by the Board. A common board paper relating to the progress of the Provider Collaborative at Scale development in Derbyshire was set out in Appendix 3 along with the proposed draft partnership agreement. The Board was aware that the PCLB will advise on priorities and areas of focus for collaboration at scale, and to engage to help realise opportunities in A&E, ambulance service and GP out of hours services. The shadow PCLB is proposed to be made up of the six Derbyshire provider CEOs plus others from within brought in to assist in the running of the group. The Chair of the shadow PCLB will also sit on the ICB Board, to represent the voice of the group.

Discussion took place on the strategy of the ICB and the need to influence its strategic intent of the provider collaboratives. Carolyn Green expressed a wish to patient responsiveness rather than patient experience being the primary measure and asked if there is body within the Clinical Reference Group that will review this strategic intent. Ifti's view was that there is a tremendous appetite to think about how the current Joined Up Care Derbyshire (JUCD) strategy can be reviewed and the role of clinicians in the leadership of the system. This is likely to happen after 1 July when the ICB is established. The Board will have the opportunity to collectively lever this influence as part of the provider collaborative.

Having noted the current progress around the development of provider collaboratives locally the Board formally acknowledged its continued support of the provider collaborative and approved the adoption of the Partnership Document, including Derbyshire HealthCare's full participation in the shadow PCLB in Derbyshire.

In terms of activity within the Trust, discussions held at Staff Forum concerned the rising cost of living and how this was becoming an increasing concern for more colleagues within the Trust. Another specific area of concern included mileage remuneration, wear and tear on personal vehicles as well as concern about rising fuel costs. Ifti reported that he had committed to carry out a full review of the travel policy and to provide help and advice to colleagues.

	With great sadness Ifti referred to the passing of two colleagues within Derbyshire Healthcare. Phathisani 'Prince' Ncube, who worked in the Crisis Team and in services on the Kingsway Hospital site and at the Radbourne Unit and Mark Wright, who was known to many colleagues from the South and City Early Intervention Team. Board members joined Ifti in offering their condolences to their families and friends at this very difficult time. Ifti advised that he would be issuing a statement to all staff recognising the current situation in Ukraine and urging colleagues affected by current events, to seek support from the wide range of wellbeing support that is being made available to colleagues. The Trust stands against the unprovoked invasion of Ukraine and expresses its solidarity with the people of Ukraine at this very difficult time. **RESOLVED: The Board of Directors:** **1) Scrutinised the report, noting the risks and actions being taken** **2) Received significant assurance from the key issues raised** **3) Approved the adoption of the Partnership Document, including Derbyshire HealthCare's full participation in the shadow PCLB in Derbyshire**
DHCFT 2022/023	**PERFORMANCE AND ACTIVITY REPORT** The Board of Directors was updated on key finance, performance and workforce measures at the end at the end of January 2022. **Operations** Lee Doyle acting for Chief Operating Officer, Ade Odunlade highlighted the significant reduction in waiting times for services. Although an increase in wait times remains in place for CAMHS and autism assessments these are being addressed. Improving Access to Psychological Therapies (IAPT) recovery performance is showing positive signs of improvement and adult acute out of area placements have reduced to zero. A number of outpatient appointments continue to be defaulted with some 15% of people not attending despite the issue of reminders encouraging people to attend. Patients with psychiatric intensive care needs are currently placed out of area in Psychiatric Intensive Care Units (PICU). Work is in progress build a PICU provision in Derbyshire to bring these patients back to local services. **Finance** Deputy Chief Executive and Director of Finance, Claire Wright updated the Board on the financial position at month 10. There was a surplus of £0.4m against a planned surplus of £0.3m. Claire drew attention to the need for additional expenditure in agency nursing costs for the final three months of the year and to continue with Infection Prevention and Control (IPC) costs in response to COVID. The forecast outturn at the end of the year remains at breakeven. The key focus will be on future planning in 2022/23 and onwards. The Board was assured that the Finance and Performance Committee will have oversight of these matters over the coming months. The Trust was slightly above plan with self-funded capital by £0.9m and is forecast to be within plan at the end of the financial year. The above-plan forecast expenditure is related to the self-funded elements of the dormitory eradication programme, PICU and acute-plus plans and are part of the capital prioritisation for use of system capital departmental expenditure limit (CDEL). Claire was pleased to report that in addition to receiving capital funding for the initial stages of the dormitory eradication programme, covering 2020/21, additional funding has now been agreed for 2022/23 ahead of the dormitory eradication full business case. **People performance** Director of People and Inclusion, Jaki Lowe reported that priorities for people performance include reintroducing appraisal processes and training requirements,

	managing staff absence and continuing to recruit across services. Sickness absence rates have increased with staff affected by the Omicron variant and having to self-isolate. The rate of turnover has been higher than the Trust target range of 8-12% for the last six months which is reflective of other mental health trusts. In the latest national data the Trust was ranked 11th highest mental health trust for stability of the workforce. Plans have been developed hold conversations with staff about staying within the organisation. The Board recognised that staff are experiencing difficulties with pay and was assured that People Services will work towards building a framework to ensure the Trust continues to be an attractive place to work where staff can develop their career. Although a number of training programmes had to be paused throughout the pandemic training will resume when the latest wave of the pandemic reduces. The training recovery plan is improving training compliance and is maximising the use of technology to deliver training and adopting a more flexible approach. **Quality** Carolyn Green assured the Board of the stability maintained in quality metrics despite the difficulties experienced in the most recent wave of the pandemic. Carolyn was pleased to report that face to face contact appointments have increased which has in turn reduced the number of complaints received from patients. There has also been a reduction in the use of restrictive practice and of prone restraint which is much lower than the regional average. The positive trajectory and improvement in the percentage of reviewed care plans was noted by the Board. Non-Executive Director, Geoff Lewins referred to the increase in wait times for CAMHS and autism assessments. He was aware of the specific activity that took place to reduce wait times towards the end of 2021 and asked if anything could be done to sustain this work. Lee Doyle reported that resource is being found to replace a number of staff in these areas, especially in specialist roles that will improve wait times in these areas. Ifti was mindful that there might be some instances of long COVID included in sickness absence rates and was interested to know more about the economic and social impact of COVID on absence. Jaki reported that support is being offered to individuals identified with long COVID. The main focus is to support the health and wellbeing of staff within the Trust through its comprehensive health and wellbeing offer. She was disappointed that some colleagues are not taking up this offer early enough and would arrange for benefits of the offer to be further communicated to staff. **RESOLVED: The Board of Directors received limited assurance from current performance across the areas presented.**
DHCFT 2022/024	**<u>QUALITY POSITION STATEMENT - USE OF RESOURCES</u>** The Board considered an updated quality position statement on the use of resources in the context of delivering high quality services and patient care. The report presented by Claire Wright provided an overview in support of the Trust's strategic objective *'Best Use of our Money'* as well as in support of regulator assessments in considering the use of resources. The main content of the paper provided an update on key considerations for the highest ten priorities for use of resources taking account of the effects that the pandemic has had on resources and a look ahead at areas of further focus. Claire highlighted how investment in new technology has had a positive impact on practice and quality improvements. These benefits were evident following learning from multi-agency discharge events (MADE) and from new approaches developed in administration and communication. The Finance and Performance Committee will be concentrating on building further benefits from this initiative. Richard Wright considered the advancements made over the past two years to be quite outstanding especially with regard to the use of technology. In support of workforce

	planning the data has been triangulated around supply and demand and predicted workforce and the recruitment to services. Geoff Lewins referred to the management of agency costs which have risen during the pandemic and suggested that the management of agency costs triangulated with workforce planning and recruitment should be further scrutinised by the Finance and Performance Committee. Non-Executive Director, Ashiedu Joel referred to the need to increase levels of meaningful data capture and asked for this to be clarified. Claire expressed the need for data not just to be recorded correctly but for it to improve people's experience of care by staff asking the right questions for data to be of more value. Staff are being coached on the Trust's inclusive model and equality diversity and inclusion (EDI) infrastructure to capture the details of patients' protected characteristics in order to inform and influence clinical change and improvement. **RESOLVED: The Board of Directors:** **1) Considered the overview of the use of resources** **2) Proposed that the management of agency costs triangulated with workforce planning and recruitment be scrutinised by the Finance and Performance Committee.**
DHCFT 2022/025	**<u>LEARNING FROM DEATHS MORTALITY REPORT</u>** This report covering the period July 2021 to January 2022 was presented by Carolyn Green on behalf of Medical Director, John Sykes. The report detailed how the Trust continues to review and learn from any deaths of people who have been in contact with the Trust's services. The report is produced as a statutory process that involves taking the learning obtained from deaths analysed during mortality reviews. The report is also reviewed at length by the Quality and Safeguarding Committee. The next stage in the development of this report is to train and supervise staff in asking specific questions to capture the details of patients' protected characteristics. The report assured the Board that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths. It was agreed that the report is to be published on the Trust's website. **RESOLVED: The Board of Directors accepted this Mortality Report as assurance of the Trust's approach and agreed for the report to published on the Trust's website as per national guidance.**
DHCFT 2022/026	**<u>GUARDIAN OF SAFE WORKING REPORT</u>** This report from the Trust's Guardian of Safe Working (GOSW) provides data about the number of junior doctors in training in the Trust, full transition to the 2016 Junior Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation. The Board acknowledged that the report demonstrated the positive engagement between the GOSW and junior doctors and was pleased to note that two junior doctors have been recruited as Freedom to Speak Up Champions which will enable junior doctors to have a better understanding of the role of the Freedom to Speak Up Guardian. **RESOLVED: The Board of Directors noted the contents of the report as assurance of the Trust's approach in discharging its statutory duties regarding safe working for medical trainees.**

DHCFT 2022/027	**ANNUAL GENDER PAY GAP REPORT** A summary of the Trust's gender pay gap information for the period to 31 March 2021 was considered by the Board. Jaki Lowe outlined the improvements that have taken place over the last year that attributed to the Trust's commitment to equality, diversity and inclusion. Actions that will further contribute to reducing the pay gap include continuing the commitment to flexible working by default, supporting an inclusive approach to recruitment and talent management and making the Trust a place of work where everyone feels they can engage, participate, develop and grow. There is more work to do on wider disparities as there is significant bias towards particular groups. Jaki and the People and Inclusion team are looking to close the gap by looking at how the gender pay gap impacts different ethnic communities. Gareth Harry welcomed the offer of flexibility by default. In his experience women returning from maternity leave can negotiate flexible working when they return to their roles but then find it difficult to move on because they are unable to further negotiate flexibility to progress their roles. Gareth asked if there were any actions the Trust could take to deliver better flexibility. Jaki described how workforce planning will make changes not just to people that are recruited to the Trust but colleagues who are already within the organisation. It is also important for line managers to understand individual differences and adapt them to meet service needs. This has to be included in the job planning process before when we recruit. The Board supported flexible working and was disappointed to hear that people who want a part time role are sometimes discouraged or prevented from working in specific roles. The majority of the workforce are women and it is wrong that there is a gender pay gap in the NHS. Senior Independent Director, Margaret Gildea encouraged the involvement of people who want to work flexibly in developing solutions to reduce disparities amongst the workforce. The Board echoed Margaret's thoughts, and approved the Gender pay Gap report and received significant assurance on the improvements achieved in reducing the gender pay gap over the last year. The also Board acknowledged the discretionary effort of staff in navigating the pandemic over the last two years which has been an important factor in creating and furthering the careers of Trust colleagues. **RESOLVED: The Board of Directors:** **1) Approved the Gender Pay Gap report prior to forwarding to the Government Office and publishing on the Trust's website** **2) Received assurance on the work in progress and that this data will inform engagement with our people and further work to be done.**
DHCFT 2022/028	**BOARD ASSURANCE FRAMEWORK UPDATE** The Board reviewed the fourth and final issue of the Board Assurance Framework (BAF) for 2021/22. Trust Secretary, Justine Fitzjohn summarised that since Issue 3 of the BAF was presented to the Board on 2 November 2021 associated risks within the BAF have been reviewed by the director leads. Issue 4 was then reviewed by the Executive Leadership Team (ELT) and by the Audit and Risk Committee on 27 January. The one BAF risk rated as extreme, risk 21-22 3a, *"There is a risk that the Trust fails to deliver its revenue and capital financial plans"* underwent a 'deep dive' at the Audit and Risk Committee and it was agreed that the risk rating would remain the same. The Finance and Performance Committee also agreed with this rating remaining rated extreme at year-end and into the next financial year.

	Since Issue 3 of the BAF one of the key gaps in control changed from Amber to Blue as the Psychiatric Intensive Care Unit (PICU) and Dormitory Eradication Programme team is now recruited to and there is a programmed governance structure in place. A new system risk has been added to the BAF that impacts on and shared by multiple organisations; *'There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS inpatient LD bedded care'.* This risk was reviewed by the Executive Directors, the CEO and received by the Audit and Risk Committee and discussed as a highly rated strategic risk. In response to the Audit and Risk Committee, it was agreed that the Director Leads will report to the Quality and Safeguarding Committee on 8 March the responsibilities of the committees cited as a 'responsible committee' as well as updates on key gaps in control and the actions to close the gaps. This risk will be controlled through system working and the next issue of BAF will evidence how this risk is mitigated within the Trust. The Board accepted that the BAF is thoroughly scrutinised by the Board Committees for the risks they are responsible for and approved this fourth and final issue of the BAF for 2021/22. **RESOLVED: The Board of Directors:** **1) Approved this fourth issue of the BAF for 2021/22 and received assurance from 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) Agreed to continue to receive updates in line with the forward plan for the Trust Board.**
DHCFT 2022/029	**<u>FREEDOM TO SPEAK UP GUARDIAN REPORT</u>** The Trust's Freedom to Speak Up Guardian (FTSUG) Tamera Howard joined the Board and presented her half yearly of Freedom to Speak Up (FTSU) cases within the Trust. The report also included an analysis of trends within the organisation and actions being taken. The total case numbers have decreased by 61.4% compared to cases reported to the Board in September 2021. Emerging, or ongoing, themes include cases from two specific areas around staffing levels where staff logged concerns around risk to staff and the impact on staff wellbeing as well as quality of patient care, although patient safety concerns are low. Another theme centred around policy and procedure where the FTSUG heard some concerns around exit interviews within the Trust relating to how many are carried out and what the Trust does with the information which is an ongoing theme. The higher number of people speaking up was seen as a positive indication. Incidents of bullying and harassment have increased but are still lower than the national average. The number of people contacting the Guardian from the BME network is thought to be as a result of the use of FTSU Champions from a BME background and the regular attendance of the FTSUG within a wide range of the Trust's networks. Thanks were extended to Executive Directors and the FTSU Non-Executive Director lead for their support within the Trust on speaking up. Richard Wright was pleased that the FTSUG was welcoming openness and colleagues were feeling more confident in speaking up. The Board noted the significant improvement seen in cases of bullying and harassment which was seen as a positive indication of improved leadership culture and training. The FTSUG has written a draft Freedom to Speak Up Strategy for the Trust which will require further development and consultation with a range of stakeholders across the

	Trust. The strategy has been shared locally with the FTSU NED and FTSU Champions. It will be shared with staff networks for consultation and the Executive Lead for Speaking Up, as well as the Board. The Board considered that the report positively reflects that the Trust continues to encourage staff to speak up and identifies key themes being raised. The feedback from individuals was heartening to see and it was clear that colleagues appreciate Tam's kindness and service as FTSUG. **RESOLVED: The Board of Directors:** **1) Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda** **2) Received significant assurance that the FTSU agenda within the Trust and the proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up** **3) Supported the development of an FTSU Strategy for the Trust as recommended by the National Guardian's Office and FTSU Board Self-review guidance.**
DHCFT 2022/030	**<u>APPROVAL OF AMENDMENT TO STANDING FINANCIAL INSTRUCTIONS</u>** Claire Wright confirmed the amendment to paragraph 8.18 of Standing Financial Instructions (SFI) approved by the Audit and Risk Committee members on 27 January 2022. Amendment to SFI paragraph established that documents above £100,000 shall be signed by the Director of Finance, Chief Executive or nominated officer with appropriate approval limit. Augmentation to the sentence in the contract protocol section of the SFIs was agreed. **RESOLVED: The Board of Directors confirmed approval of amendment to SFI paragraph 8.18.**
DHCFT 2022/031	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES</u>** The Board Committee Assurance Summaries demonstrated the work of the committees since their last update to the Board and were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. Discussions held within the committees during January and February were summarised by the Committee Chairs as follows: **Finance and Performance Committee:** Key finance and performance and workforce measures discussed by the Committee had been covered during today's performance review. The planning permission and progression of the business cases for the dormitory eradication and PICU projects were seen to be making remarkable progress. It was disappointing that the live rollout for phases 3 and 4 OnEPR was disrupted by the Covid Omicron wave but this is now on track as shown in today's performance report. **Audit and Risk Committee:** A significant amount of time was spent discussing the BAF and how the system risk would develop subject to further discussions to be held by the Quality and Safeguarding Committee. A detailed review of the finance risk resulted in the decision to retain the current extreme rating of this risk due to the unpredictability of costs in the ongoing pandemic at this point. A thorough review and of the accounting policies for 2021/22 provided assurance on the Trust's preparedness for publishing the Annua report and Accounts. **People and Culture Committee:** A review of the medical workforce is a key focus. The People and Inclusion team continue to support and improve retention of staff and achieve better outcomes for the future. A review of safer staffing provided assurance that all

	services are staffed at appropriate levels and where there are issues mitigations have been put in place. **Quality and Safeguarding Committee**: Clarity of responsibilities and updates on the system risk were discussed although was too early to give assurance regarding gaps in control. Clarity on actions to close these gaps will be further reported in March and April. Good discussions were held on the transformation of Community Mental Health Framework (CMHF) against delivery of the local plan and how community services should modernise to offer whole-person, whole-population health approaches, aligned with Primary Care Networks. This discussion highlighted the increased emphasis on improving community care which is at the heart of treating people closer to their home. It is within the Board Committees where much of the scrutiny and challenge takes place which is such an important part of the Trust's governance requirements. Thanks were extended to the Board Secretary for condensing extensive discussions so they can be reviewed by the Board. **RESOLVED: The Board of Directors noted the Board Assurance Summaries.**
DHCFT 2022/032	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** None.
DHCFT 2022/033	**2022/23 BOARD FORWARD PLAN** The 2022/23 forward plan outlining the programme for the remainder of the year was noted and will be reviewed further by all Board members for the financial year ahead.
DHCFT 2022/034	**MEETING EFFECTIVENESS** Board members agreed that the meeting had been successfully conducted as a live streamed meeting. The papers prompted useful discussions and were informative.
The next meeting to be held in public session will be held at 9.30am on 10 May 2022. Owing to the current rate of infection during the coronavirus pandemic this meeting will be held digitally and will be live streamed via MS Live Events.	

				BOARD OF DIRECTORS (PUBLIC) ACTION MATRIX - MAY 2022			
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
1.3.2022	DHCFT 2022/020	Outcome of patient stories	Board Secretary	Outcome of patient stories to feature every two years in the Board forward plan	10.5.2022	Reporting on outcome of patients stories is featured as a bi-annual report in the forward plan.	Green

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

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 activity with and for the Trust since the previous Board meeting on 1 March 2022. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

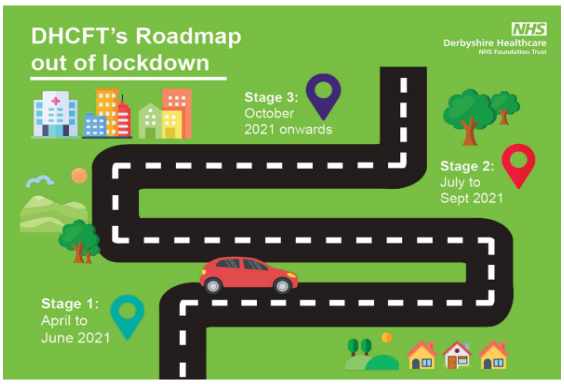
1. It has been a challenging time for our colleagues with the ongoing COVID-19 variant with higher numbers of staff absences as well as having to manage patients coming in with the now dominant BA.2 variant and maintaining the safety of other patients. I am immensely proud of our staff and how they continue to deliver quality care in such difficult circumstances. I have paused my visits to services in light of this and will resume them during May. I am looking forward to reconnecting with staff, services and service users through this process.

2. In the meantime, I have been attending as many of the team live engagement events being hosted via MS Teams. These meetings are very useful to me in terms of understanding how staff are feeling and engaged with the Trust. I am pleased to note that several NEDs continue to join these calls.

3. On 3 March I met with Ifti Majid, CEO; Jaki Lowe, Director of People and Inclusion and Anna Shaw, Director of Communications regarding our communication strategy in line with our revised strategy for 2022 onwards.

4. We continue to support staff and offer opportunities to take up the offer of a vaccination against COVID. My thanks go out to all who have been involved in this important process, and to all our staff for listening and taking informed decisions. This has been such an important step forward on the road to recovery.

5. We continue with the Trust's RoadMap out of Lockdown which was instigated in April 2021. Whilst we have had to pause at times due to COVID surges and increased infection rates, I welcome this careful approach to recovery, with an emphasis on the ongoing building of team resilience for all our staff. Thank you to all staff for your on-going commitment and dedication shown to the Trust and our service users over an extraordinary time. I know that we will all welcome a return to a more stable way of life but know that we will all need to work together to help this happen.



6. The results of the NHS Staff results published was especially one for celebration for our Trust. We are in the top five mental health trusts in England out of 51 mental health trusts. We had our highest response rates to date with 62% of our staff taking part. Particularly pleasing was that we were above average on every indicator and we were top in: 'We are safe and healthy', 'We work flexibly' and 'Morale'. 72% of our staff would recommend the Trust as a place to work and similarly 72% of staff would recommend a friend or relative who needed treatment with the standard of care provided by the Trust. This is an excellent testament to the positive culture of the Trust and down to the leadership of our team leaders, managers and senior leadership team and the Board.

Council of Governors

7. Following the election of new Governors, I would like to welcome Angela Kerry – Amber Valley, Ivan Munkley – Bolsover and North East Derbyshire, Jill Ryalls – Chesterfield, Graeme Blair – Derby City East, Jane Elliott – Derby City East, Ogechi Eze – Derby City West, Thomas Comer – Erewash, Hazel Parkyn – South Derbyshire, Annette Gilliland – Rest of England, Laurie Durand – Staff Governor, Medical and Andrew Beaumont – Erewash – who was re-elected for second term of office. I look forward to working them all.

8. Our Governors have the key responsibilities of holding the Board to account, connecting the Trust with our communities and bringing intelligence about how Derbyshire residents are experiencing our services. I have begun meeting our Governors on a one to one basis in order to get to know them better and hear about their concerns and ideas for the Trust. So far, I have met with Orla Smith, Andrew Beaumont, Chris Mitchell, Jodie Cook, Rachel Bounds and David Charnock. Sadly Valerie Broom was not re-elected for a second term. We will miss her invaluable contributions and I would like to thank Valerie for all her support to the Trust.

9. We held a virtual Extraordinary Council of Governors meeting on 13 March to approve the appointment of Ralph Knibbs as Non-Executive Director, who will be replacing Margaret Gildea in June.

10. The Council's Nominations and Remuneration Committee met on 25 April to receive the appraisals of myself and four NEDs (Margaret Gildea, Geoff Lewins, Richard Wright, Ashiedu Joel) and to discuss and agree the process for the recruitment of the remaining NED role.

11. The Governance Committee of the Council met on 5 April chaired by Ruth Grice, the new Chair of the Governance Committee. Once again it was heartening to see the level of attendance and participation from so many of our Governors at this meeting. I continue to be grateful to our Governors for their support for the Trust at this time.

12. I had my first meeting with Susan Ryan, Lead Governor and Julie Boardman, Deputy Lead Governor on 20 April. The purpose of these meetings with the Lead Governors is to ensure that we are open and transparent around the challenges and issues that the Trust was dealing with. Regular meetings between the Lead Governors and Chair are an important way of building a relationship and understanding of the working of both governing bodies.

13. The next meeting of the Council of Governors will be on 10 May, following the Public Board meeting. The next Council of Governors meeting will then be on 6 September and the next Governance Committee takes place on 8 June.

Board of Directors

14. All meetings continue to be held as virtual meetings using MS Teams, enabling Board members to keep connected whilst working remotely. We have continued to live stream our Public Board meetings to enable members of the public and our staff to observe these meetings.

15. On 16 March the Remuneration and Appointments Committee met to note the appointment of Vikki Taylor as Director of Business Improvement and Transformation from 1 June 2022. This is a non-voting Board appointment. I would like to thank current incumbent Gareth Harry for his time with the Trust and his work in representing the Trust in the system and shaping the system integration agenda at local and regional level. The Committee also reviewed the status of mandatory training for the Board.

16. At the Board Development session on 16 March we received an update on developments regarding the Perinatal Mental Health Provider Collaborative and discussed models of governance and risk management.

17. In April we concluded the recruitment process for our two upcoming Non-Executive Director vacancies to replace Margret Gildea when she moves to the Integrated Care Board (ICB) in July and successfully recruited Ralph Knibbs to the Trust Board. Ralph is currently the Head of Human Resources at United Kingdom Athletics Limited and a previous HR Director at Rolls Royce. He is also a former rugby union player for the Bristol Bears and continues to work with England Rugby, being Vice Chair of the Diversity and Inclusion Working Group. Ralph will become our lead NED for People and Culture and building on the good work of Margaret Gildea. I look forward to welcoming Ralph to the Trust in June.

18. I would also like to welcome Jas Khatkar who joined the Board on 1 April as NExT Director. Jas is a chartered accountant and an experienced management consultant who specialises in finance transformation and business strategy. A former director with Accenture, Jas has worked multiple industries including telecoms, utilities and pharmaceuticals. Jas lives in Derby and impressed the interview panel with his passion and his focus on communities and quality improvement.

19. On 5 April a confidential Board meeting was held to consider matters related to the development of our estate and approve some key dormitory eradication and Psychiatric Intensive Care Unit (PICU) project stages and the Business Cases for the Northern Derbyshire Older Adults Service Relocation and the Organisational and Cultural Change Strategy, Framework, and Implementation Plan. The Board noted the risks arising from the changing environment, the impact that rising inflation and the war in Ukraine will have on these programmes. Updates were also provided on the Perinatal Mental Health Programme and the Learning Disabilities Services harmonisation programme.

20. On 25 April an extraordinary meeting of the Finance and Performance Committee was held to approve the final sign off of 2022/23 plan submission to NHS England.

21. The Non-Executive Directors (NEDs) have met regularly with Ifti Majid and me to ensure we have been fully briefed on developments as needed. I have also continued to meet with all NEDs individually and we have also continued with the informal NED meetings and Cross Committee Chair meetings.

System Collaboration and Working

22. The Interim NHS System Strategic Oversight Board met on 17 March and discussed issues regarding future governance, accountability and priorities post 1 July 2022.

23. On 24 March a virtual meeting on MS Teams was held with the Chairs of Provider Trusts and CEOs. This was convened to better understand the communication lines, accountability mechanisms and governance of provider collaboratives. The meeting was convened and led by Ifti Majid.

24. I have continued to meet regularly with the chairs of the East Midlands Alliance of mental health trusts, which has been a very useful source of sharing best practise and peer advice. We met more formally on 24 March to receive an update from the CEOs on the progress that has been made and the issues that needed resolution. This includes the governance processes that will need to be in place to support the provider collaboratives which are either in place or soon to be operating (e.g. Child and Adolescent Mental Health Services (CAMHS) and Adult Eating Disorders).

Regulators, NHS Providers and NHS Confederation and others

25. I attend fortnightly briefings from NHS England and NHS Improvement (NHSE/I) for the Midlands region, which has been essential to understand the progress of the management of the pandemic, the vaccination progress and plans for recovery and regional developments. More recently ambulance waits and the flow and discharge of patients have been areas of priority as well as the impact of covid infections amongst the workforce.

26. I have also joined when possible the weekly calls established for chairs of mental health trusts hosted by the NHS Confederation Mental Health Network in collaboration with the Good Governance Institute where support and guidance on the Board through the pandemic has been a theme as well as the focus on recovery and stabilisation of services.

27. On 4 March I attended a virtual Population Health Management – System Development workshop, giving us a good perspective on the current situation including inequalities by place and challenges and opportunities ahead. It was good to hear from Primary Care Colleagues about the work that is being done at a place level.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

- The Board can take assurance that the Trust's 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 and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

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. I have also continued to develop my own awareness and understanding of the inclusion challenges faced by many of our staff.

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

As a Board member I have ensured that I am visible in my support and leadership on all matters relating to Diversity and Inclusion. I attend meetings to join in the debates and conversation and to challenge where appropriate, and to learn more about the challenges of staff from groups who are likely to be or seem to be disadvantaged. I ensure that the NEDs are also engaged and involved in supporting inclusive leadership within the Trust.

New recruitment for NEDs and board members has proactively sought to appoint people from protected characteristics, thereby trying to ensure that we have a Board that is representative of the communities we serve.

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: **Selina Ullah**
Trust Chair

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 10 May 2022

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 should be used to support strategic discussion on the delivery of the Trust strategy. The Board should note that the report reflects a wider view of the Trust's operating environment and serves to horizon scan for risks that may affect the organisation. Risks identified are highlighted in the report and taken forward to assess their operational and strategic impact, and recorded on operational risk registers, or the Board Assurance Framework, as appropriate.

National Context

1. The government has committed to develop a new cross-government, ten-year plan for mental health and wellbeing for England. The aim is to ensure the new plan responds to the public's priorities and set out what needs to be done as a whole society to drive better outcomes.

   A discussion paper and call for evidence to ask the public a range of questions to help develop the new plan has been launched. The document asks the public a range of questions about six key areas:

   - Promoting positive mental wellbeing
   - Preventing the onset of mental ill health
   - Intervening early when people need help
   - Improving the quality and effectiveness of treatments
   - Supporting people living with mental health conditions
   - Improving support to people in crisis

   The government is asking for stakeholders to provide suggestions for tangible commitments and actions they think should be priorities for the new plan. They ask that responses should reflect what is needed for a range of different groups: from infants and their parents or primary caregivers and children and young people, to working age and older adults, and those that are more likely to experience poor mental health and wellbeing.

   There are many questions still to be answered about funding and the further ten year strategy and the link with the review of the Long Term Plan for mental health, however, I am sure the Board will join me in welcoming this consultation.

   Board colleagues and the public can find the consultation document on the Department of Health and Social Care Website or follow the link Mental health and wellbeing plan: discussion paper - GOV.UK (www.gov.uk). We have until 5 July to make any representations.

2. On 11 March 2022, the COVID-19 inquiry team, chaired by the Rt Hon Baroness Heather Hallett DBE, published its draft terms of reference for consultation, which sets out the aims and scope of the independent public inquiry into the COVID-19 pandemic in the United Kingdom. The inquiry team is working closely with key stakeholders across the four nations to understand their priorities and concerns.

   The inquiry will examine, consider and report on preparations and the response to the pandemic in England, Wales, Scotland and Northern Ireland, up to and including the inquiry's formal setting-up date. In doing so, it will consider reserved and devolved matters across the United Kingdom, as necessary, but will seek to minimise duplication of investigation, evidence gathering and reporting with any other public inquiry, established by the devolved administrations.

   The inquiry aims include:

   - Examine the COVID-19 response and the impact of the pandemic in England, Wales, Scotland and Northern Ireland, and produce a factual narrative account considering the response of public health decision making, the response of the health and care sector and the economic response of the pandemic including how the government intervened.
   - Understand lessons learnt from the pandemic thereby to inform future pandemic planning which means the inquiry will:
     - listen to the experiences of bereaved families and others who have suffered hardship or loss as a result of the pandemic
     - highlight where lessons identified from preparedness and the response to the pandemic may be applicable to other civil emergencies
     - consider the experiences of and impact on health and care sector workers, and other key workers, during the pandemic
     - consider any disparities evident in the impact of the pandemic and the state's response, including those relating to protected characteristics under the Equality Act 2010 and equality categories under the Northern Ireland Act 1998
     - have reasonable regard to relevant international comparisons
     - produce its reports (including interim reports) and any recommendations in a timely manner.

   I note there are a couple of areas within the terms of reference where our Board should note we may be asked for evidence in common with all trusts and system leaders nationally.

   1. The management of the pandemic in hospitals, including infection prevention and control, triage, critical care capacity, the discharge of patients, the use of 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions, the approach to palliative care, workforce testing, changes to inspections, and the impact on staff and staffing levels.

2. The consequences of the pandemic on provision for non-COVID related conditions and need.

Local Context

3. We are progressing well with the planning and development of the East Midlands Perinatal Mental Health Provider Collaborative and have established our role as aspiring Lead Provider across our stakeholders. We are working to the proposal that we implement the clinical model from 1 October 2022 with the formal contract and finances from 1 April 2023. This will provide opportunity to shadow the financial arrangements before we formally take over the perinatal services contract. We are working with NHS Improvement and NHS England (NHSEI) to finalise the schedule for the Gateway Assurance Process, which will take place during June - August. The DHCFT programme team are working to confirm requirements for all elements of the assurance process and agree expectations for clinical 'go live'.

   We are undertaking finance and activity due diligence to seek assurance for the Trust Board that the contract we will take on as Lead Provider of the provider collaborative is safe for us to do so and any risks are identified and mitigated. Similarly, we are undertaking quality and safety due diligence to evaluate these areas and draw up development plans where required.

   The Lead Clinician role in the collaborative is a key post to provide leadership and coordinate clinical engagement and we are interviewing for this role on 29 April. The Clinical and Professional Reference Group, which will be chaired by the Lead Clinician, has agreed terms of reference and membership and meets for the first time in early May.

4. We are working closely with NHSEI regional colleagues and national teams to develop arrangements for Experts by Experience input to the collaborative and continue to work closely with East Midlands colleagues to build upon and learn from implementation of established provider collaboratives in the region.

5. A System green plan has been developed by Joined Up Care Derbyshire that Board colleagues can see in appendix 1. In 2020, the NHS launched the campaign "For a Greener NHS " and an Expert Panel, chaired by Sir Simon Stevens set out a practical, evidence-based and quantified path to a 'Net Zero' NHS. In response to this call by the NHS for the Integrated Care System (ICS) to develop a regional level approach to sustainability, the Derbyshire ICS Greener NHS Delivery Group have worked together with support from an external consultancy to develop this ICS Green Plan.

   Each partner organisation to JUCD has its own individual Trust Green Plan and Board members will be aware of our own Green Plan signed off by the Board. This joint ICS Green Plan does not simply merge these individual plans; instead, it identifies elements which are better undertaken together, where co-ordination is required across organisations or where additional value can be brought to the System by working together. As such the ICS Green Plan sets out the sustainability plans for Derbyshire ICS for the next three years and will sit alongside, and build on, our Trust Green Plan.

The plan presents the regional level carbon footprint data and outlines the national drivers, local drivers and targets; and the ICS's commitment to sustainability. It summarises the organisation-level Green Plans, including carbon hotspots and the sustainability strategies employed to address them.

The Green Plan describes a total of 11 interventions through which the strategies and priorities of Derbyshire NHS Trusts and partners will be coordinated and integrated. A separate action plan outlines the ways and timescales by which our organisations will be held to account over reducing carbon emissions and making progress on net-zero.

We are asked to formally support the plan that will be owned and implemented through the Derby and Derbyshire Integrated Care Board (ICB) post-July.

6. The Joined Up Care Derbyshire (JUCD) Senior Leadership Team (SLT) met on Friday, 8 April with a significant focus on our planning, financial and transformation agenda as we move towards the new financial year.

   System pressure continues and SLT received an update from SORG on ongoing steps being taken to tackle it. A regional request for a formal progress update was met by the Friday, 8 April, 5pm deadline, covering topics including ambulance handovers and the need continue to deliver weekend day approach to discharges through the weekend. Friday, 8 April also saw a request made to Local Resilience Partners for the release of available staff to support the homecare workforce, aiming to improve the flow of patients from inpatient / residential care settings into de-escalated levels of care.

   The system's detailed financial planning continues, and the £196m unmitigated financial gap outlined in March has now closed to £89.9m through a range of measures. Having made our financial submission to NHSEI in March, it has been confirmed that JUCD has not been placed in escalation by NHSEI.

   Our Digital Board provided an update on progress against priorities. The Derbyshire Shared Care Record is online and will continue to expand operability during the next six months. All developments are in line with the planning guidance, and in addition we are working on care records and interconnectivity with our regional border systems.

   The Board should note that at the time of submitting the report, system pressure, particularly around discharges from acute hospitals (flow), was still a significant pressure in the system resulting in delayed ambulance handover times.

7. On 24 March I met with members of Derbyshire's Health Scrutiny Committee for a briefing on Mental Health Transformation and an overview of our services. This included a discussion about the dormitory eradication and Psychiatric Care Unit (PICU) programme. Whilst not a formal meeting, it was helpful to hear members' support for our capital plans and their recognition of how incredible colleagues in Derbyshire Healthcare have been throughout the last two years of the pandemic. They also noted the circa £20m of new investment into the JUCD System over the last year and planned for the next few years to support the delivery of the long-term plan.

Within our Trust

8. At our 1 March Public Board meeting we launched our Organisational Strategy Review, in light of learning lessons from the last twoi years of the pandemic, the changing system environment we are operating in and the continual transformational requirement of delivering the long-term plan.

   During the last few months, the draft strategy has been shared widely in our Organisation, with all other Health and Care Organisations in Derbyshire and with members of Place via the Place Executive Chair.

   The plan was to update Board this month with a view to signing off the new strategy or agreeing further updates based on feedback from colleagues and partners.

   Themes of feedback included:

   - The need to include specific reference to all service areas, including substance misuse, given the significant transformational investment recently secured over the next three years
   - Impact on Voluntary Community and Social Enterprise (VCSE and link to new Community Mental Health Team (CMHT) framework
   - Could we be more ambitious with respect to prevention and reducing health inequalities?
   - Does the strategy overly focus on efficiency?
   - Great vision and values
   - Good alignment to System aims and objectives
   - Need to include measurable metrics
   - Too many abbreviations - please write them out in full
   - An important message repeated multiple times about the complexity of the document and the need to simplify it
   - Equally colleagues were feeling that we could do more to prioritise the asks over three years and spell out the ‘absolute priorities’

   Given this feedback, my proposal to Board is that we delay launch of the Strategy until the July meeting, to enable time to have a discussion on the points raised at May Executive Leadership Team (ELT) and Board Development meetings in May.

   There is full support for the vision, values and the fourth new Strategic Objective, so Board can agree to use those to drive and enable the Board Assurance Framework (BAF), and Committee activity is aligned to the new strategy from this point forward.

9. I am sure Board members will want to join me in congratulating Clare Exton. Clare – who is a member of our South Derbyshire and South Dales Older Adults Team – was invited to the Women of the Year awards by Ruth May, the Chief Nursing Officer for England for her work to change the law around embryo fertilisation research to help those at risk of mitochondrial disease. Clare won the award, alongside other colleagues working in the NHS. This is a fabulous achievement and well-deserved recognition for Clare for all she has done to raise awareness of the disease.

10. Tuesday, 8 March was an important day in our Trust inclusion calendar. As well as marking International Women's Day, it was also the launch of our new Women's Network, which aims to make gender equality a key priority for our Trust. The theme for International Women's Day this year was #BreakTheBias and this was a theme discussed during all the events of the week.

    As part of the launch for the network, we held a series of virtual events between Tuesday, 8 March to Friday, 11 March via Microsoft Teams. I was delighted to be present at the opening event on 8 March and through the course of the week we heard inspiring contributions from Jaki Lowe, Carolyn Green and Claire Wright, as well as from our Network Chair, Dr Chinwe Obinwa.

    The week closed with a speech from Jenny Garrett – a leading women's empowerment inspirational speaker. She is an award-winning career coach with over 13 years' experience of running a global business. Jenny has written an Amazon bestselling book, Rocking Your Role, about female breadwinners, and is an Associate member of the Professional Speakers Association. To say she was inspirational was an understatement!

11. In March it was great to spend a session discussing the changes to the Derbyshire System with our medical colleagues at the Trust Medical Advisory Committee (TMAC) and being joined to do that by Dr Chris Clayton (ICB CEO elect), presenting and discussing the four new components of system working:

    - Integrated Care Board
    - Integrated Care Partnership
    - Place Executive Board
    - Provider Collaborative

    It was helpful to hear how quickly our senior clinicians were recognising and identifying benefits for integrated working, as well as some concerns about clinical leadership, capacity and patients' voice that I have already fed back to system colleagues.

12. During March, we continued our all-staff question and answer sessions. These sessions have been well attended throughout the pandemic with generally around 50 colleagues attending and, on some occasions, considerably more. The March session was equally well attended. Key areas that were discussed at the March session included:

    - The tension between a reduction in measures in society and continued healthcare restrictions around infection prevention and control measures
    - Expectations for any reductions in Infection Prevention and Control (IPC) restrictions in the NHS (this was prior to the national review)
    - The desire to meet up with and connect with colleagues as soon as possible
    - Discussions around the lifting of temporary restrictions we added in during the Omicron wave and focus back on mandatory training
    - Home working and returning to work in the office and a hope of teams being able to come together to reconnect in the near future.

My thanks to all colleagues who took time out to join the calls and share honest feedback about those things that were a cause for concern.

13. I was fortunate to be able to attend the April BME Network, as both a BME colleague with lived experience, and as the network executive sponsor. At the network we heard about a vital research project that has been commissioned in our organisation with support from Charities Together funding. The research is about understanding more about people's lived experience of discrimination in our Trust. The research is being led by partners from De Montfort University in Leicester and the University of Amsterdam in The Netherlands.

    The programme will have two aims:

    - Identify systems and barriers that facilitate inequalities or prevent inclusion
    - Co-develop solutions for sustainable institutional change

    There will be six stages to the work that will include surveying the whole organisation, small focus groups and solution focussed planning. The piece of work is being facilitated and supported by the network and I am keen that, once completed in Autumn, the report is presented to the Board.

14. Board colleagues will be aware that during March and April the Trust saw a further significant spike in COVID-related absences and a very significant increase, to our highest level ever in the pandemic, of positive patients in our in-patient wards. The restrictions that we needed to deploy to manage these outbreaks added further pressure to flow within our mental health system in Derbyshire and sadly did result in higher numbers of people needing to receive bedded care out of Derbyshire.

    Throughout the pandemic we have noted at the Board the amazing and consistent efforts our colleagues have gone to in order to keep providing the best care possible to those vulnerable people who need our services. This peak was no different. I have been very impressed with the ongoing application of strict infection prevention and control standards being applied in all our services, the ongoing flexibility and dedication colleagues have shown, and colleagues' desire to make a personal impact through innovation has been undaunted (as I mention in my paragraph around St Pauls Intensive Hub, for example).

    Through this dedication, I am delighted that outbreaks were quickly brought under control and, at the time of writing, we have only one positive patient in our wards and the number of staff away from work is down below 60 – much more manageable levels.

    Board colleagues will want to join me in thanking our staff for their ongoing effort and support during what has been a long haul for them.

15. In April, I was fortunate to meet with colleagues from our 0-19 Service Intensive Hub at St Pauls House. My thanks to colleagues for sharing with me their expertise and passion for developing a new model for working with an increasing number of complex families. The way colleagues have embraced

new ways of working has been very impressive and even in the short space of time since implementation, the benefit for families is absolutely clear.

It was also very helpful to see the Chathealth App whereby families and patients can 'live chat' with a practitioner to seek help or advice. It is very well used and has had very positive feedback. It is also something that is a great model for access and improving patient experience in other services.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	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, people who use our services, and members of the public, is being reported into the Board.

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

This document is a mixture of a strategic scan of key policy changes nationally, and changes in the Derbyshire Health and Social Care environment, that could have an impact on our Trust. The report also covers updates to the Board on my engagement with colleagues in the Trust, the reporting of internal actions and feedback I have received relating to the strategy delivery.

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

There were areas of concern but also good practice in relation to the discussion about our Colleagues' Networks and the commitment to further resource them to ensure they continue to develop and thrive is great news.

Both national policy consultations I report in this document have the potential, if we implement them in conjunction with local communities, to be very impactful on health inequalities. We know that services that are more integrated between health and social care also tend to adopt more of a focus on local communities, rather than health infrastructure, and this will be the case with the development of Place in Derbyshire.

The development of a 10 year plan for mental health and wellbeing must be about levelling up health outcomes for a group in society who continue to have significantly poorer health outcomes. In addition, within that overall group, people from a BME background with mental health difficulties have even poorer health outcomes and experience of services – I will be pressing, both in a general response and in my role with the NHS Confederation, for this to feature heavily in the new strategy.

I am delighted at the best practice the Trust is showing in partnering with two Universities to do more research into inclusion and discrimination. All opportunities for increasing understanding and providing a voice to colleagues to speak up is a very good thing.

It is also good to see digital technology being used through the ChatHealth App to increase access to our services. Whilst not a panacea, it does offer increased opportunity to some of the communities we serve, particularly as the App and the live conversations automatically translate into the language the phone is set in.

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
3) Agree to support the JUCD Green Plan.

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

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

Joined Up Care Derbyshire

ICS Green Plan

2022 - 2025

Contents

1.0 FOREWORD

There is increasing evidence of the impacts of climate change upon the environment and human health. The UK's Climate Change Act 2008 sets a national target to achieve net-zero carbon emissions by 2050. The NHS has acknowledged its responsibility in this agenda and has committed to achieving a net-zero health service by 2045.

As part of this commitment, NHS England has made it mandatory for all Trusts and Integrated Care Systems (ICSs) to produce a board-approved Green Plan which establishes a sustainability strategy for the next 3 years.

This Green Plan is our response to this call, establishing the system-level strategy for sustainability at Joined Up Care Derbyshire ICS. Firstly, it presents our regional-level carbon footprint data and outlines our commitment to sustainability. Then it summarises our organisation-level Green Plans, including our carbon hotspots and the sustainability strategies employed to address them.

Lastly, we present a total of 11 interventions through which the strategies and priorities of Derby and Derbyshire Integrated Care Partnership (ICP) will be coordinated and integrated. A separate document outlines the ways and timescales by which our organisations will be held to account over reducing carbon emissions and making progress on net-zero.

Organisations across the Derbyshire ICP stand ready to tackle the causes of climate change and are collectively committed to improving our sustainability credentials. This Green Plan provides the framework and pathway to embed sustainability at an ICS level and delivering these partnership actions, alongside individual organisational commitments, must be a shared priority.

Helen Dillistone
Net Zero Senior Responsible Officer, Derbyshire Integrated Care System

2.0 INTRODUCTION

2.1 Our ICS

Joined Up Care Derbyshire Integrated Care System is Derby and Derbyshire's recently formed ICS. We are constituted of a range of health and social care organisations, including local GP practices and NHS Trusts, which work collectively to plan, commission, and provide services to meet the needs of Derby and Derbyshire. We serve more than 1 million people across the East Midlands, including the populations of Derby city, Chesterfield, Ilkeston and Long Eaton, Amber Valley, the Derbyshire Dales, Bolsover District, High Peak, and Glossop (see Figure 1).

Figure 1: Our Communities

Our specialised services include treating cardiovascular, respiratory, and musculoskeletal diseases; strokes and cancers; and mental health problems. In addition, we have a core focus on preventative care, and work to ensure that factors contributing to poor health and health inequalities are addressed. We are passionate about our role in the local communities in which we serve and are keen to ensure that our impact on the environment is reduced.

2.2 What is Sustainability?

Sustainability has been defined by the United Nations Brundtland Report (1987) as:

"…development that meets the needs of the present without compromising the ability of future generations to meet their own needs…"

Sustainability is based upon environmental, economic, and social considerations. These three issues are often referred to as the 'three pillars of sustainability'. To maximise the sustainability of our organisation, all three of these pillars must be aligned. An intervention which focuses on the environment but neglects economic and social aspects cannot be considered sustainable. Therefore, a sustainability strategy, such as this Green Plan, must look to integrate all three pillars of sustainability as far as possible.

A sustainable health and care system can be achieved by delivering high quality care and improved public health without excessively depleting natural resources, costing too much, or negatively impacting the health and wellbeing of staff and patients (see Figure 2).

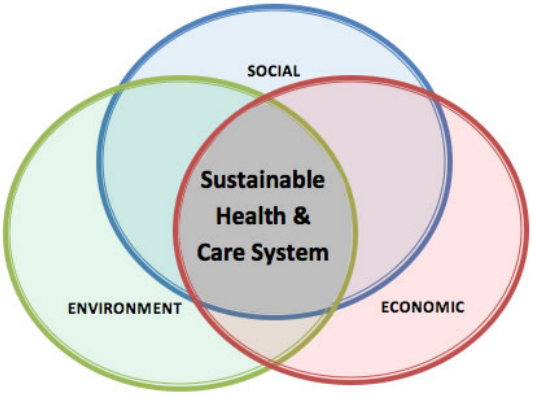


Figure 2: Model of Sustainability for the Health and Care Sector

Addressing a single issue like air pollution provides a strong example of how all three pillars of sustainability can be improved as per the example below.

Air pollution is caused by excess emissions of pollutants such as particulate matter and harmful gases. This creates a negative environmental impact, through the consumption of fossil fuels and natural resources, the pollution of the environment, and by contributing to climate change.

From a social perspective, air pollution causes and exacerbates cardiovascular, respiratory, and mental health issues. It is estimated that high levels or air pollution contributes towards an annual 40,000 premature deaths in the UK. Air pollution also disproportionately impacts more deprived communities, creating health inequalities.

The increased incidence of illness also creates an economic impact. People suffering illness caused by air pollution may become so ill that they cannot work, negatively impacting their financial status. Additionally, high rates of illness within a population place increased stress on the NHS due to higher patient numbers and associated costs. NHS activity leads to an increase in carbon emissions, which in turn contributes to air pollution and more illness which places yet more demand on NHS services.

Consequently, working to reduce carbon emissions from NHS activities can deliver a more sustainable and equitable health and care system, as reduced air pollution will reduce the environmental, social, and economic impacts of Joined Up Care Derbyshire ICS.

2.3 What is Carbon Net-Zero?

Carbon net-zero, often referred to as being 'carbon neutral', is defined as a state in which an organisation avoids emitting greenhouse gases (GHGs) through its generation and use of energy, travel, waste, medicines, and supply chain. Achieving net-zero carbon emissions is a core aim of national and local policy and a key driver of this Green Plan.

To achieve net-zero emissions, Joined Up Care Derbyshire ICS must reduce emissions as much as possible, and then offset the remaining emissions. Within the NHS, there are instances where the generation of carbon emissions is unavoidable, for example, the need for anaesthetics. Where emissions cannot be reduced to zero, carbon offsetting through investment into bio sequestration (e.g. tree planting) and technology-based carbon capture and storage can be utilised to offset the residual emissions and achieve carbon net-zero.

2.4 Our System Strategy

Delivering a net-zero NHS has the potential to secure significant benefits across the population, and particularly for vulnerable and marginalised populations, addressing existing health inequalities. These benefits will only be fully realised through public participation, involvement, and engagement with those communities as this work progresses, having regard to the need to reduce health inequalities and considering the public sector equality duty.

As a key priority, the NHS and the local system will be working to reduce air pollution and improve local environments, thereby supporting the development of local economies in geographical areas of deprivation.

The agenda of Joined Up Care Derbyshire ICS is summarised in the ICS's Health Inequalities Green Plan on a Page (see Appendix B). The ICS seeks to reduce the avoidable and unjust differences in health outcomes for the population of Derby and Derbyshire. To fulfil this vision, the ICS aims to ensure that all people of Derby and Derbyshire have an equal chance to start life well, live well and remain well. The workstreams that Joined Up Care Derbyshire ICS will undertake to support this agenda comprise several key actions.

2.4.1 Improve the estate and travel to increase access for staff and patients

The NHS estate and its supporting facilities services – including primary care, trust estates and private finance initiatives – comprises 15% of the total carbon emissions profile. There are opportunities for emissions reductions in the secondary and primary care estates respectively, with significant opportunities seen in energy use in buildings, waste and water, and new sources of heating and power generation.

Delivering a net-zero health service will require work to ensure that new hospitals and buildings are net-zero compatible, as well as improvements to the existing estate. Joined Up Care Derbyshire ICS's strategy will support the capital and estates elements of the net-zero agenda in several ways. To ensure that the most disadvantaged communities, staff, and patients can have equal access to the NHS estate, Joined Up Care Derbyshire ICS will promote active travel – through, for example, using salary sacrifice schemes – and next-best low carbon alternatives where possible.

To improve access to a greener estate, Joined Up Care Derbyshire ICS will also ensure that all opportunities to 'green' the estate are maximised, with a focus on those areas within the most deprived communities. Joined Up Care Derbyshire ICS are planning for all major refurbishments and new builds to consider the need to reduce emissions, and that wherever possible maintenance or the replacement of equipment is undertaken in a way that improves energy efficiency and reduces emissions. For example, in the coming years, a series of new developments within Derbyshire Healthcare NHS Foundation Trust will be built with the aspects of greenery and greenspace at the heart of its estate.

2.4.2 Align with the role of an anchor institution

An anchor institution is an institution that, alongside its main function, plays a significant and recognised role in a locality by making a strategic contribution to the local economy through sizeable assets used to build wealth through spending power, workforce, buildings, and land. Anchor institutions can make a positive impact on wider determinants of health, for example in terms of supporting improvements to socioeconomic factors. By adopting the role of an anchor institution, ICSs therefore can have greater capacity to reduce health inequalities.

The role of an anchor institution is one that Joined Up Care Derbyshire ICS is looking to align to, and is considered a core component of the ICS's development. Joined Up Care Derbyshire ICS has established a System Anchor Group to develop its plans and approaches as anchor institutions. The System Anchor Group has linked formally with the NHS Derby and Derbyshire Integrated Care Board (ICB), as well as other system groups such as the People and Culture Board and the Derby City and Derbyshire County Health and Wellbeing Boards (HWBs).

Through this group, a range of priorities and opportunities that exist for Derbyshire's people and communities have been identified and progressed. These opportunities mainly pertain to our workforce and employability, due to the significant impact that Covid has had on the employment, health, and wellbeing of communities across the county. Recruitment, pay and working conditions, training and development, and health and wellbeing all form key priorities moving forward, and alongside our estate plans form a core component of our Green Plan.

2.5 About this Green Plan

This Green Plan sets out the organisational strategy for sustainability at Joined Up Care Derbyshire ICS for the next 3 years, and responds to a call by the NHS for the ICS to develop a regional level approach to sustainability based on the sustainability strategies of their member organisations. It summarises and presents the interventions through which the strategies of the NHS Trusts of Joined Up Care Derbyshire ICS will be coordinated and integrated, whilst addressing the priorities of system-wide partners.

This Green Plan is structured as follows. Section 3.0 reviews the local and national legislative drivers and contractual requirements with which Joined Up Care Derbyshire ICS must align and establishes several targets to achieve a more sustainable performance. Section 4.0 details the carbon footprint of Joined Up Care Derbyshire ICS on both regional and Trust-level scales; discusses data on carbon emissions associated with the ICS's procurement processes; and provides narration on the actions that the Trusts of Joined Up Care Derbyshire ICS have determined in their Green Plans to address their respective environmental aspects. Section 5.0 outlines Joined Up Care Derbyshire ICS's commitment to sustainability and the methodology by which the ICS has gone about determining its combined sustainability strategy. Lastly, section 6.0 details Joined Up Care Derbyshire ICS's strategic sustainability objectives, the interventions that the ICS will deliver, and an explanation for how they will be delivered in an integrated way. It also outlines the benefits of the joint interventions and by whom they shall be led.

The successful delivery of this strategy will require commitment in resources both from within existing capacity but also may require additional funding for some of the actions. Where actions may require additional resource this will need to be assessed and agreed as appropriate by the relevant organisations and through appropriate system governance.

A separate Sustainable Action Plan to be delivered at the ICS level has also been provided as a framework to support the implementation of specific interventions and help monitor Joined Up Care Derbyshire ICS's sustainability progress (see Appendix A). It details how and by when the Trusts of Joined Up Care Derbyshire ICS will be held to account over reducing carbon emissions and making progress on net-zero.

This Green Plan was developed over the winter of 2021-22 and [has been approved by the ICS's respective NHS Trusts]. These include Chesterfield Royal Hospital NHS Foundation Trust (CRHFT), Derbyshire Community Health Services NHS Foundation Trust (DCHS), Derbyshire Healthcare NHS Foundation Trust (DHCFT), East Midlands Ambulance Service NHS Trust

(EMAS), and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB). The Green Plan [will also be approved by the formal statutory NHS Derby and Derbyshire ICB in July 2022]. The actions and interventions included within this plan will start to be implemented from early 2022, with the timeframe of delivering the activity being 2022 to 2025.

3.0 THE REQUIREMENT FOR SUSTAINABLE HEALTHCARE ORGANISATIONS

A report published last year by the Intergovernmental Panel on Climate Change (IPCC) followed decades of updates which stressed the threats that climate change poses to the environment. In recent years, climate change has also been recognised as a significant risk to human health. The World Health Organisation (WHO), British Medical Association, and various Royal Colleges are just some of the organisations which view climate change as the greatest threat to global health of the 21st century. The urgency to act on sustainability is mirrored by various levels of guidance and legislation to which Joined Up Care Derbyshire ICS and this Green Plan responds.

3.1 Driving the Net-Zero Transition in Healthcare

3.1.1 National Drivers

In accordance with the Climate Change Act 2008, the UK has established a mandatory target to reduce carbon emissions to net-zero by 2050. The NHS is the UK's largest public sector employer and contributes up to 5% of the nation's carbon emissions. Therefore, it is essential that the organisation plays a vital role in supporting this national target.

In 2020, NHS England and Improvement (NHSE&I) released a report called *Delivering A Net Zero National Healthcare Service* which provides a sector-wide approach for achieving decarbonisation objectives in healthcare settings. Alongside a range of potential pathways, the plan sets two net-zero targets – to achieve net-zero by 2040 for the NHS Carbon Footprint and by 2045 for the NHS Carbon Footprint Plus. Figure 3 illustrates the scope of these two carbon footprints.

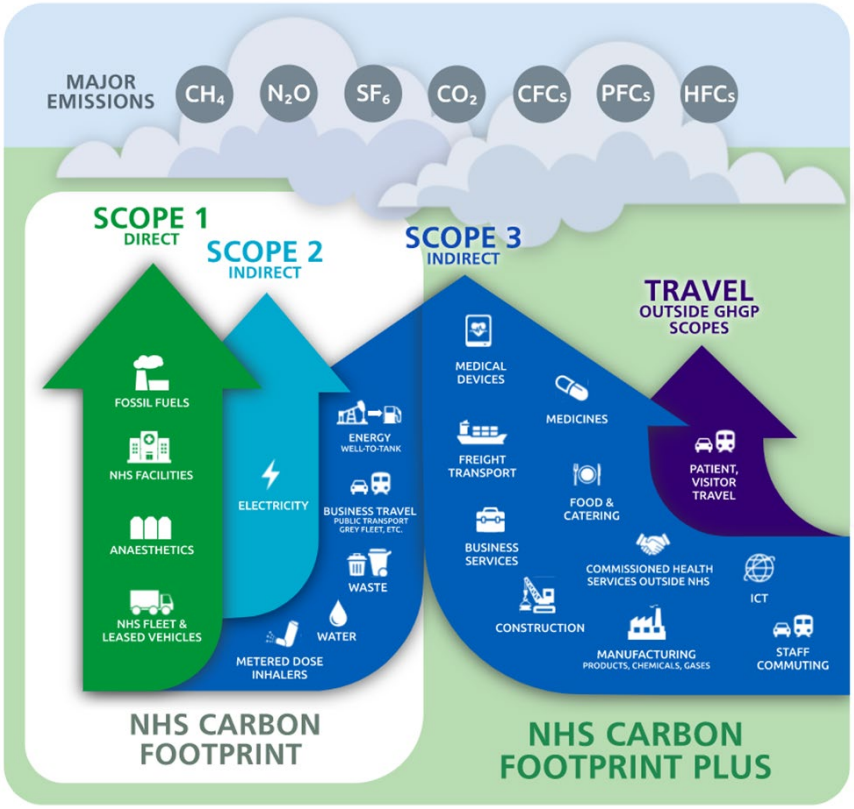


Figure 3: NHS Greenhouse Gas Emission Scopes

Simultaneously, the "For a Greener NHS Campaign" was published by the Chief Executive Officer (CEO) of NHSE&I, which provides top-down support to NHS organisations to decarbonise their operations, reduce their impact on the environment, and improve health. The campaign builds upon the work already being carried out within the NHS to improve sustainability, and will ensure that high-level backing is provided to support NHS organisations in their work to become net-zero.

To become a net-zero health service, reduce air pollution, and reduce waste the NHS requires the commitment of all Trusts, staff, and partners. An expert panel has subsequently been formed to map the best path for the NHS to become carbon net-zero, the findings of which shall be continually reviewed by the ICS and used to update this plan as required.

Additional drivers for sustainability in the NHS are set out in a suite of organisation-specific documents, which include the following:

- NHS Long Term Plan
- NHS Standard Service Contract 2021/22
- NHS Operational Planning and Contracting Guidance
- Delivering a Net Zero National Health Service

The *NHS Long Term Plan* details the method by which the NHS will develop until 2030, and includes considerations pertaining to sustainable development. The *NHS Standard Service Contract 2021/22* highlights several targets and objectives associated with sustainability within the NHS, including the reduction of water used and waste generated. The *NHS Operational Planning and Contracting Guidance* provides advice on the actions required to assist the organisation in achieving the national carbon reduction targets and to improve the NHS's resilience.

Delivering a Net Zero National Health Service provides details on the modelling and analytics that have been used to determine the NHS carbon footprint and future projections. It also covers the actions that will be implemented by the organisation to reduce emissions, including a series of immediate actions that must be taken to meet the 2040 net-zero target. To ensure that the NHS is on track to meet its long-term commitments and retains the ambition it requires to achieve them, this report will be continuously reviewed.

Significant progress has already been made on reducing carbon emissions within the NHS, with a 62% reduction between 1990 and 2020 having been achieved nationally through the implementation of several strategies. However, as climate change is growing in significance and the time available to address the problem diminishes, the number and scope of drivers for change are expected to increase. The NHS is continually updating guidance to ensure the organisation is tackling climate change effectively. This includes the new *Net Zero Carbon Hospital Standard*, which establishes best practice requirements for the integration of sustainability in capital projects and energy efficiency. Joined Up Care Derbyshire ICS will continue to engage with the NHS's sustainability agenda and will monitor legislation and guidance changes as progress towards net-zero is made.

3.1.2 Local Drivers

The Local Authorities across the region in which the Trusts of Joined Up Care Derbyshire ICS operate have responded to the increasing pressure to act on climate change. In 2019, Derby City Council formally declared a climate emergency. Both Derby City Council and Derbyshire County Council have also established targets in accordance with national guidance to achieve carbon neutrality across the region.

Achieving the targets established across the above local authority areas will require all actors to make a sustained effort, and there is a clear commitment to reducing carbon emissions to net-zero throughout the region with the offering of support from the above partner organisations. Across the broad network of members in which Joined Up Care Derbyshire ICS operates, a collaborative approach will be taken to reducing emissions, as set out in this Green Plan.

3.2 Our Targets

In line with the series of national and local drivers outlined above, the Trusts of Joined Up Care Derbyshire ICS will aim to achieve the following targets:

3.2.1 Carbon Reduction

- Achieve a 100% reduction of direct carbon dioxide equivalent (CO2e) emissions by 2040. An 80% reduction (from a 1990 baseline) will be achieved by 2032 at the latest.

- Achieve a 100% reduction of indirect CO2e emissions by 2045. An 80% reduction (from a 1990 baseline) will be achieved by 2039 at the latest.

3.2.2 Air Pollution

- Convert 90% of the fleet to low, ultra-low and zero-emission vehicles by 2028.

- Cut air pollution emissions from business mileage and fleet by 20% by March 2024.

3.2.3 Waste

- Adopt a Zero to Landfill policy.

4.0 OUR ENVIRONMENTAL ASPECTS & STRATEGIES

Joined Up Care Derbyshire ICS is formed of five NHS Trusts, each of which accounts for a portion of the regional carbon footprint. Recent data reveals that the ICS's 2019-20 NHS Carbon Footprint emissions (Scopes 1 and 2) totalled 94,920 tCO2e, much of which derived from electricity and gas used to power buildings, business travel, and metered dose inhalers (see Figure 4). The carbon emissions associated with EMAS's fleet, data for which has been absorbed by Joined Up Care Derbyshire ICS due to its role as lead commissioner, also equalled 7,500 tCO2e in 2020-21, which in addition to the above equals an annual Carbon Footprint of roughly 102,420 tCO2e.

Meanwhile, Joined Up Care Derbyshire ICS's NHS Carbon Footprint Plus emissions (Scope 3) totalled 444,250 tCO2e in 2019-20, the majority of which came from the procurement of medicines and equipment, and some of which related to the commuting patterns of the ICS's workforce (see Figure 5). It is important to note that the Carbon Footprint Plus data below is not fully representative of the ICS's indirect emissions, and further information regarding the ICS's procurement related emissions can be found in the following section. Data is being continuously refined, and Joined Up Care Derbyshire ICS seeks to improve the reporting of its carbon footprint in years to come.

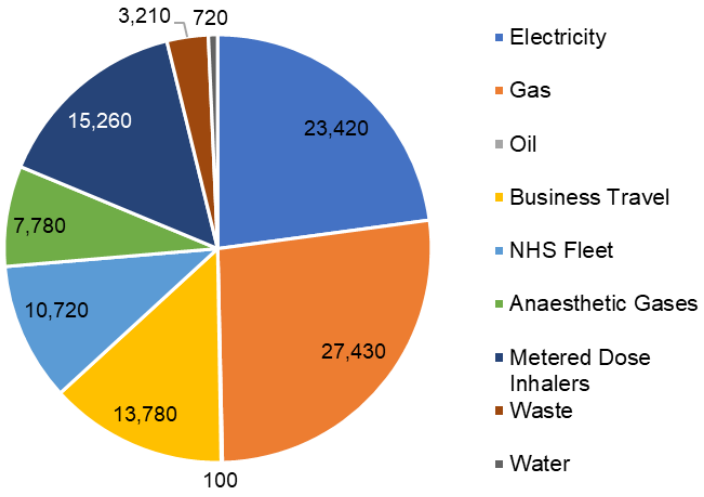


Figure 4: JUCD ICS Carbon Footprint (tCO2e)

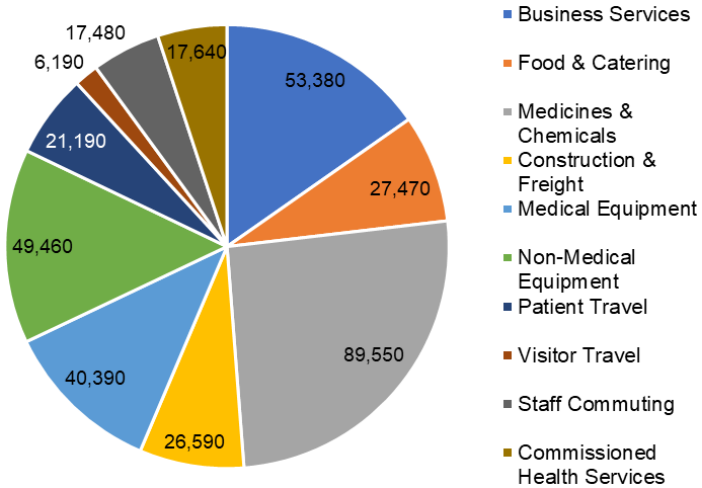


Figure 5: JUCD ICS Carbon Footprint Plus (tCO2e)

These graphs show Joined Up Care Derbyshire ICS's Carbon Footprint (Figure 4) and Carbon Footprint Plus (Figure 5) emissions from 2019-20 (including more recent data where necessary). The footprints are broken down into several categories, each of which is listed to the right of the graphs and represented by a colour.

The order by which these categories are listed corresponds to the order by which they appear in a clockwise sequence within the graphs. For example, in Figure 4, the first listed category of 'Electricity', represented by a medium blue, corresponds to the first wedge from the top of the graph reading '23,420 tCO2e'. The second listed category of 'Gas' corresponds to the orange wedge as found in clockwise direction after the 'Electricity' wedge.

In some cases, the quantity of carbon emissions associated with a particular category is comparatively small. For example, the use of oil across the ICS, which has been largely phased out and only used as a back-up energy supply, produced a total of only 100 tCO2e in 2019-20. Consequently, the grey coloured category of 'Oil' in Figure 4 is difficult to visualise. In such instances, the associated carbon emissions are represented only by the numerical figure which can be found around the edge of the graph next to the thin non-visible wedge it relates to.

4.1 CO2 Procurement Analysis

[Placeholder for procurement analysis]

The following sections provide summaries of each of Joined Up Care Derbyshire ICS's organisation-level Green Plans. Firstly, the Trusts' main environmental aspects and carbon hotspots are highlighted. Following this, each organisation's key actions, which have been determined at a Trust-level to address these aspects, are detailed. It is important to note that the data included has been provided by each Trust and has not been verified at a system-level. It is also important to note that the carbon data provided by each Trust was varied in size and scope. As such, the data discussed is indicative of our organisations' impacts and requires further analysis, a factor we are committed to working on, as will be outlined in Section 6.9.

4.1 Chesterfield Royal Hospital NHS Foundation Trust (CRHFT)

CRHFT is a medium-sized Trust employing around 3,400 staff and providing a range of health services to over 375,000 people. Its role as an acute care provider means that its carbon footprint large and diverse.

In 2019/20, its NHS Carbon Footprint totalled 9,567 tCO2e, formed mainly from the consumption of gas (5,757 tCO2e) and electricity (3,693 tCO2e). A reduction of 19% in total carbon emissions has been achieved since the Trust's baseline year of 2013/14. However, it is important to note that the Trust's Carbon Footprint does not include emissions other than those related to energy use in buildings, whilst its NHS Carbon Footprint Plus emissions have not been quantified. Consequently, there remains work to be done by the Trust to make progress on the NHS's 2040 and 2045 net-zero targets.

Over the next 4 years, the organisation will undertake actions across several areas to address its carbon footprint more urgently. CRHFT's Green Plan underlines the importance of its workforce in becoming a more sustainable organisation, with actions such as the integration of sustainability within recruitment processes and staff training. The Green Plan also has a focus on continuous improvement, with ambitions to replace carbon-intensive anaesthetic gases and assess the efficiency of delivery pathways concerning metered dose inhalers. The most pertinent action to address its quantified sources of carbon are the Trust's plans surrounding asset management and utilities. Emissions associated with energy usage will be reduced through a series of energy efficiency schemes, a switch to 100% renewable energy, and the use of more sustainable approaches to generating heat and power across its estate.

4.2 Derbyshire Community Health Services NHS Foundation Trust (DCHS)

DCHS is one of the largest Community Trusts in England providing specialist community health services. It employs over 4,200 staff and serves an average of 4000 patients per day across a range of community hospitals, clinics, GP practices, schools, care homes, and through visits to homes. Due to the wide geography across which its services are delivered, its carbon footprint is equally as expansive.

In 2020/21, its NHS Carbon Footprint totalled 7,775 tCO2e, formed mainly from the use of gas and oil (4,890 tCO2e), electricity (1,703 tCO2e), and business travel (1,057 tCO2e). Meanwhile, its NHS Carbon Footprint Plus adds 22,300 tCO2e, derived from the inclusion of

Procurement (20,489 tCO2e), commuting (1,557 tCO2e) and patient and visitor travel (254 tCO2e). This means that the Trust's total combined Carbon Footprint Plus for 2020/21 equaled 30,074 tCO2e. It should be noted that the above data does not yet include emissions from areas such as anaesthetic gases and metered dose inhalers, but these are relatively low for DCHS as a community trust. The Procurement emissions figures have only just been calculated, so further analysis is still required on these figures.

DCHS's Green Plan outlines the Trust's plans to undertake action on several key areas to reduce its carbon emissions over the next 3 years. First and foremost, the Trust will move away from unsustainable forms of heating and lighting through increased use of renewable energies, and improve the energy efficiency across its buildings through measures such as estate rationalisation. The Trust's reliance on business travel and outpatient visits has also led the Green Plan to highlight the need to reduce the use of transport by staff and patients. Consequently, actions include delivering services through digital means such as telehealth wherever appropriate, through optimised arrangements such as mobility hubs and centrally located treatment rooms, and offering staff alternative means of transport. Additionally, to make progress on the monitoring of Scope 3 emissions, DCHS will work with partners to comprehensively assess procurement-related carbon to identify the areas to be targeted for the most significant future reductions.

4.3 Derbyshire Healthcare NHS Foundation Trust (DHCFT)

DHCFT provides mental health, learning disabilities, substance misuse services, and children's services to a population of around 1 million people. It employs over 2,800 staff operating from a series of community bases across the county. Its role as a mental health and community services provider means that its carbon footprint is reasonably small.

In 2020/21, its NHS Carbon Footprint totalled 3,226 tCO2e, formed from the use of energy across its sites. However, this figure does not include those carbon emissions associated with other primary sources such as business travel which may be significant due to the wide area across which the Trust travels and operates. The Trust plans to transform its existing estate in future years through the addition of new builds and upgrades. Resultingly, efforts to achieve the NHS's 2040 and 2045 net-zero targets must continue to be made by DHCFT.

The organisation's Green Plan outlines the actions it will take over the next 3 years to reduce carbon emissions and make progress on sustainability. To tackle the emissions associated with energy use across its estate, several key interventions involve running energy efficiency schemes and embedding a sustainability philosophy into all capital projects. To counter the emissions associated with business travel, a core element of DHCFT's sustainability strategy also involves taking advantage of digital solutions to increase the efficiency and flexibility of working processes and the delivery of care.

4.4 East Midlands Ambulance Service NHS Trust (EMAS)

EMAS provides emergency and non-emergency services for approximately 4.8 million people across 5 counties. The Trust operates from over 70 premises across the East Midlands, including ambulance stations, control centres, fleet workshops, educational centres, and administrative offices.

In its Green Plan, EMAS provides an overview of the actions it will take throughout the next 3 years to tackle its carbon footprint. Operating 800 vehicles, the trust's fleet makes up 65% of the trust's direct emissions. Electric vehicle charging is therefore a priority to support the decarbonisation of the fleet which will have the biggest impact on reducing emissions. Some of the Trust's fleet-based emissions are currently largely unavoidable until technology develops, so non-emergency vehicles are being transitioned to zero emission first.

To tackle business travel emissions, travel policies will be revised to include environmental considerations, work will be conducted online where possible, and awareness over the impact of avoidable business travel will be promoted amongst staff.

EMAS will explore initiatives to reduce the climate impact of anaesthetic gas use, whilst building energy will be made more sustainable through the procurement of renewable alternatives and improvements to building efficiency.

4.5 University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)

UHDB is one of the largest hospital Trusts in the UK, comprised of hospitals located across 5 sites. It is responsible for managing acute, obstetrics and neonatal healthcare for a population of over 750,000 people. Given its significant size and scope, The Trust has a correspondingly large carbon footprint.

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

In 2020/21, its overall carbon footprint totalled 131,148 tCO2e, primarily constituted from procurement (122,994 tCO2e), utilities (4657 tCO2e), and food (2488 tCO2e). UHDB has managed to reduce its emissions by 35% since 2018/19, however there is clearly much greater progress to be made to achieve the NHS's 2040 and 2045 net-zero targets.

UHDB's Green Plan details of several key areas in which its carbon emissions shall be reduced over the coming years. A significant action focuses on the mobilisation of its workforce in the sustainability agenda, underpinned by interventions such as raising awareness of topics like sustainable procurement and waste management. Another important set of actions are focused on travel, with interventions such as offering cycling facilities and developing expenses policies to incentivise use of sustainable transport. Finally, the Trust has a core interest in enhancing the quality of greenspace through biodiversity plans, monitoring, and grounds work for the dual benefit of improving physical and mental wellbeing and carbon sequestration.

5.0 OUR COMMITMENT TO SUSTAINABILITY

As an ICS of diverse organisations, we recognise our responsibility to urgently minimise our contribution to climate change to improve the wellbeing of our local population. The health of Derbyshire's communities is notably affected by issues like air pollution, and are thus more vulnerable to the health problems it creates.

The Trusts of Joined Up Care Derbyshire ICS already have a strong commitment to sustainability. We want to ensure that high-quality care is provided in a way which does not negatively impact the environment, achieves positive financial performance, and contributes to the wellbeing of our communities. We have formed a series of strategic sustainability objectives to demonstrate this commitment and make progress on our targets.

5.1 Methodology

Our sustainability strategy has been developed using a structured process. Firstly, a review of sustainability across Joined Up Care Derbyshire ICS was undertaken. This involved scoping each Trust's Green Plan to understand the environmental impacts of the ICS's members and list the actions that have been formed by each to address carbon reduction. A combined total of 251 actions were identified and then grouped under thematic headings to assist their interpretation. These thematic headings were based on the Sustainable Development Action Tool (SDAT), a framework created by the NHS's Sustainable Development Unit (SDU) for exploring and tracking progress made on sustainability within the NHS. A new sustainability action framework is currently being developed for the NHS. Consequently, some of our Trust-level Green Plans have used the SDAT to categorise their actions, whilst some have not. To make our data collection consistent and enable the simplification and streamlining of the resulting analysis, the SDAT was selected as a thematic tool.

Secondly, an analysis was conducted of the actions identified. A trust-action matrix tool (see Figure 6) was used to uncover common themes and opportunities between Trusts which demonstrated potential for partnership working and collective implementation. These overlapping action areas are underpinned by a combined total of 213 relevant actions which were sourced from the prior review of individual Trust Green Plans (and do not constitute an action plan for the ICS Green Plan). The resulting action summaries are by no means exhaustive in agglomerating interventions committed to at an individual level. Where Trusts have committed to actions which diverge from the interests of others, these were excluded unless they reasonably contributed towards system-level priorities. Conversely, some of the action areas may indeed be new for organisations within Joined Up Care Derbyshire ICS. In these cases, the action areas resemble a work-in-progress for the Trusts who will look to progress their own actions to achieve synergy with Joined Up Care Derbyshire ICS's areas of interest.

SDAT Module	Action Summary	Relevant Actions
Our People	Education, training & engagement	35
	Transformation & continuous improvement	47
	Anchor institution & community focus	15
Sustainable Care Models	Digitisation of work & practice	19
Travel & Logistics	Active travel	16
	Electric vehicles & infrastructure	19
Asset Management & Utilities	Energy efficiency	10
Adaptation	Adaptation planning	7
Carbon & GHGs	Data monitoring & analysis	7
Corporate Approach	System sustainability	20
Sustainable Use of Resources	Waste management	18

Figure 6: Joined Up Care Derbyshire ICS's
Current Organisation Sustainability Themes and Actions

The development of the strategic sustainability objectives was then established, with the resulting interventions developed through an assessment of their deliverability. This included a consideration of the roles required to coordinate the interventions at a system-wide level and the organisations best placed to adopt these roles, and the benefits that each intervention may present such as carbon or cost savings and social value aspects. A risk assessment of each intervention and the generation of associated mitigation measures was also undertaken.

To inform the plan and shape a joined-up sustainability strategy, a workshop was conducted with senior leaders and colleagues from across Joined Up Care Derbyshire ICS. A discussion was held over the merits of each intervention being jointly delivered, which enabled the further shortlisting and refinement of the interventions. The workshop concluded with the establishment of consensus amongst partners on the interventions to be pursued and the ICS-wide strategic objectives to be expressed. To ensure the strategy reflects the priorities of wider regional actors, further discussions were held with key partners such as Derbyshire County Council, Derby City Council, and GP Practices which play a significant role in meeting sustainability targets.

Our strategic sustainability objectives have been created to support Joined Up Care Derbyshire ICS's overall strategic objectives on improving health and patient care, addressing health inequality, and building a resilient healthcare system. By undertaking the interventions outlined in the following section, the ICS will make progress on realising its vision to become a sustainable healthcare organisation.

6.0 OUR JOINED-UP SUSTAINABILITY INTERVENTIONS

The visions and strategic sustainability objectives of Joined Up Care Derbyshire ICS are presented in Table 1. A timeline for the associated interventions and their expected completion dates has also been provided (see Figure 7). Further details of these objectives are presented in Appendix A.

Vision	Strategic Objective
An agile and informed workforce which understands sustainability and is empowered to make sustainable choices in their professional and personal lives.	Promote and increase awareness of sustainability through communications, education, and training.
An ICS where low-carbon best practice is readily identified, shared, and rolled out between partners.	Provide an ICS-wide forum for discipline-specific collaborative professional networks.
An anchor institution which improves the physical and mental health of its patients and communities, addresses health inequalities, and helps to build a resilient healthcare system.	Create and operate an ICS-level community outreach hub through which initiatives can be promoted and signposted to those disadvantaged by health inequalities.
An ICS which strategically utilises digital innovation.	Collectively utilise and share digital platforms and applications to increase the efficiency of working practices and care.
An inspired workforce and patient base who feel confident and incentivised to make active transport choices where able to do so.	Collectively promote, encourage, and provide access to active travel options through consistent communications.
An ICS which is prepared for the nation-wide transition to zero emission vehicles.	Establish and consolidate an ICS-wide system of shared charging point infrastructure for staff and Trust electric vehicles.
An ICS of driven and committed partners which pursue energy reduction and efficiency measures.	Collectively utilise a 100% renewable energy provider and seek additional energy efficiency opportunities.
An ICS which is prepared for a future of uncertain climatic conditions.	Collectively develop a strategy for enhancing the resilience of care to extreme weather events.
An ICS which has detailed oversight and knowledge of its carbon footprint to drive systemic change through data-led intelligence.	Build a network of accountable trans-departmental figures to investigate, monitor, and collate carbon data associated with the ICS's activities.
An ICS where sustainability has been mainstreamed into systems and processes to improve environmental health, social value, and staff experiences.	Create a strategy for developing and embedding sustainability throughout all ICS activities.
An ICS which adopts the circular economy.	Develop guidelines for dealing with materials and waste in an environmentally sound and uniform approach.

Table 1: Our Strategic Sustainability Objectives

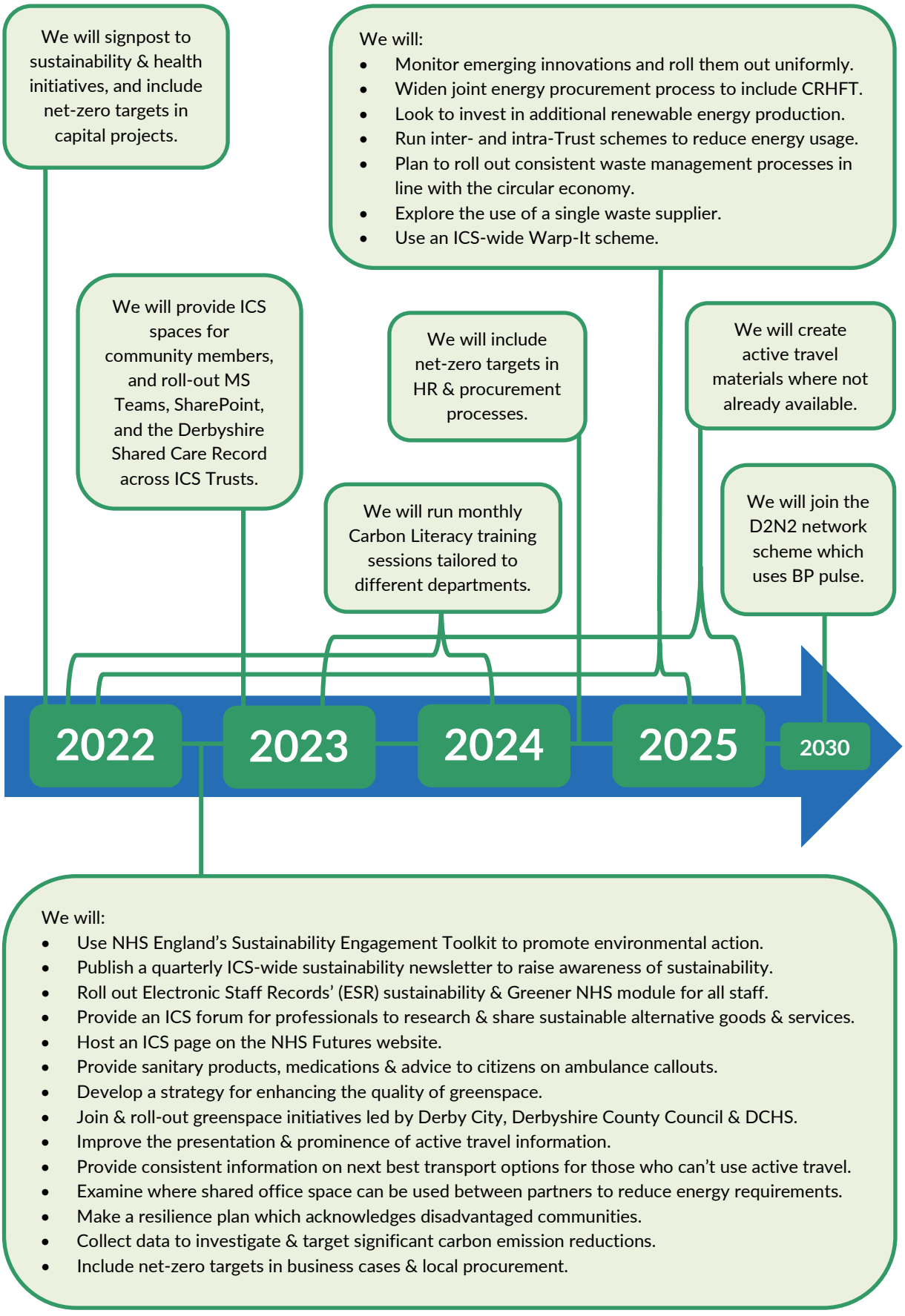


Figure 7: Joined Up Care Derbyshire ICS's Timeline for Sustainability Interventions

6.1 Promote and increase awareness of sustainability

A common vision amongst Joined Up Care Derbyshire ICS is that of workforce which feels empowered to make sustainable lifestyle choices as a result of an increased understanding of sustainability. To achieve this, we will jointly promote and increase awareness of sustainability through communications, education, and training arrangements. Overseen by our ICS HR Lead, our actions will include publishing a quarterly sustainability newsletter, running monthly Carbon Literacy sessions across different departments, and rolling out sustainability and Greener NHS modules for all staff. Awareness-raising efforts will also be underpinned by the Greener NHS Campaign Toolkit, which provides guidance and resources for engaging staff in sustainability. Joined Up Care Derbyshire ICS is hopeful that the collective mobilisation of our workforce across the region will build a regional culture shift and create greater savings in both carbon emissions and costs.

6.2 Provide an ICS-wide forum for professional networks

Joined Up Care Derbyshire ICS seeks to become an ICS where best practice concerning low-carbon products and practices is readily identified, shared, and rolled out. To achieve this, the ICS will provide a regional forum for discipline-specific professionals to collaborate and share knowledge. A new ICS-level Sustainability Coordinator will create, facilitate, and coordinate a forum for staff to research and assess sustainable alternatives to carbon-intensive works, goods, and services. To build interest in the forum, we will host an ICS page on the NHS Futures website, and use the quarterly sustainability newsletter to promote the forum's activities and achievements. The sharing of best practice will increase the likelihood that goods are purchased by Trusts in the most environmentally and financially efficient manner.

6.3 Create an ICS-level community outreach hub

An overlapping vision of the Trusts of Derbyshire ICS is for all Trusts to enhance their roles as anchor institutions which improve the health of their communities, address health inequalities, and help to build a resilient healthcare system. This agenda is summarised in Joined Up Care Derbyshire ICS's Health Inequalities Green Plan on a Page (see Appendix B). To realise this ambition, the ICS will create and operate a system-level community outreach hub where initiatives and opportunities can be promoted to enable disadvantaged groups to access them. We will signpost, join, and roll-out a series of existing initiatives such as 'Warmer Derbyshire' led by Derbyshire County Council to address the wider environmental determinants of health. However, our actions will extend beyond mere promotion. We will also seek to provide spaces such as meeting rooms for community group activities, and sanitary products, medications, and advice on ambulance callouts. Lastly, we plan to develop an ICS-wide strategy for enhancing the quality of greenspace across our Trusts to realise the co-benefits of reduced air pollution and carbon emissions, and increased physical and mental health. The involvement of local people in the ICS's activities, including greenspace initiatives, will enhance relationships within and between the organisation and communities.

6.4 Collectively utilise digital platforms and applications

Joined Up Care Derbyshire ICS aspires to become an ICS which strategically utilises digital innovation for the benefit of its workforce, patients, and the environment. To achieve this, we plan to collectively use and share digital platforms and applications to increase the efficiency of working practices and care. Overseen by the Derbyshire Digital and Data Board, we plan to roll out applications such as MS Teams, SharePoint, and the Derbyshire Shared Care Record across our Trusts, as well as uniformly monitoring emerging technological approaches and

digital innovations. The transition to digital services in care will lead to increased carbon savings, whilst sharing applications may save costs on subscriptions.

6.5 Collectively promote, encourage, and provide access to active travel

Joined Up Care Derbyshire ICS has a vision of an inspired workforce and patient base who feel confident and incentivised to make active transport choices. To realise this ambition, we will seek to collectively promote, encourage, and provide access to active travel through consistent communications across the ICS. Led by our organisation-level Travel and Transport Leads, our actions will include the creation of active travel information and materials, and provision of signposting across our Trusts and partners to ensure the information is available and accessible. For those who cannot use active transport methods, the ICS will provide information on next-best alternatives. Joined Up Care Derbyshire ICS hopes that the collective promotion of active travel will lead to healthier communities and reduced future pressures on the region's health services.

6.6 Establish an ICS-wide system of charging points

Joined Up Care Derbyshire ICS aspires to become an ICS which is prepared for the nation-wide transition to zero emission vehicles. A timely opportunity has arisen for the ICS to achieve this by aligning itself with regional plans for a system of shared EV infrastructures. Once more led by our Travel and Transport Leads, early-stage discussions are currently being held regarding the opportunity for the ICS to join Derbyshire County Council's D2N2 network scheme. This scheme will see the construction of an additional 782 BP pulse charging points to an existing 218 by 2025 for sharing between NHS staff and patients, other public sector organisations, and wider communities. If successful, the upscaling and standardisation of charging points across the region will provide Joined Up Care Derbyshire ICS with a reliable, secure, and consistent supply of electricity underpinned by joint procurement costs.

6.7 Collectively utilise a 100% renewable energy provider

Joined Up Care Derbyshire ICS strives to become an ICS of driven and committed partners which pursue energy reduction and efficiency opportunities. To fulfil this ambition, we will seek to collectively utilise a 100% renewable energy provider and explore other energy efficiency measures. Our organisation-level Energy Managers will oversee the integration of CRHFT into our existing joint energy procurement process. In addition to purchasing REGO-backed energy, we will also look to invest in increased renewable energy production through PPAs at a local scale for private use by the ICS. Our other actions involve examining where office space can be shared between partners, and running a series of inter-and-intra Trust schemes to both optimise and drive down energy usage. The collective use of a single energy supplier and competitions will lead to savings in both carbon and costs.

6.8 Collectively develop a strategy to enhance the resilience of care

The potential impacts of climate change pose a threat to the health and safety of future generations. Joined Up Care Derbyshire ICS seeks to be prepared for a future climatic uncertainty through the collective development of a strategy to enhance the resilience of care to extreme weather events. Our emergency planning group Leads will create a resilience plan – scoped with the assistance of the National Audit Office's Climate Change Risk Assessment Guide, and applied through an ICS workshop – which pays particular attention to the potential impacts of climate change on disadvantaged communities. An ICS-wide approach to adaptation is hoped to enhance the resource security of our Trusts across the region.

6.9 Build a network of trans-departmental figures to collate carbon data

A common vision amongst the members of Joined Up Care Derbyshire ICS is that of an ICS which has extensive oversight and knowledge of its carbon footprint to drive associated reductions in emissions. As seen in Section 4.0, the data we have on our carbon footprint is limited in that we haven't been able to explore our emissions in detail. To target the most significant carbon reductions, our ICS Lead will build and lead a network of accountable trans-departmental figures to investigate, monitor, and collate carbon data associated with our activities. To support the intervention, we will call upon the assistance of our Clinical Support Unit through which the ICS commissions data intelligence services. An ICS-level approach to tracking and targeting carbon hotspots is hoped to offer a considerable improvement to the data currently amalgamated under the banner of NHS Midlands.

6.10 Create a strategy for embedding sustainability throughout the ICS

Carbon emissions cannot be reduced solely through promotion and awareness raising. To improve environmental health, social value, and staff experiences, Joined Up Care Derbyshire ICS envisions becoming an ICS where sustainability has been embedded into all organisational systems and processes. Our new Sustainability Coordinator will create a strategy which focuses on the inclusion of net-zero targets across staff recruitment, employment, and appraisal processes; capital projects; and business cases, as well as focusing on the procurement of local goods and services where possible. Joined Up Care Derbyshire ICS is hopeful that the collective use of metrics to integrate sustainability across ICS would lead to a more equitable landscape of employment benefits and potentially lead to increased staff retention.

6.11 Develop guidelines for dealing with materials and waste

A common theme amongst our members' Green Plans is the need for effective and sustainable waste management. Joined Up Care Derbyshire ICS has a vision to become an ICS which adopts the circular economy. To achieve this, we will develop guidelines for dealing with materials and waste in an environmentally sound and uniform approach. Our organisation-level Waste Managers will plan for the roll out of consistent waste management processes across the ICS in line with circular economy principles. Other actions will include the exploration of the use of a single waste management supplier, as well as the collective use of the Warp-It re-use application at an ICS level. The standardisation and promotion of waste management measures across Joined Up Care Derbyshire ICS is hoped to enable staff to intuitively deal with waste through the appropriate method, making considerable savings on carbon emissions and disposal costs.

7.0 GLOSSARY OF TERMS

Air Pollution: the presence and introduction into the air of a substance which is harmful to human health.

Carbon Intensity: a means of calculating the amount of carbon generated for a specific energy source (e.g. electricity).

Carbon Net-Zero: a state in which an organisation emits no carbon emissions from its activities. Or a state in which all remaining carbon emissions are offset.

CO_2e (Carbon Dioxide Equivalent): a unit used to express total greenhouse gas emissions. There are multiple GHGs, each with a different impact on climate change. CO_2e equates all GHGs to the impact of carbon dioxide. CO_2e is used to report all GHG emissions.

Greenhouse Gas (GHG): a gas that contributes to the greenhouse effect, leading to climate change (e.g. CO_2).

Global Warming Potential (GWP): a measurement that enables the comparison of global warming impacts of different greenhouse gases.

kWh (Kilowatt Hours): a unit of measurement for energy usage (e.g. gas and electricity).

Direct Emissions: CO_2e emissions from sources which are owned or controlled by the Trust.

Indirect Emissions: CO_2e emissions from sources which are not owned or controlled by the Trust, but are generated due to the Trust's activities (e.g. purchase of electricity, procurement, waste disposal).

Scope 1 Emissions: direct emissions from owned or controlled sources (e.g. on-site fuel combustion, company vehicles, anaesthetic gases).

Scope 2 Emissions: indirect emissions from the generation of purchased electricity, steam, heating, and cooling.

Scope 3 Emissions: all other indirect emissions that occur in an organisation's supply chain (e.g. purchased goods, employee commuting, waste disposal).

Appendix A: strategic sustainability objectives of the Derbyshire ICS

No.	Vision	Strategic Objective	Intervention Detail	Timescale	Role	Benefits	Risks
1	An agile and informed workforce which understands sustainability and is empowered to make sustainable choices in their professional and personal lives.	Promote and increase awareness of sustainability through communications, education, and training.	Sustainability engagement toolkit from NHS England.	2022/23	[ICS HR Lead] [Group of Trust-specific HR Leads] [Sustainability Coordinator – NEW]	Collective mobilisation of the ICS workforce will lead to a regional culture shift which creates greater carbon and energy cost savings.	Must ensure interventions are tailored to Trust/department level for biggest impact. Voluntary nature of interventions risks diminished focus on sustainability. Intervention lead requires strong communication skills.
			Quarterly ICS-wide publication/ sustainability newsletter.	2022/23			
			Electronic Staff Records' (ESR) sustainability and Greener NHS module rolled out for all staff.	2022/23			
			Monthly ICS-led Carbon Literacy training sessions tailored to different departments (e.g. Estates, Theatres, Procurement).	2022-2024			
2	An ICS where low-carbon best practice is readily identified, shared, and rolled out between partners.	Provide an ICS-wide forum for discipline-specific collaborative professional networks.	Provide, facilitate, and coordinate an ICS forum for groups of professionals to research, explore, review, and assess sustainable alternatives to carbon-intensive works, goods, and services.	2022/23	[Sustainability Coordinator – NEW]	Sharing best practice will ensure many works, goods, and services are not paid for multiple times, improving the financial sustainability of the ICS.	Time required of staff to collaborate and share ideas may be significant.
			ICS page hosted on the NHS Futures website.	2022/23			
			Quarterly ICS-wide publication/sustainability newsletter (including details of actions and news).	2022/23			
3	An anchor institution which improves the physical and mental	Create and operate an ICS-level community	Provision of ICS spaces for community members (e.g.	2023	[To be nominated by	Involvement of local people in ICS	Requires the commitment of

No.	Vision	Strategic Objective	Intervention Detail	Timescale	Role	Benefits	Risks
	health of its patients and communities, addresses health inequalities, and helps to build a resilient healthcare system.	outreach hub through which initiatives can be promoted and signposted to those disadvantaged by health inequalities.	meeting rooms for community group activities).		Directors of Public Health]	activities will enhance social value, community relationships and reputational benefits. A regional approach to enhancing greenspace may lead to a more equitable distribution of physical and mental health benefits.	more time and resources. Need to diversify greenspace strategy amongst Trusts due to differences in estate.
			Signposting to initiatives (e.g. Warmer Derbyshire).	2022			
			Provision of sanitary products, medications, and advice by ambulance staff to citizens.	2022/23			
			Collectively develop a strategy for enhancing the quality of greenspace which addresses air pollution, climate change, and adaptation aspects.	2022/23			
			Join/roll-out existing greenspace initiatives led by Derby City, Derbyshire County Council, and DCHS.	2022/23			
4	An ICS which strategically utilises digital innovation.	Collectively utilise and share digital platforms and applications to increase the efficiency of working practices and care.	Roll-out and use of MS Teams, SharePoint, and the Derbyshire Shared Care Record across ICS Trusts.	2023	Ged Connelly-Thompson Jim Austin	Transition to digital services and care will lead to carbon savings, whilst sharing applications will save on subscription costs.	Data protection and security risks.
			Monitoring emerging approaches and innovations and rolling them out uniformly.	2022-2025			
5	An inspired workforce and patient base who feel confident and	Collectively promote, encourage, and	Improve the presentation and prominence of active travel information.	2022/23	[Travel & Transport Lead – NEW]	Promotion of active travel on wide scale	Must ensure active travel methods are compatible with

No.	Vision	Strategic Objective	Intervention Detail	Timescale	Role	Benefits	Risks
	incentivised to make active transport choices where able to do so.	provide access to active travel options through consistent communications.	Creation of materials where not already available.	2023-2025		will lead to healthier communities and reduced future health service pressures.	regional infrastructure and transport networks to avoid safety risks.
			Inter-organisation signposting to ensure that information is available (could be with external partners, e.g. Council).	2022/23			
			For those who cannot use active travel, the ICS will provide consistent information on next best transport options.	2022/23			
6	An ICS which is prepared for the nation-wide transition to zero emission vehicles.	Establish and consolidate an ICS-wide system of shared charging point infrastructure for staff and Trust electric vehicles.	Join D2N2 network scheme which uses BP pulse.	2030	[Travel & Transport Lead – NEW]	Shared charging points will provide staff and Trust vehicles with regional security of electricity supply. Potential for shared procurement and reduced costs.	Must ensure same system (e.g. one card or application) is rolled out on regional level to support consistent site updates and usage. Short-term expense.
7	An ICS of driven and committed partners which pursue energy reduction and efficiency measures.	Collectively utilise a 100% renewable energy provider and seek additional energy	Widen joint energy procurement process to include CRHFT.	2022-2025	[Procurement Managers] [Energy Managers]	Inter-trust schemes will lead to carbon reductions, whilst collectively signing on to	Risk of poor resilience should energy provider fail to provide service.
			Look to invest in additional renewable energy production (e.g. through a PPA) at a local level for private use by the ICS	2022-2025			

No.	Vision	Strategic Objective	Intervention Detail	Timescale	Role	Benefits	Risks
		efficiency opportunities.	in addition to purchasing REGO-backed sources.			one renewable energy provider could save on financial costs.	
			Examine where shared office space can be used between partners to reduce overall energy requirements.	2022/23			
			Run intra- and inter-Trust schemes and competitions to drive down energy usage.	2022-2025			
8	An ICS which is prepared for a future of uncertain climatic conditions.	Collectively develop a strategy for enhancing the resilience of care to extreme weather events.	A resilience plan which pays particular attention to disadvantaged communities, ensuring no one is left behind. Resilience plan to be scoped with National Audit Office's Climate Change Risk Assessment Guide, applied through an ICS workshop.	2022/23	[Lead of county-wide emergency planning groups] [Sustainability Coordinator – NEW]	A regional approach to adaptation might enhance Trust relationships, resilience, and resource security.	Must ensure strategy accounts for all Trusts' individual circumstances and services.
9	An ICS which has detailed oversight and knowledge of its carbon footprint to drive systemic change through data-led intelligence.	Build a network of accountable trans-departmental figures to investigate, monitor, and collate carbon data associated with the ICS's activities.	Widespread collation of data used to investigate and target the most significant carbon emission reductions. Call upon the Clinical Support Unit, through which the CCG commissions data intelligence services, to support intervention.	2022/23	[ICS Lead]	An ICS-level approach to tracking carbon footprint to monitoring and identifying where further carbon reductions can be achieved would be a considerable	Requires a lot of time and resources. Must ensure consistent information format and scope for uniform approach across ICS.

No.	Vision	Strategic Objective	Intervention Detail	Timescale	Role	Benefits	Risks
						improvement to NHS Midlands carbon data.	
10	An ICS where sustainability has been mainstreamed into systems and processes to improve environmental health, social value, and staff experiences.	Create a strategy for developing and embedding sustainability throughout all ICS activities.	Inclusion of net-zero targets across: Staff recruitment, employment, and appraisal processes	2024/25	[Sustainability Coordinator – NEW] [Senior Operational Lead]	Using shared metrics to integrate sustainability across ICS would lead to a more equitable employment and work benefits landscape.	Shared sustainability criteria may create non-ideal approach to addressing sustainability at Trust-level.
			Capital projects	2022			
			Business cases	2022/23			
			Local procurement	2022/23			
			Procurement contracts and tenders	2024/25			
11	An ICS which adopts the circular economy.	Develop guidelines for dealing with materials and waste in an environmentally sound and uniform approach.	Plan for the roll out of consistent waste management processes in line with circular economy principles across ICS.	2022-2025	[Waste Managers]	Enables staff to intuitively know and deal with waste in the appropriate way, saving carbon emissions and waste disposal costs.	Requires a lot of time and resources for minimal carbon savings. Waste management processes are complex due to different arrangements in all Trusts, so may not be possible.
			Explore the use of a single waste management supplier.	2022-2025			
			Collectively use an ICS-wide Warp-It scheme.	2022-2025			
			Assess additional recyclable streams (e.g. toothpaste tubes, toothbrushes, medical blister packs), the outcome of which will allow the ICS to work with new start-ups to see if new collection scheme can support recycling activities.	2022-2025			

Appendix B: JUCD Health Inequalities – Green Plan on a Page

VISION

To reduce the avoidable and unjust differences in health outcomes for the population of Derby and Derbyshire

OBJECTIVES

To ensure that the people of Derby and Derbyshire will have an equal chance to…

Start Well	***Live Well and Stay Well***	***Age Well and Die Well***

OUR POPULATION HEALTH OUTCOMES

Increase life expectancy (LE)

Increase healthy life expectancy (HLE)

Reduce inequalities in life expectancy and healthy life expectancy

OUTCOME INDICATORS

Promoting equal access to low carbon travel, for staff and patients, to the NHS estate	Reducing avoidable differences in the optimal management of respiratory disease	Increasing access to a greener NHS estate

HOW

- Ensuring that the most disadvantaged communities have equal access to active travel to the NHS estate or low carbon alternatives
- Promoting low carbon and active travel to staff e.g., through salary sacrifice schemes
- Ensuring that the 20% most deprived and key inclusion groups receive optimum care of their respiratory disease, in particular to reduce the use of breakthrough medication
- Ensuring that the opportunities to 'green' the NHS estate are maximised, with a focus on those areas within the most deprived communities. Ensuring the green space is available for all to enjoy.

Joined Up Care
Derbyshire

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 10 May 2022

Performance Report

Purpose of Report

The purpose of this report is to provide the Board of Directors with a brief update of how the Trust was performing at the end of March 2022 during this extremely challenging period. The report focuses on key finance, performance and workforce measures.

Executive Summary

The report provides the Board of Directors with information that demonstrates how the Trust is performing against a suite of key targets and measures. Performance is summarised in an assurance summary dashboard with targets identified, where a specific target has been agreed. Where a specific target has not been agreed or specifically commissioned, colleagues will be able to track performance over time and discuss/challenge any specific variation that may be of concern or unusual. The charts have been generated using an adaptation of a tool created by Karen Hayllar, NHS England and NHS Improvement (NHSEI), which enables much easier interpretation of how each process is performing. The main areas to draw the Board's attention to are as follows:

Operations

Three-day follow-up of all discharged inpatients
The national standard for follow-up has been exceeded throughout the 24-month period.

Data quality maturity index
Although statistically our level of data quality has been significantly lower than expected for the last 13 months, it continues to be at a high level when benchmarked with other Trusts (see appendix 2) and we would expect to consistently exceed the national target.

Early intervention 14-day referral to treatment
Patients with early onset psychosis are continuing to receive very timely access to the treatment they need.

Early intervention 14-day referral to treatment – incomplete (people currently waiting to be seen)
The service continues to exceed the national 14-day referral to treatment standard.

IAPT 18-week referral to treatment
The 95% standard has consistently been exceeded.

IAPT 6-week referral to treatment
Following a period of special cause concerning variation as a result of staff being redeployed to support other services as the pandemic progressed, the staff returned to their posts in IAPT and from that point the national standard has been achieved once more.

IAPT patients completing treatment who move to recovery
Year to date we are exceeding target.

Adult acute inappropriate out of area placements
The significant reduction in in appropriate out of area placements has been difficult to maintain during the most recent spike in the COVID-19 pandemic. Given our significant dormitory bed base and the requirement to ensure social distancing and effective and safe cohorting arrangements, it has resulted in a temporary increase in inappropriate out of area bed use. A number of actions have been put in place and it is expected that this will reduce over the coming weeks as the impact of this wave of the pandemic subsides.

Psychiatric intensive care unit (PICU) inappropriate out of area placements
There is no local PICU so anyone needing psychiatric intensive care needs to be placed out of area, however, work is in progress towards a new build PICU provision in Derbyshire. The last two months has seen a significant reduction in PICU placements.

Waiting list for care coordination
The average wait to be seen has remained significantly low over the last 11 months.

Waiting list for adult autistic spectrum disorder (ASD) assessment
The average wait is currently 70 weeks and the longest wait is over 3½ years. The situation is likely to continue to worsen until there is an increase to investment in the service, as demand for the service far outstrips commissioned capacity. The team continues to receive around 66 new referrals per month but is commissioned to undertake 26 assessments per month. There are currently 1,657 people waiting for adult ASD assessment, which is an increase of almost 100 since the last report and an increase of 73% over the two-year period.

Waiting list for psychology
As we have seen over the last few months, the number of people waiting continues to gradually reduce. Investment has been made into the service and recruitment to a number of vacant and part-time posts across adult services is progressing, with vacancies reducing by 3% since the last report. However, around 19% of posts are currently vacant across all of psychological services, with the biggest gaps seen in the community mental health teams (CMHTs).

Waiting list for Child and Adolescent Mental Health Services (CAMHS)
The waiting list initiative resulted in a significant reduction in waiting times, however since then there has been a month-on-month increase, with the current average wait being 14 weeks. The number of children waiting has been gradually increasing and is significantly high at 509 children, the highest it has been for 2 years. The current trend and volume of referrals received is not sustainable, therefore a review of the operating model of the service is in progress.

Waiting list for community paediatrics
We continue to see a steady rise in waiting times for referral to treatment in community paediatrics. The wait time is now in excess of 44 weeks and currently sits on the risk register as a high risk. Sickness and COVID-19 absences are still having an impact on clinics as the Paediatricians have continued to work face to face throughout the pandemic. We recognise that flow is an issue for the service and are working to review the Core offer and what we could do differently to help manage the increasing waiting list. We have plans to further review the whole medical structure: what is working well,

where the gaps are and where we need more support. Review of the referral pathways and website is ongoing. We hope to improve the experience for children, families, carers, and professionals who access our services.

Outpatient appointments cancelled by the Trust
The level of cancellations has been significantly low for the last 14 months and close to target for the last 2 months.

Outpatient appointment "did not attends"
The trust target of 15% or lower is likely to be consistently achieved.

Finance

Outturn Performance at March 2022	Plan £m	Actual £m	Variance £m
Operating income	178.488	178.318	(0.170)
Operating expenses	(174.569)	(174.405)	0.164
Operating Surplus/(Deficit)	**3.919**	**3.913**	**(0.006)**
Non-operating expenses	(3.819)	(3.850)	(0.031)
Surplus/(Deficit)	**0.100**	**0.063**	**(0.0.37)**

At the end of the financial year there was a small surplus of £63k against a planned surplus of £0.1m. *This information is taken from the key data submission and draft annual accounts, which is subject to audit.*

Income is behind plan by £0.2m at the end of the financial year. Slippage on new investments related to the second half of the financial year has been retained. Pay is underspent by £2.8m at the end of the financial year, which mainly relates to the slippage on new investments but also general vacancies. This also includes agency expenditure of £5.7m and bank expenditure of £7.1m. Non-pay is above plan by £2.7m at the end of March. This includes £0.8m of impairments.

Efficiencies
The full year plan included an efficiency requirement of £2.3m, mainly phased in the second half of the financial year. As per the previous forecast this was over delivered by £0.2m.

Agency
At the end of March agency expenditure is above the ceiling by £2.7m which equates to 89%. The highest areas of agency spend relates to Medical staff, Qualified Nursing and Ancillary staff (mainly domestics). The outturn was slightly higher than forecast last month mainly due to an increase in Qualified Nursing expenditure. Some of this nursing expenditure has been recharged to the Commissioner as it related to some specialised nursing care packages.

Out of Area Placements
Expenditure for adult acute out of area placements and stepdown placements remains in budget at the end of the financial year, despite the increase in placements in March.

Covid costs
The Trust has an allocation of £0.7m a month for the financial year for Covid-related expenditure. At the end of the financial year expenditure of £8.4m is slightly above the allocation by £86k. Expenditure is mainly related to pay costs of

£5.7m which is mainly related to temporary staffing and non-pay expenditure of £2.8m.

Capital
With regards to self-funded capital, the Trust is slightly below plan at the end of the financial year as forecast. The Trust had previously received additional PDC capital funding for the initial stages of the dormitory eradication programme, covering 2020/21 and 2021/22, which was included in the plan. However, additional funding has been agreed for 2021/22 and 2022/23 ahead of the full business case of the dormitory eradication programme with allocations totalling £80m over the next three years, which was not included in the plan. Additional Public Dividend Capital (PDC) capital funding has also been received for some digital schemes.

Cash
Cash is at £44m at the end of the financial year, which is slightly higher than the previous forecast.

Planning 2022/23
Draft financial plans for 2022/23 were submitted in March and the system is working on the final submission of plans due at the end of April 2022.

People

Annual appraisals
We recognise that the last 12 months have continued to present challenges for colleagues in responding to the pandemic whilst returning to a level of business as usual. From April 2022 we need to reaffirm our expectation that all colleagues will have a meaningful appraisal conversation over the next 12 months.

Annual turnover
Turnover remains high and above the Trust target range of 8-12% for the last six months. We have commissioned two areas of focused work to support us to understand more about why colleagues are leaving the Trust. Firstly, a STAY survey which will be targeted at key areas. Secondly, we are now developing our own exit interview system that will allow us to capture a much higher percentage of leavers. In the latest national NHS staff turnover benchmarking data, the Trust was ranked 10th highest mental health trust for stability of the workforce.

Compulsory training
A recovery plan continues to improve training compliance. Operational teams are working closely with the training delivery team to look at ways to work differently in the delivery model including block training. The People and Inclusion team have also commissioned a review of all compulsory training and role competence requirements for all clinical and non clinical roles.

Staff absence
Sickness absence increased significantly in March with COVID-19 absence being the top reason for absence. Improvements are being made to the support provided by our external absence management provider GoodShape, to ensure we are maximising the opportunities this provides to support managers and colleagues over a period of absence. In the latest benchmarking data, our absence rate was above average for the nursing and midwifery staff group but was low compared with the peer group for the medical and dental and allied health professionals staff groups.

Supervision
The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic.

Proportion of posts filled
Recruitment fill rates continue to improve with the time to recruit now at 55 days, which is below the national NHS benchmark of 60 days. There has been a steady improvement in our vacancy rate as we continue to make improvements to recruitment practices and approaches including fast track recruitment, creative campaigns and advertisements and the roll out of DocuSign to reduce delays and unnecessary paperwork.

Bank staff
In the past 11 months bank staff usage has returned to common cause variation. The trend continues to improve where recruitment is now filling vacancies normally supported by bank staff.

Quality

Compliments
The number of compliments continues to remain below the expected level however, as face to face contact increases, so does the number of compliments received. With an increase in accessibility, it is expected that a natural increase in compliments, complaints and concerns will occur.

Complaints
In reviewing data, a large number of complaints are in relation to reduced face to face contact and reduced access to services. As services continue to stand back up and the electronic patient survey is implemented the number of complaints is expected to continue to decrease.

Delayed transfers of care
Since the multi-agency discharge events (MADE) were held, numbers of delayed transfers of care have reduced and now sit below the mean line. Work continues within the rapid review processes and clinical meetings.

Care plan reviews
The proportion of patients whose care plans have been reviewed continues to be lower than usual. Work continues to improve this month by month. As we move over to SystmOne, processes are expected to improve further.

Patients in employment
Around one third of patients have no employment status recorded. The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the current pandemic and the service is currently expanding.

Patients in settled accommodation
Around one third of patients have no accommodation status recorded.

Medication incidents
The medicines management operational subgroup are currently revising the medications error procedure, taking into account Trust values, and the Acute Inpatient Matrons and Head of Nursing are in the process of updating the relevant policies which will reduce the number of insignificant incidents.

Incidents of moderate to catastrophic actual harm
The number of reported incidents of moderate to catastrophic harm have remained within common cause variation throughout the reporting period.

Duty of Candour
There have been no instances of Duty of Candour in the last 3 months. Processes have been reviewed with the Head of Nursing team and the current DATIX reporting process has been updated to improve the real time reporting of Duty of Candour incidents.

Prone restraint
Data analysis and review has shown that even where restraint and seclusion has increased, the use of prone restraint has continued to remain below the expected level.

Physical restraint
The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period. The changes in numbers are linked to the data above relating to prone restraint and below relating to seclusion.

Seclusion
The use of seclusion has been above the common cause variation from October 2021. In further investigating this trend, there appears to be a link to a small number of patients who have been placed in seclusion on more than one occasion. This data will be monitored for patterns and further support needs for individual areas.

Falls on inpatient wards
Incidents appear to have continued to increase with an abnormal spike in March 2022. A review of falls has been commissioned. This will commence in April and will be an ongoing project, working alongside teams to reduce incidents of falls.

Care Hours Per Patient Day (CHPPD)
Work is underway to implement processes relating to staffing levels and how they are recorded in line with CHPPD and patient acuity. This will be in the form of the MHOST reporting system and SafeCare module within E-Roster.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	x
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	x

Assurances

This report should be considered in relation to the relevant risks in the Board Assurance Framework (BAF). The content provides assurance across several BAF risks related to workforce, operational performance and regulatory compliance. The use of run charts provides the Board with a more detailed view of performance over time as it enables the differentiation between normal and special cause variation.

Consultation

Versions of this report have been considered in various other forums, such as Board development and Executive Leadership Team.

Governance or legal issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

- This report reflects performance related to all of the Trust's service portfolio and therefore any decisions that are taken as a result of the information provided in this report is likely to affect members of those populations with protected characteristics in the REGARDS groups.
- Any specific action will need to be relevant to each service and considered accordingly, so for example, as parts of the report relate specifically to access to Trust services; we will need to ensure that any changes or agreed improvements take account of the evidence that shows variable access to services from different population groups.

Recommendations

The Board of Directors is requested to:

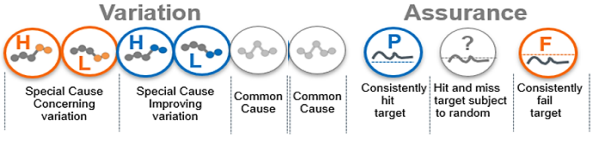
1) Confirm the level of assurance obtained on current performance across the areas presented. The proposed level is limited assurance.
2) Formally agree that this report incorporates the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting.
3) Determine whether further assurance is required.

Report presented by:	**Ade Odunlade** **Chief Operating Officer**
Report prepared by:	**Pete Henson** **Head of Performance (Operations)**
	Rachel Leyland **Deputy Director of Finance**
	Rebecca Oakley **Head of Organisational Effectiveness**
	Kyri Gregoriou **Assistant Director of Clinical Professional Practice**

Assurance Summary

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	3 day follow-up			81%	80%	78%	100%	89%
2	Data quality maturity index			97%	95%	97%	98%	98%
3	Early intervention 14 day referral to treatment - complete			96%	60%	70%	109%	89%
4	Early intervention 14 day referral to treatment - incomplete			93%	60%	71%	108%	89%
5	IAPT 18 week referral to treatment			100%	95%	100%	100%	100%
6	IAPT 6 week referral to treatment			88%	75%	79%	96%	88%
7	IAPT patients completing treatment who move to recovery			53%	50%	46%	64%	55%
8a	Average patients out of area per day - adult acute			3		-1	13	6
8b	Patients placed out of area - adult acute			10		0	22	11
9a	Average patients out of area per day - PICU			12		9	22	16
9b	Patients placed out of area - PICU			18		18	33	26
10a	Waiting list - care coordination - average wait to be seen			18		12	29	20
10b	Waiting list - care coordination - number waiting at month end			47		16	56	36
11a	Waiting list - ASD assessment - average wait to be seen			70		58	65	61
11b	Waiting list - ASD assessment - number waiting at month end			1,657		1145	1312	1229
11c	ASD assessments				26	3	29	16
12a	Waiting list - psychology - average wait to be seen			46		35	42	39
12b	Waiting list - psychology - number waiting at month end			688		735	920	827
13a	Waiting list - CAMHS - average wait to be seen			14		14	20	17
13b	Waiting list - CAMHS - number waiting at month end			509		336	487	411
14a	Waiting list - community paediatrics - average wait to be seen			18		9	15	12
14b	Waiting list - community paediatrics - number waiting at month end			1,146		602	904	753
15	Outpatient appointments cancelled by the Trust			6%	5%	5%	15%	10%
16	Outpatient appointment "did not attends"			13%	15%	9%	14%	12%
17	Annual appraisals			77%	85%	70%	77%	73%
18	Annual turnover			14%	8-12%	11%	12%	12%
19	Compulsory training			85%	85%	82%	88%	85%
20	Staff absence			9%	5%	5%	8%	6%
21	Clinical supervision			72%	95%	71%	78%	74%
22	Management supervision			72%	95%	73%	79%	76%
23	Filled posts			91%	100%	87%	92%	90%
24	Bank staff use			5%	5%	5%	7%	6%
25	Compliments received			93	119	60	130	95
26	Formal complaints received			25	13	6	26	16
27	Delayed transfers of care			0%	3.5%	-0.5%	1.4%	0.5%
28	CPA reviews			94%	95%	89%	94%	92%
29	Patients in employment			15%		12%	14%	13%
30	Patients in settled accommodation			57%		59%	62%	60%

Key to symbols[1]:



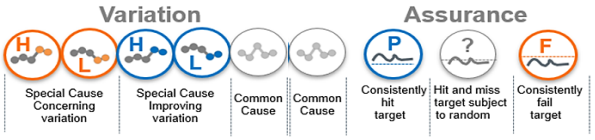
Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

	Metric Name	Variance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
31	Number of medication incidents			74		23	81	52
32	No. of incidents of moderate to catastrophic actual harm			74	48	22	75	49
33	No. of incidents requiring Duty of Candour			0	1	-2	3	1
34	No. of incidents involving prone restraint			8	12	-3	20	9
35	No. of incidents involving physical restraint			45	46	-1	88	43
36	No. of new episodes of patients held in seclusion			18	14	0	32	16
37	No. of falls on inpatient wards			49	30	14	43	29

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

Operational Services Performance Summary

Indicator	Target	Position March 2022	National benchmark	Divisional Breakdown[1] AA	AC	Ch	F&R	OP	Psy	SC	Run Chart
● 3-day follow-up	80%	82%	72%	83%			100%	67%		100%	
● Data quality maturity index	95%	97%	80%	94%	97%	85%	96%	98%	99%	97%	
● Early intervention 2-week referral to treatment	60%	96%	66%		96.3%						
● Early intervention current waits under 2 weeks	60%	93%	29%		93%						
● IAPT 18-week referral to treatment	95%	100%	98%							100%	
● IAPT 6-week referral to treatment	75%	88%	90%							88%	
● IAPT recovery rate	50%	53%	49%							53%	
● Adult acute out of area placements – daily average	0	3	9	3							
● PICU out of area placements – daily average	0	12	4	12							
● Adult ASD assessment average wait (weeks)	n/a	70	n/a						70		
● Adult ASD assessments	26	21	n/a						21		
● Psychology average wait to be seen (weeks)	n/a	46	n/a						46		
● CAMHS average wait to be seen (weeks)	4[2]	14	n/a			14					
● Paediatrics average wait to be seen (weeks)	18	18	11			18					
● Outpatient appointment Trust cancellations	5%	6%	n/a	8%	2%	0%	6%		6%	10%	
● Outpatient appointments not attended (DNAs)	15%	13%	n/a		18%	7%	7%	5%		10%	

[1] Key: AA Adult Acute Care, AC Adult Community Care, Ch Children's Services, F&R Forensic & Mental Health Rehabilitation, Psy Psychology and SC Specialist Care Services
[2] Proposed access standard (NHSE)

Performance Summary

3-day follow up
The national standard for follow-up exceeded the national average by 10% and has been achieved by all Divisions apart from Older People's Services. This process is tightly monitored by the Trust's Performance Analyst, who routinely chases up the relevant teams prior to any potential breaches to ensure patients get timely support post discharge. Investigation into the reported breaches has highlighted issues with recording on SystmOne rather than actual breaches. This should improve as people become more adept at using the new system.

Early intervention and talking therapy (IAPT)
The services continue to perform consistently highly in terms of patients accessing services in a timely manner. The quality of care provided by IAPT is seen in the recovery rate which is higher than the national standard and the national average.

Data quality maturity index
Overall, we continue to perform consistently highly against this standard.

Adult acute inappropriate out of area placements
Significant progress has been made on reducing inappropriate out of area adult acute placements and in November there were none at all. There have been a small number of placements owing to a reduction in Trust bed numbers as a result of supporting wider system needs, coupled with the pandemic necessitating a reduced bed base for infection prevention and control reasons.

PICU inappropriate out of area placements
Although these are classed as inappropriate according to the national definition, we are currently one of the few Trusts in the country without a PICU and so have no choice. However, work is in progress towards a new build PICU provision in Derbyshire.

Adult ASD assessment
An Assistant Psychologist commenced in post in order to support the assessing team, which resulted in an increase in completed assessments in March. The team receives around 66 new referrals per month but is commissioned to undertake 26 assessments per month.

Waiting times for psychology
As we have seen over the last few months, the number of people waiting continues to gradually reduce. Investment has been made into the service and recruitment to a number of vacant and part-time posts across adult services is progressing, with vacancies reducing by 3% since the last report. However, around 19% of posts are currently vacant across all of psychological services, with the biggest gaps seen in the community mental health teams (CMHTs).

Waiting list for Child and Adolescent Mental Health Services (CAMHS)
The waiting list initiative resulted in a significant reduction in waiting times, however since then there has been a month-on-month increase, with the current average wait being 14 weeks. The number of children waiting has been gradually increasing and is significantly high at 509 children, the highest it has been for 2 years. The current trend and volume of referrals received is not sustainable, therefore a review of the operating model of the service is in progress.

Waiting list for community paediatrics
We continue to see a steady rise in waiting times for referral to treatment in community paediatrics. The wait time is now in excess of 44 weeks and currently sits on the risk register as a high risk. Sickness and COVID-19 absences are still having an impact on clinics as the Paediatricians have continued to work face to face throughout the pandemic. We recognise that flow is an issue for the service and are working to review the Core offer and what we could do differently to help manage the increasing waiting list. We have plans to further review the whole medical structure: what is working well, where the gaps are and where we need more support. Review of the referral pathways and website is ongoing. We hope to improve the experience for children, families, carers, and professionals who access our services.

Outpatient appointments cancelled by the Trust
The level of cancellations has been significantly low for the last 14 months and close to target for the last 2 months.

Outpatient appointment “did not attends”
Overall, the trust target of 15% or lower is likely to be consistently achieved.

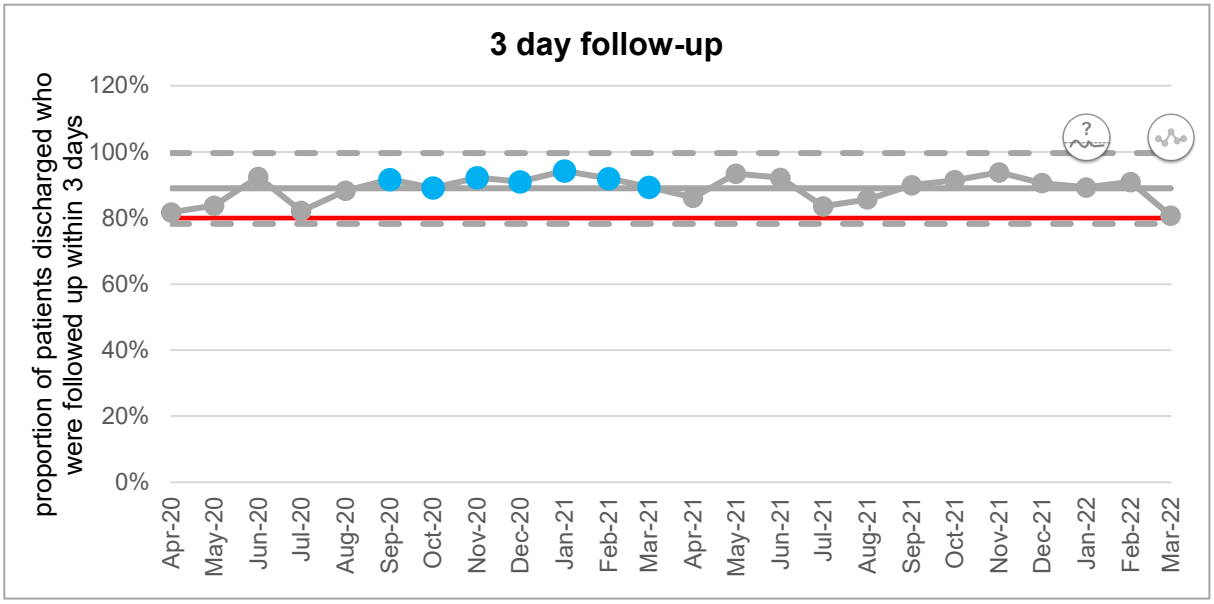
Benchmarking Sources

Measure	Data source	Date
3-day follow-up	Mental Health Statistics	Jan 22
Data quality maturity index	Data quality - NHS Digital	Dec 21
Early intervention 2-week referral to treatment	MHSDS Monthly Statistics	Jan 22
Early intervention current waits under 2 weeks	MHSDS Monthly Statistics	Jan 22
IAPT 18-week referral to treatment	Psychological Therapies: reports	Dec 21
IAPT 6-week referral to treatment	Psychological Therapies: reports	Dec 21
IAPT recovery rate	Psychological Therapies: reports	Dec 21
Adult acute out of area placements – daily average	Out of Area Placements	Dec 21
PICU out of area placements – daily average	Out of Area Placements	Dec 21
Paediatrics average wait to be seen (weeks)	Referral to Treatment Waiting	Jan 22

Detailed Narrative

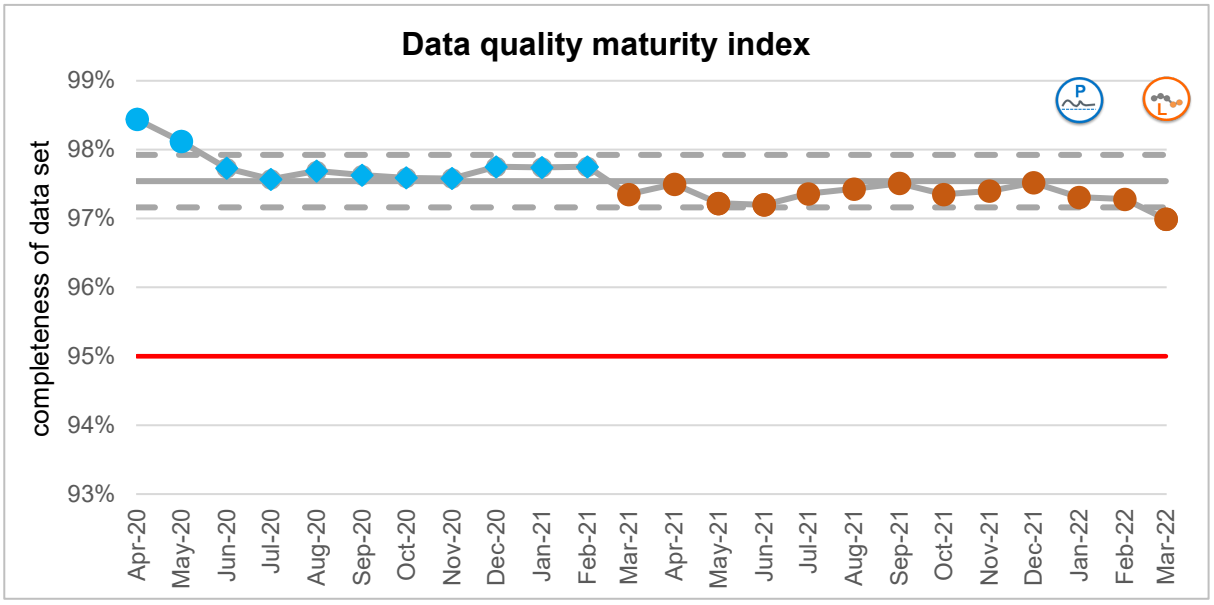
Operations

1. Three-day follow-up of all discharged inpatients



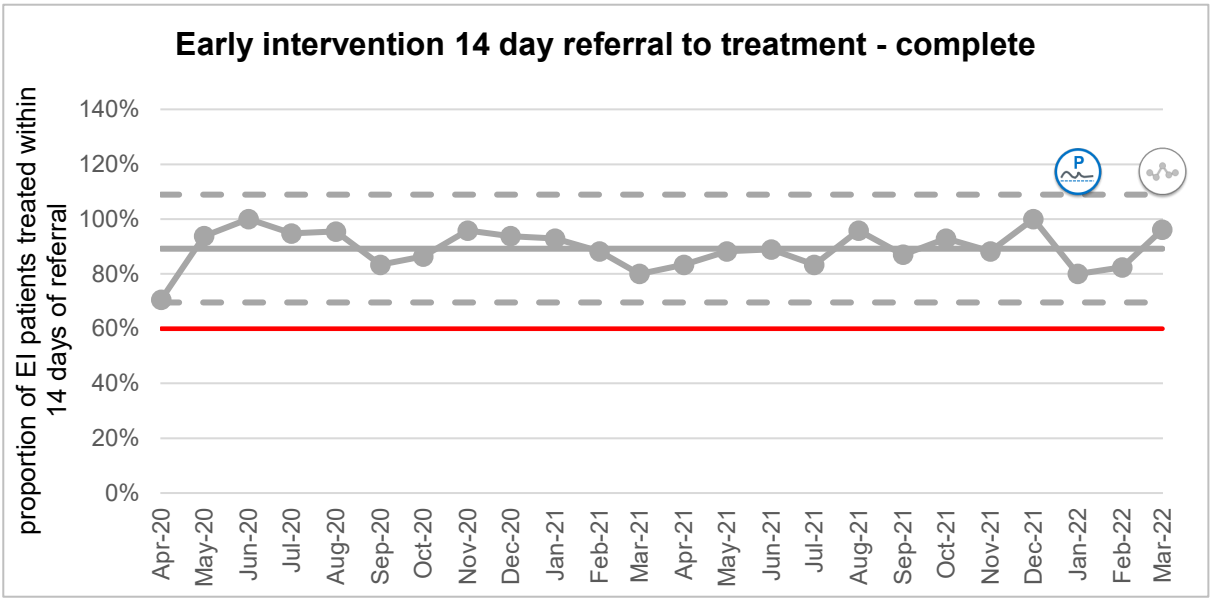
Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are at their most vulnerable. The national standard for follow-up which came into effect from 1 April 2020 has been exceeded throughout the 24-month period.

2. Data quality maturity index



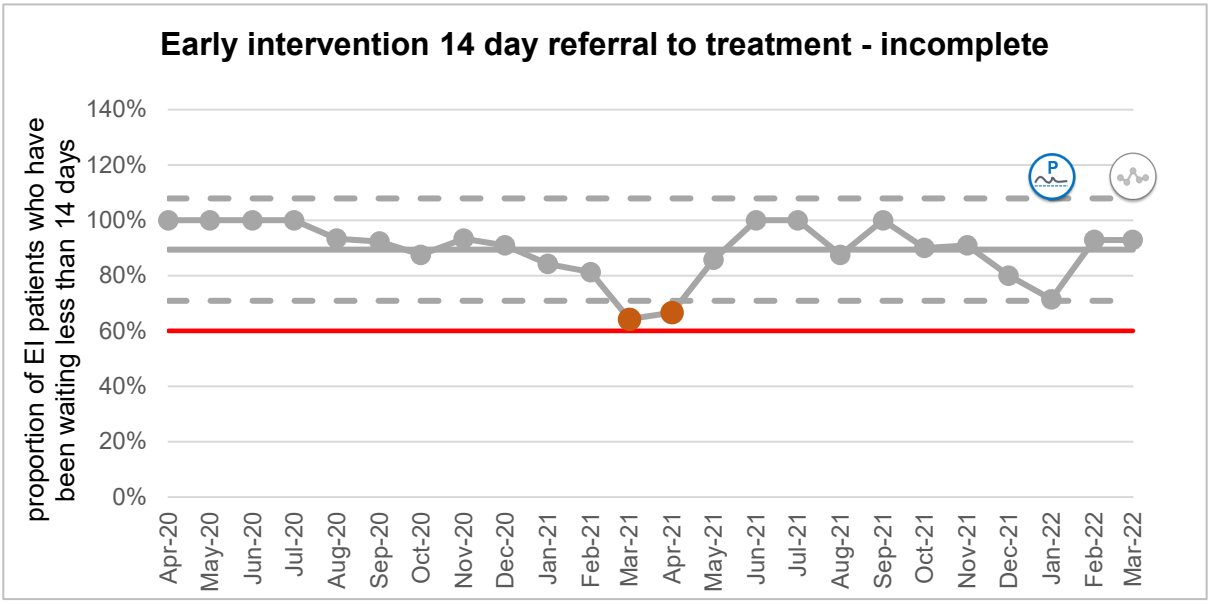
Although statistically our level of data quality has been significantly lower than expected for the last 13 months, it continues to be at a high level when benchmarked with other Trusts (see appendix 2) and we would expect to consistently exceed the national target.

3. Early intervention 14-day referral to treatment



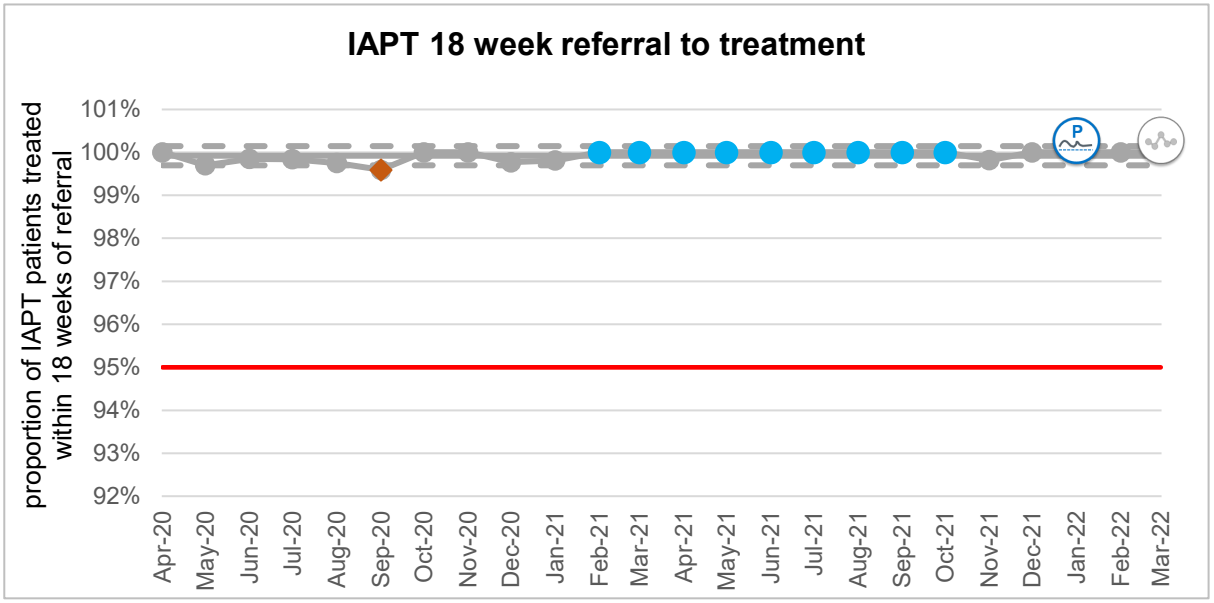
Patients with early onset psychosis are continuing to receive very timely access to the treatment they need.

4. Early intervention 14-day referral to treatment – incomplete (people currently waiting to be seen)



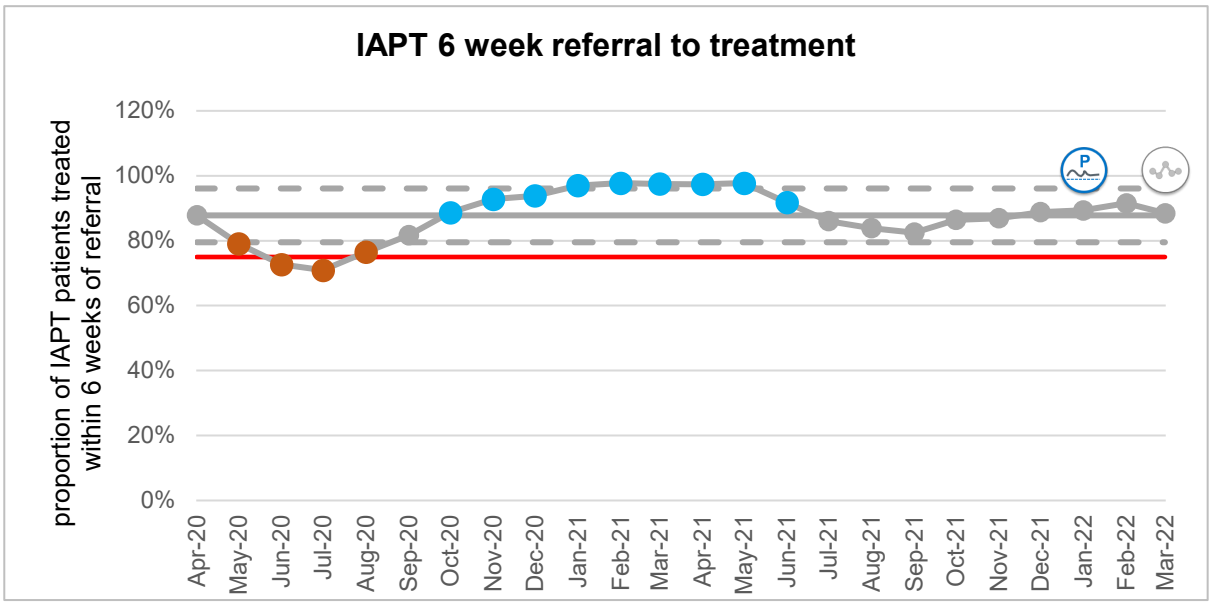
The service continues to exceed the national 14-day referral to treatment standard of 60% or more people on the waiting list to be have been waiting no more than 2 weeks to be seen.

5. IAPT 18-week referral to treatment



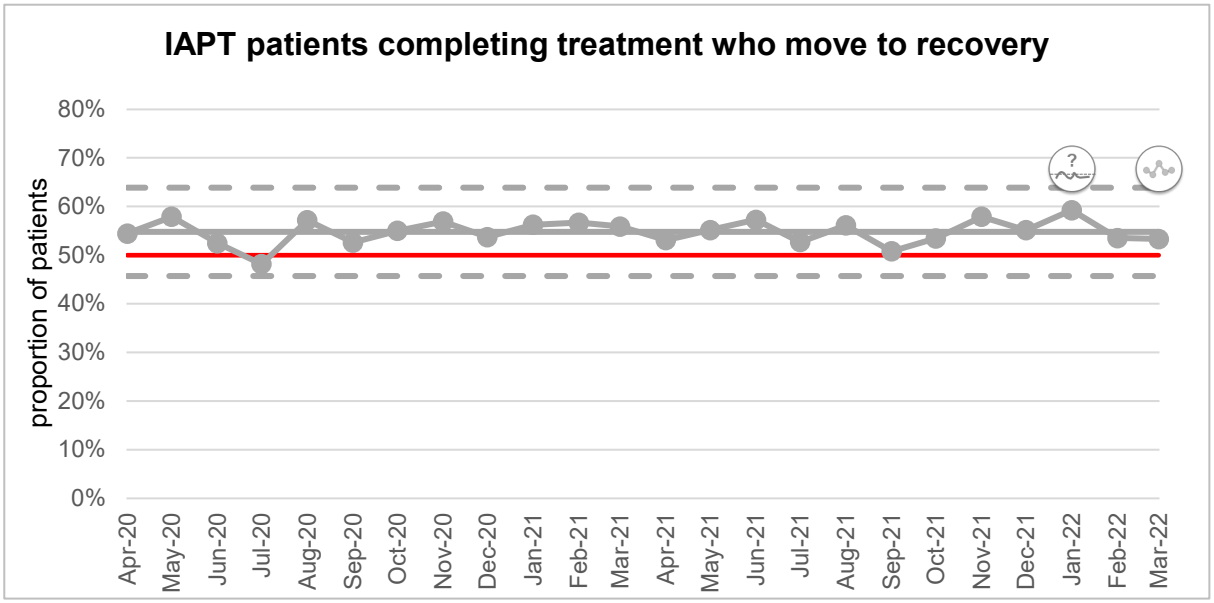
This is an example of a very tightly controlled process and we would expect to consistently exceed the 95% standard.

6. IAPT 6-week referral to treatment



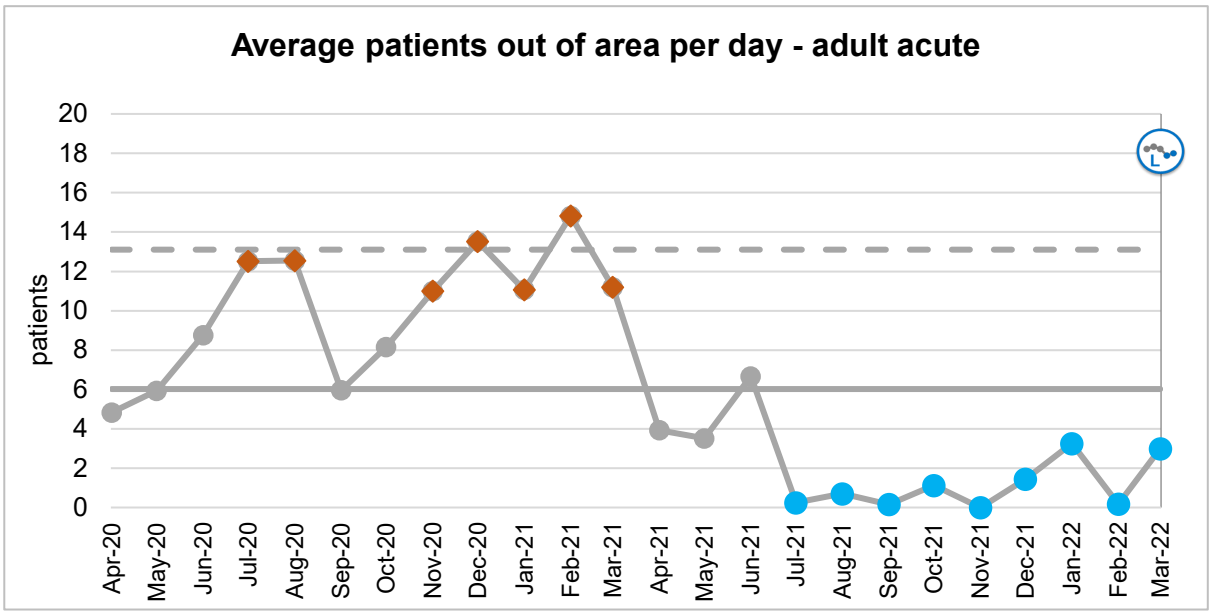
Following a period of special cause concerning variation as a result of staff being redeployed to support other services as the pandemic progressed, the staff returned to their posts in IAPT and from that point the national standard has been achieved once more.

7. IAPT patients completing treatment who move to recovery



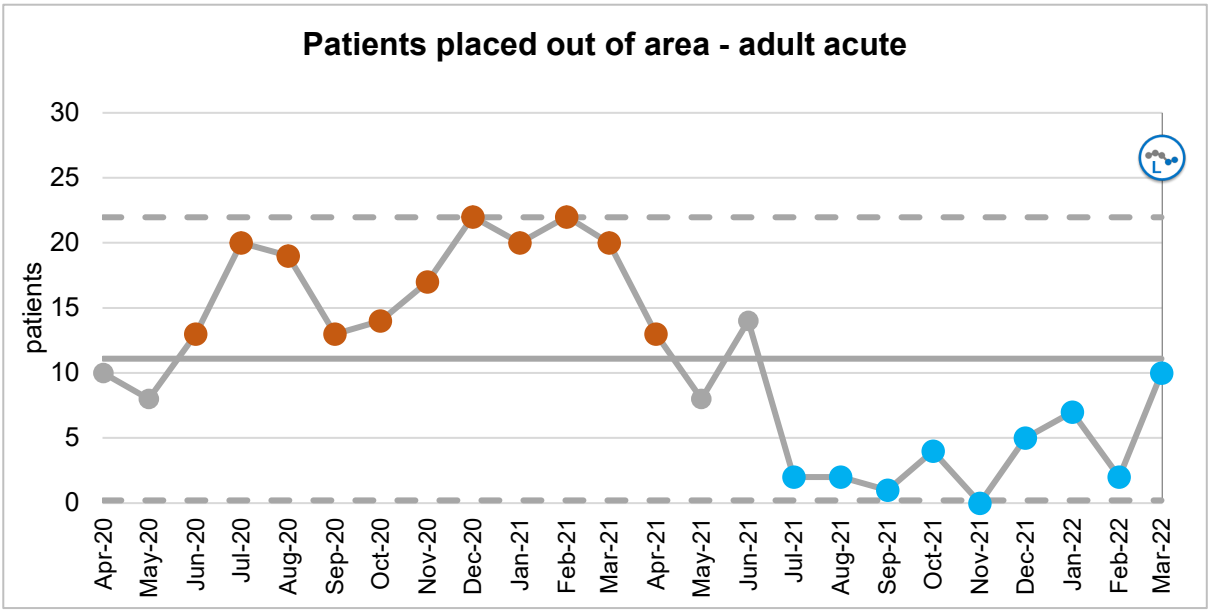
This is an annual target and year to date we are exceeding target. For the past 20 months the national standard has been achieved, with common cause variation seen throughout the data period.

8a. Average number of patients placed out of area per day – adult acute

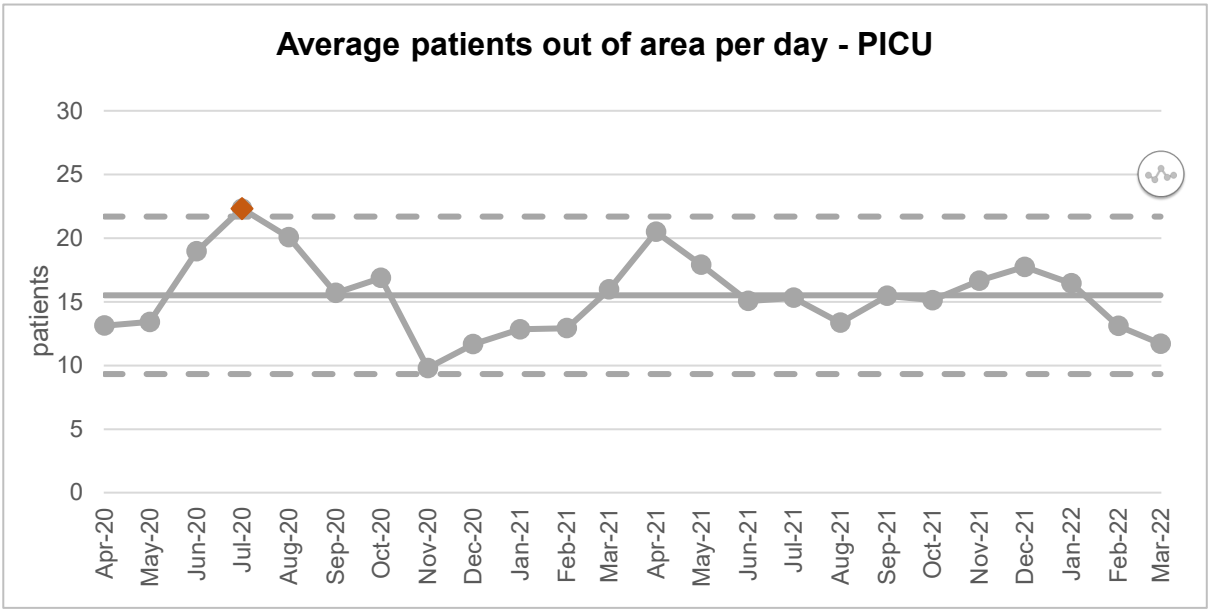


The significant reduction in in appropriate out of area placements has been difficult to maintain during the most recent spike in the COVID-19 pandemic. Given our significant dormitory bed base and the requirement to ensure social distancing and effective and safe cohorting arrangements, it has resulted in a temporary increase in inappropriate out of area bed use. A number of actions have been put in place and it is expected that this will reduce over the coming weeks as the impact of this wave of the pandemic subsides.

8b. Patients placed out of area per month – adult acute

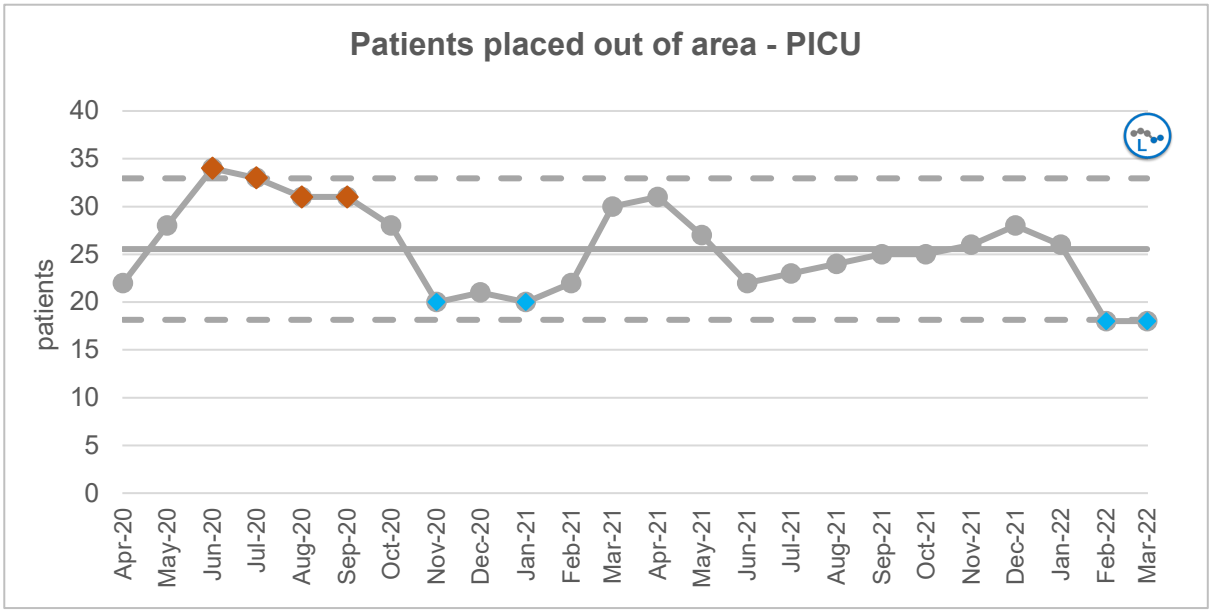


9a. Average number of patients placed out of area per day– Psychiatric Intensive Care Units



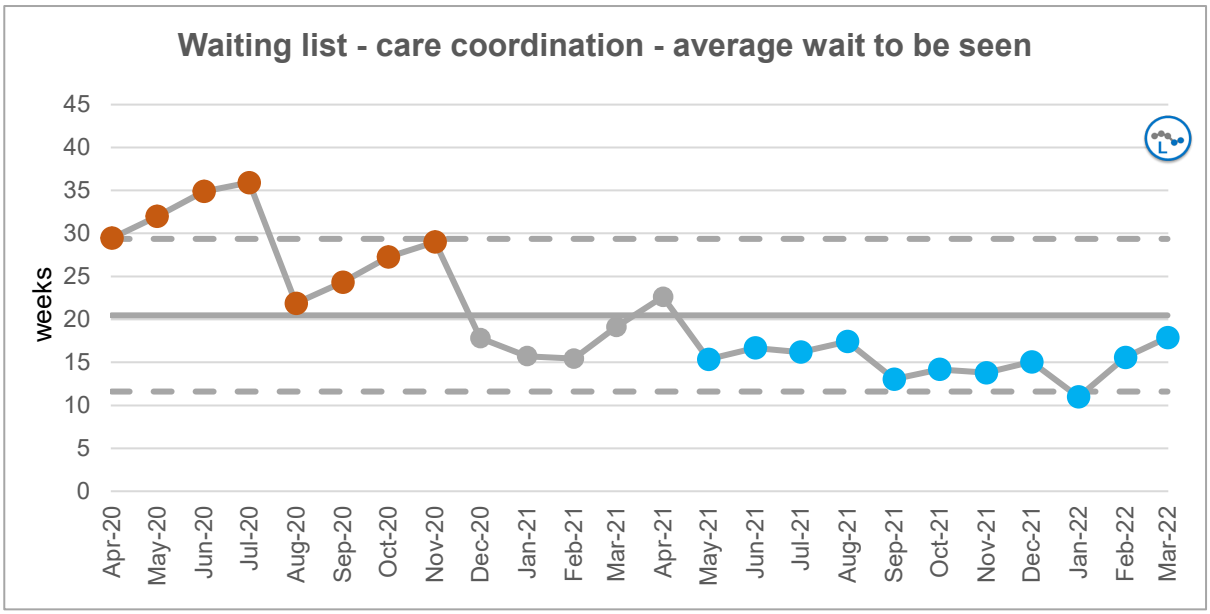
Out of area PICU usage has remained within common cause variation for the last 18 months. There is no local PICU so anyone needing psychiatric intensive care needs to be placed out of area, however, work is in progress towards a new build PICU provision in Derbyshire.

9b. Patients placed out of area per month – Psychiatric Intensive Care Units (PICU)



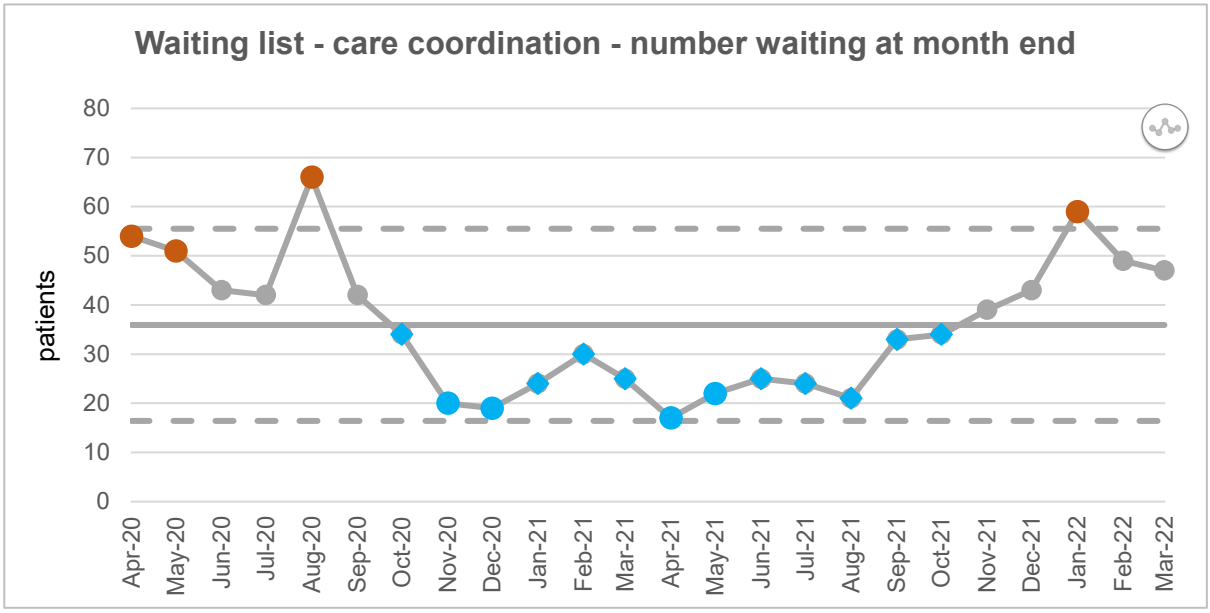
The last 2 months has seen a significant reduction in PICU placements.

10a. Waiting list for care coordination – average wait

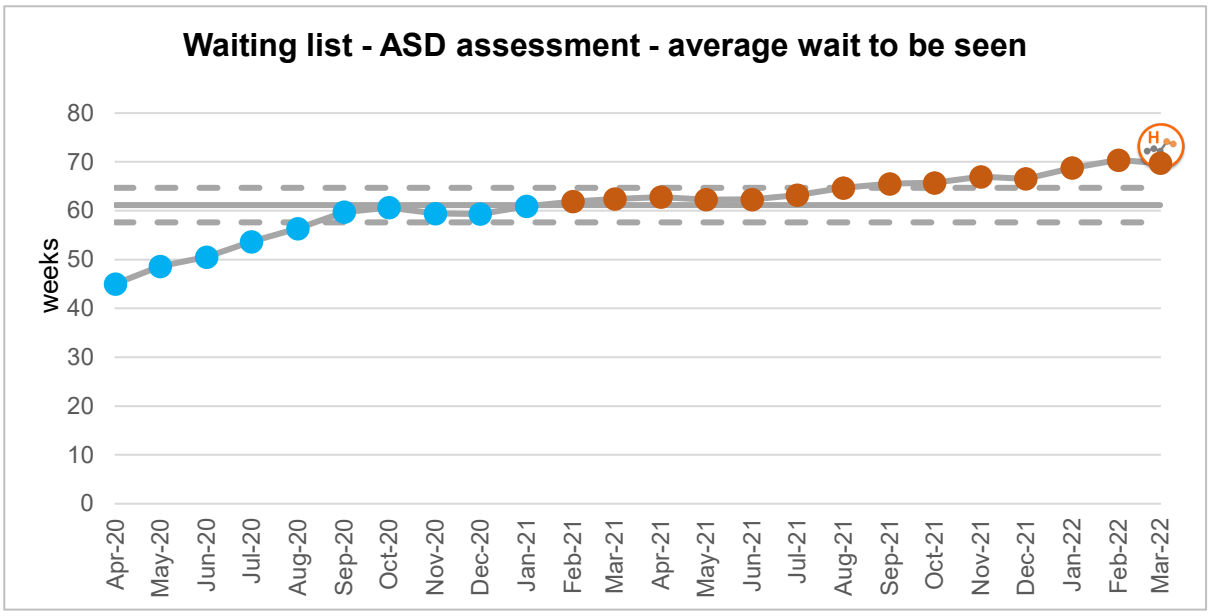


The average wait to be seen has remained significantly low over the last 11 months.

10b. Waiting list for care coordination – number waiting

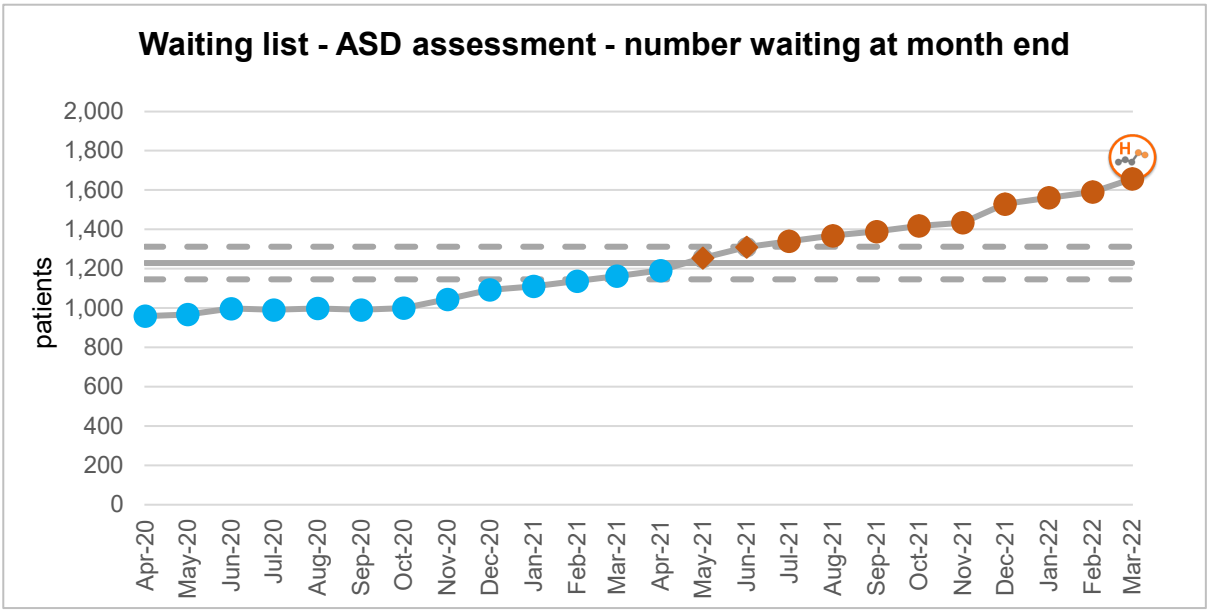


11a. Waiting list for adult autistic spectrum disorder (ASD) assessment – average wait



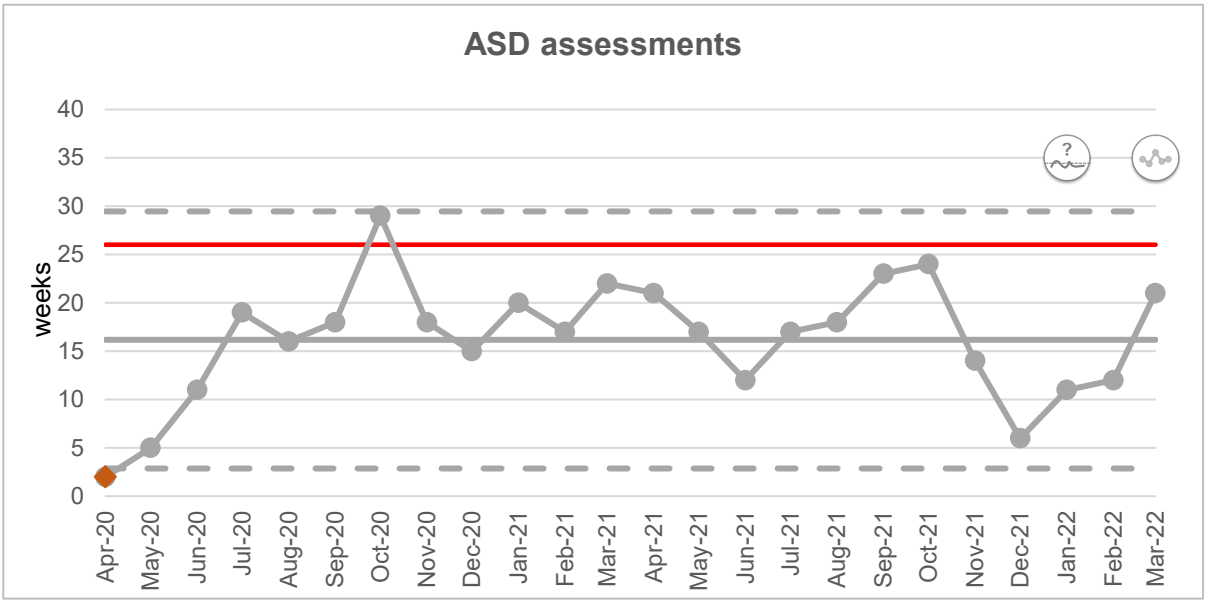
The average wait is currently 70 weeks and the longest wait is over 3½ years. The situation is likely to continue to worsen until there is an increase to investment in the service, as demand for the service far outstrips commissioned capacity.

11b. Waiting list for adult autistic spectrum disorder assessment – number waiting



There are currently 1,657 people waiting for adult ASD assessment, which is an increase of almost 100 since the last report and an increase of 73% over the 2-year period.

11c. Adult autistic spectrum disorder assessments per month



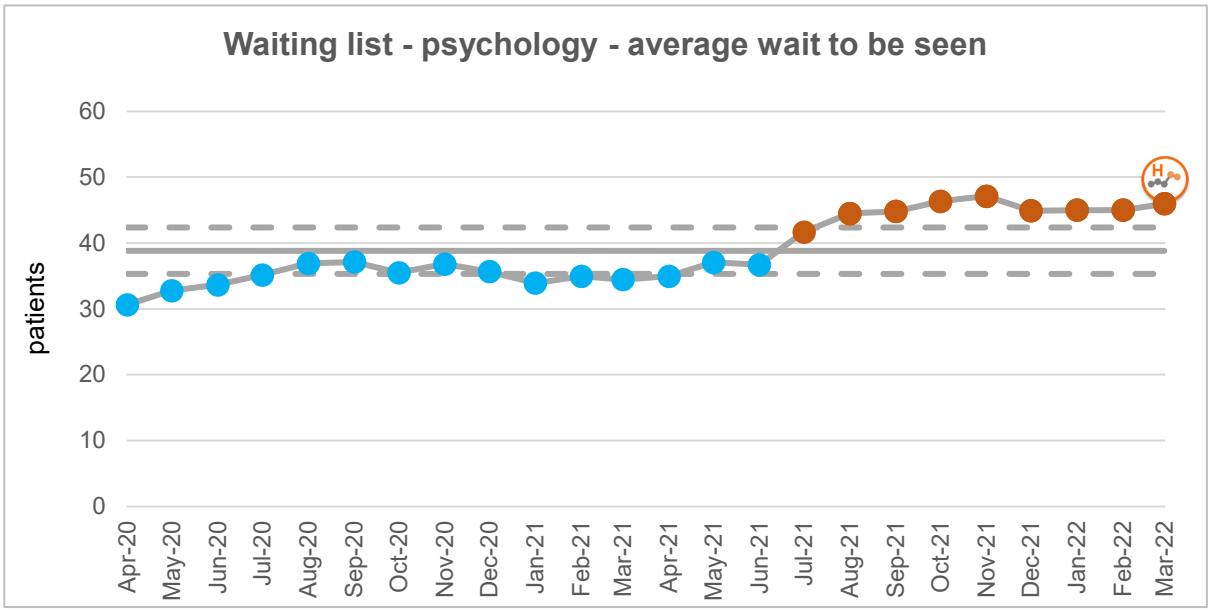
The team currently consists of 5 part-time assessors. There has been a significant reduction in capacity to undertake assessments in the last 3 months owing to the absence of 2 of the team as a result of unforeseen life events. An Assistant Psychologist commenced in post recently and is supporting throughout f assessment. One of the team has recently returned on a slow phased return to work. Once they are back fully in role, this will again increase the number of assessments undertaken.

We continue to look for solutions to this challenge and are again reviewing the literature in relation to assessment tools and service delivery. We have also recently recruited a senior clinician, who will support this team where possible. Once trained in relevant assessment tools this clinician will be able to undertake a small number of assessments.

The team continues to receive around 66 new referrals per month but is commissioned to undertake 26 assessments per month. It is hoped the team will soon be back to delivering this number.

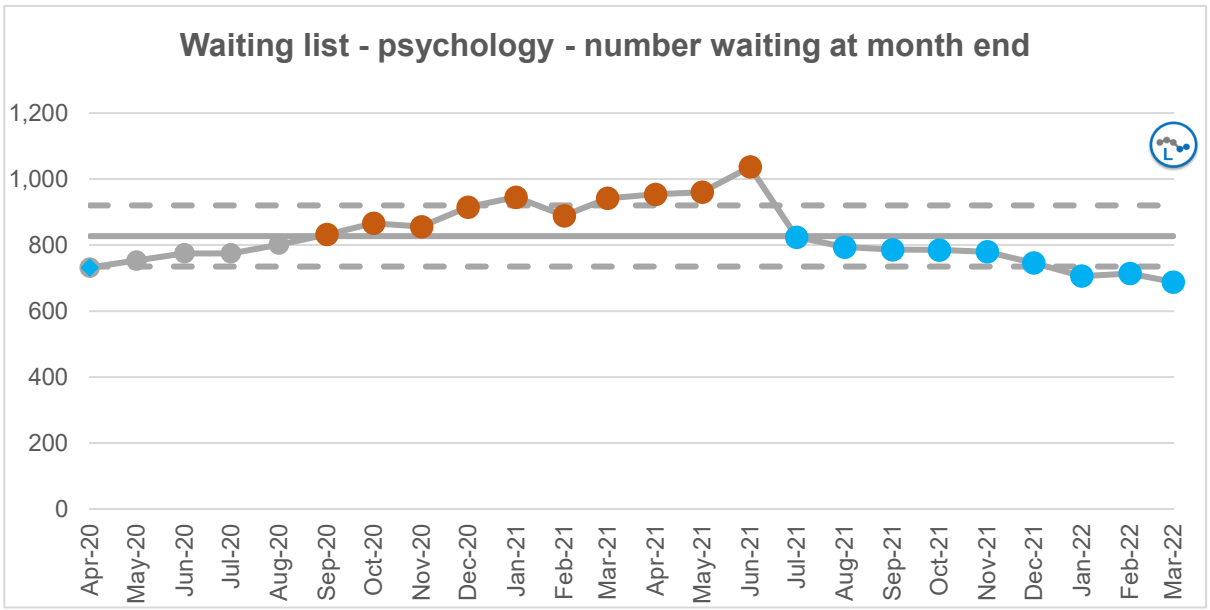
COVID-19 recovery plans have continued. Locations, timings, and protocols for safe COVID-19 face to face appointments are in place. All team members continue to alternate between offering some online appointments and some face-to-face.

12a. Waiting list for psychology – average wait



The average wait to be seen has remained significantly high in recent months at around 46 weeks. Many patients are still waiting owing to the pandemic and a personal preference to be seen face to face as opposed to by video call. Referrals remain steady, averaging 89 per month.

12b. Waiting list for psychology – number waiting



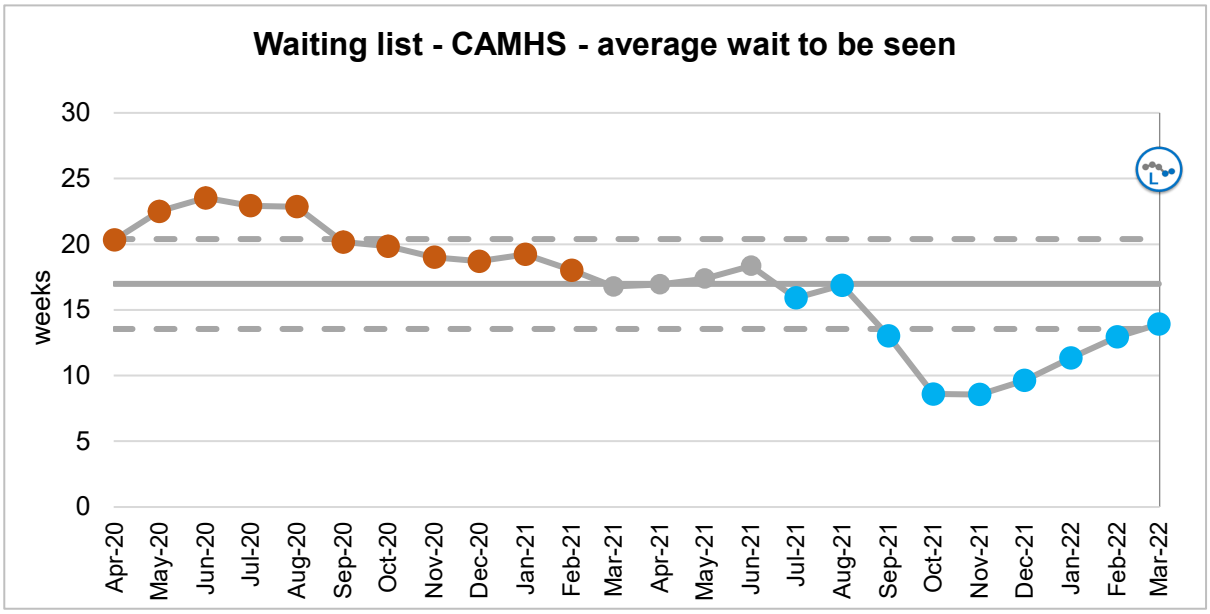
As we have seen over the last few months, the number of people waiting continues to gradually reduce. Investment has been made into the service equating to an increase by 18% of funded whole time equivalent posts since December 2020. Recruitment to a number of vacant and part-time posts across adult services is progressing and vacancies have reduced by 3% since the last report. However, around 19% of posts are currently vacant across all of psychological services, with the biggest gaps seen in the community mental health teams (CMHTs).

As reported last month, there is a national shortage of qualified psychologists, with all Trusts struggling to recruit. We remain in line with our regional colleagues with this figure.

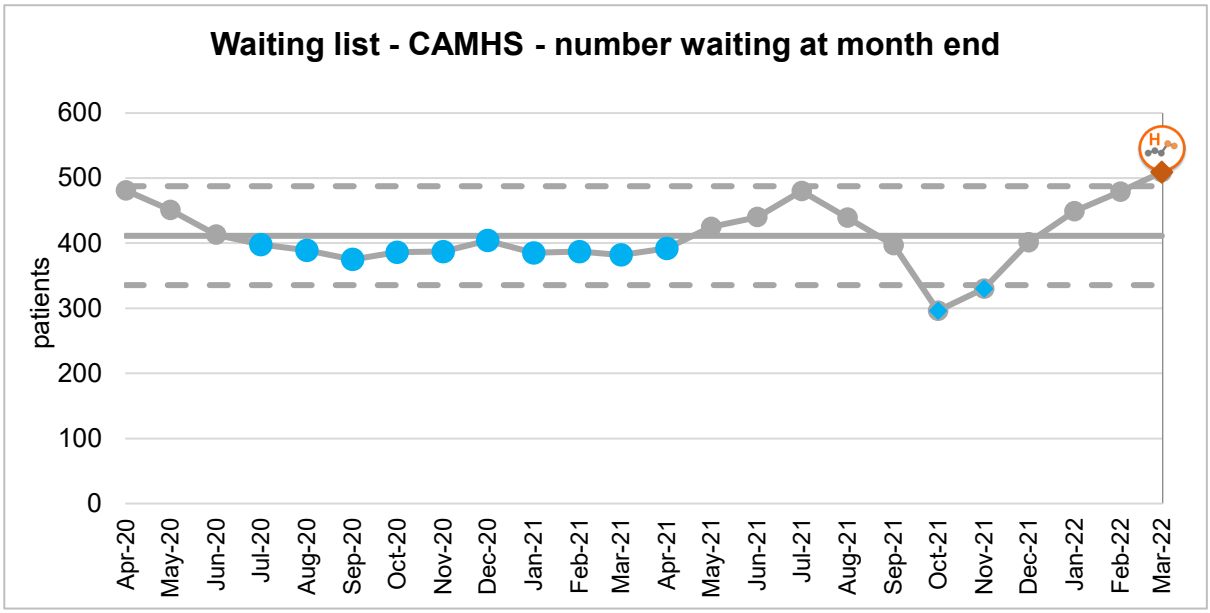
The pilot study working with a company to increase our exposure in the marketplace and to engage better with potential candidates through videos and sharing experiences starts at the end of the month with an aim of filling our vacancies.

We continue to review the waiting lists in line with trauma sensitive working in considering how we manage people on a waiting list and barriers of movement between services. This work continues to develop as the Living Well transformation takes place. Further we are reviewing the structure of psychological service to create a division to try and better utilise the skills we have in supporting people across the Derbyshire landscape. This will include how we manage flow and waiting lists.

13a. Waiting list for Child and Adolescent Mental Health Services (CAMHS) – average wait



13b. Waiting list for Child and Adolescent Mental Health Services – number waiting

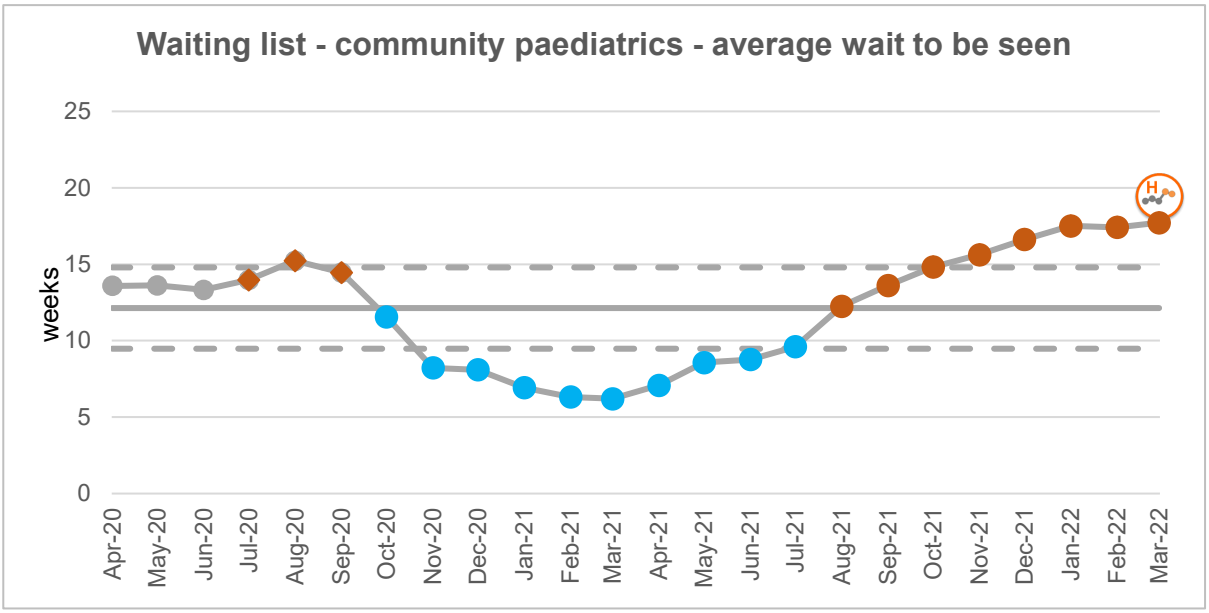


The waiting list initiative in September and October 2021 resulted in a significant reduction in waiting times, however since then there has been a month-on-month increase, with the current average wait being 14 weeks. The number of children waiting has been gradually increasing and is

significantly high at 509 children, the highest it has been for 2 years. Owing to the service focusing solely on initial assessments for a concentrated period of time, much of the routine caseload work was put on hold. This meant that although a significant amount of the waiting list was addressed (roughly 50% of the total), after the initiative was completed the service faced a large backlog of work. In addition, the nursing capacity of this small team of 6 nurses was reduced by 50% owing to long term sickness and a vacant post. The ASIST currently have a caseload of 300, in addition to the current number waiting for initial assessment of over 500. Capacity and waiting lists present a major issue nationally, with some areas having average waits of over a year.

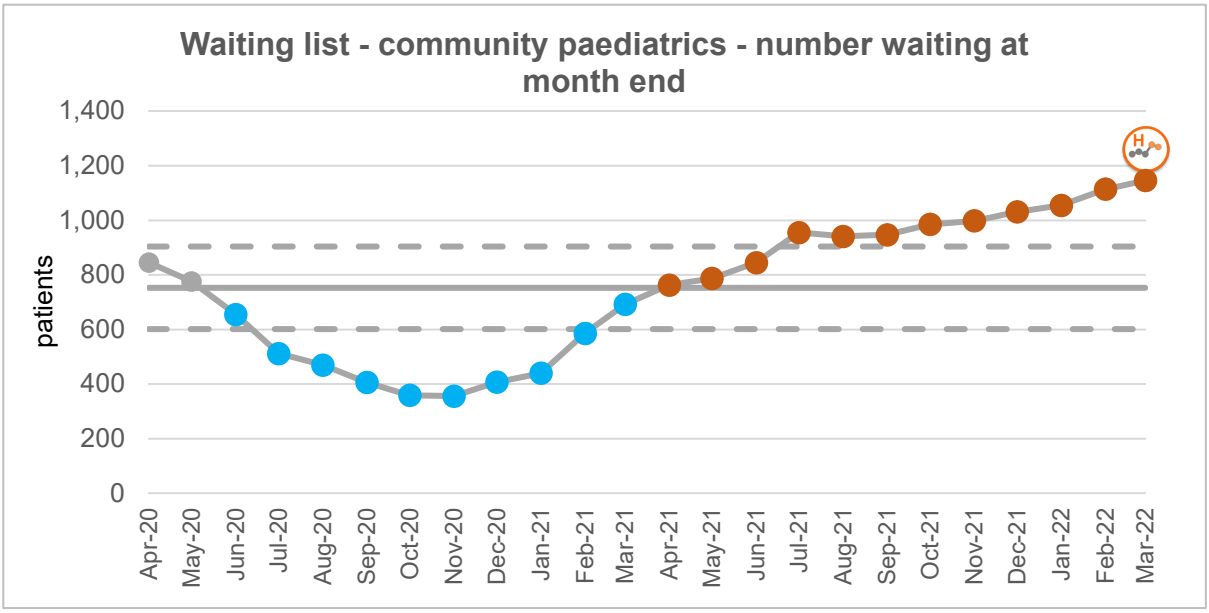
The current trend and volume of referrals received is not sustainable, therefore a review of the operating model of the service is in progress. Initial plans discussed within CAMHS senior leadership have proposed removing the function of case management from the service, to enable ASIST clinicians to focus solely on assessments. This would give the practitioners capacity to assess in excess of 1800 people a year, which would be in line with demand. Those young people requiring follow up (including the 300 already on caseload), would be managed via a hub model with ability to flow through more effectively, with specialisms inputting a service, including Psychiatrist. Plans need greater thinking, but this is the proposal we are working towards.

14a. Waiting list for community paediatrics – average wait



We continue to see a steady rise in waiting times for referral to treatment in community paediatrics. The wait time is now in excess of 44 weeks and currently sits on the risk register as a high risk. We are carrying a vacancy which has been advertised a total of 5 times without any applicants this post has been redesigned to a more generic post which will hopefully make this more appealing. Sickness and COVID-19 absences are still having an impact on clinics as the Paediatricians have continued to work face to face throughout the pandemic. To Mitigate we have a locum in post 4 days per week until July 2022 and a further 5-day week Locum in post for 3 months starting in April. We recognise that flow is an issue for the service and are working to review the Core offer and what we could do differently to help manage the increasing waiting list.

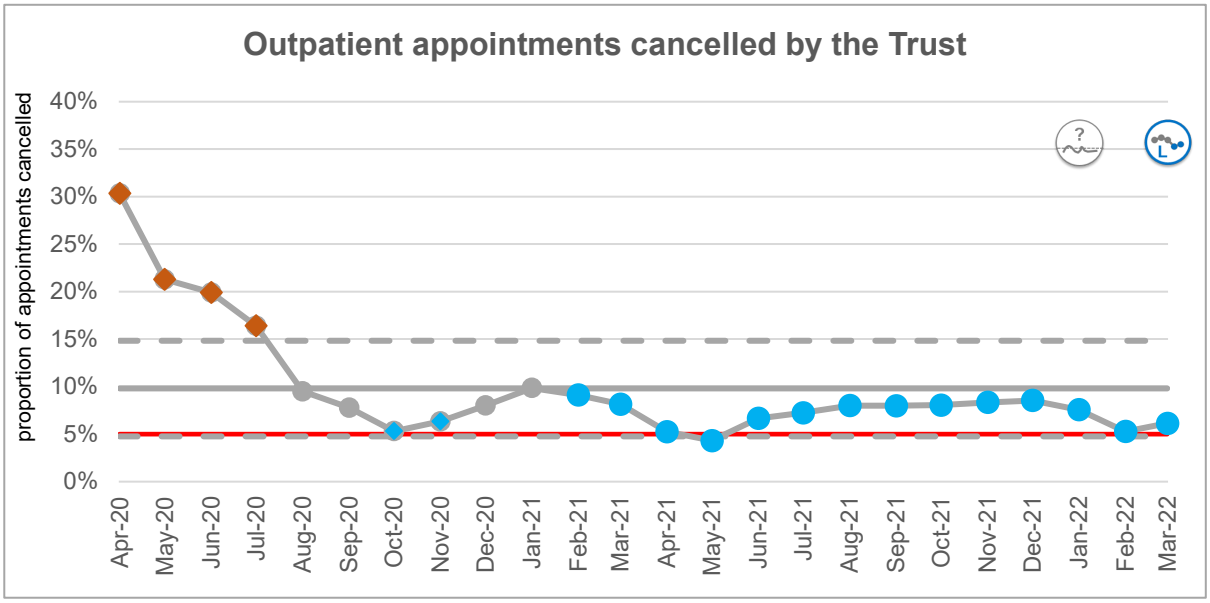
14b. Waiting list for community paediatrics – number waiting



The neuro-developmental pathway development is ongoing, and we have recently advertised the Speciality Doctor post into a full-time substantive post. The business case also includes a second fixed term Speciality Doctor to focus on the autistic spectrum disorder pathway. Securing these posts will have a significant impact on the waiting list. This is a really positive development for the service line.

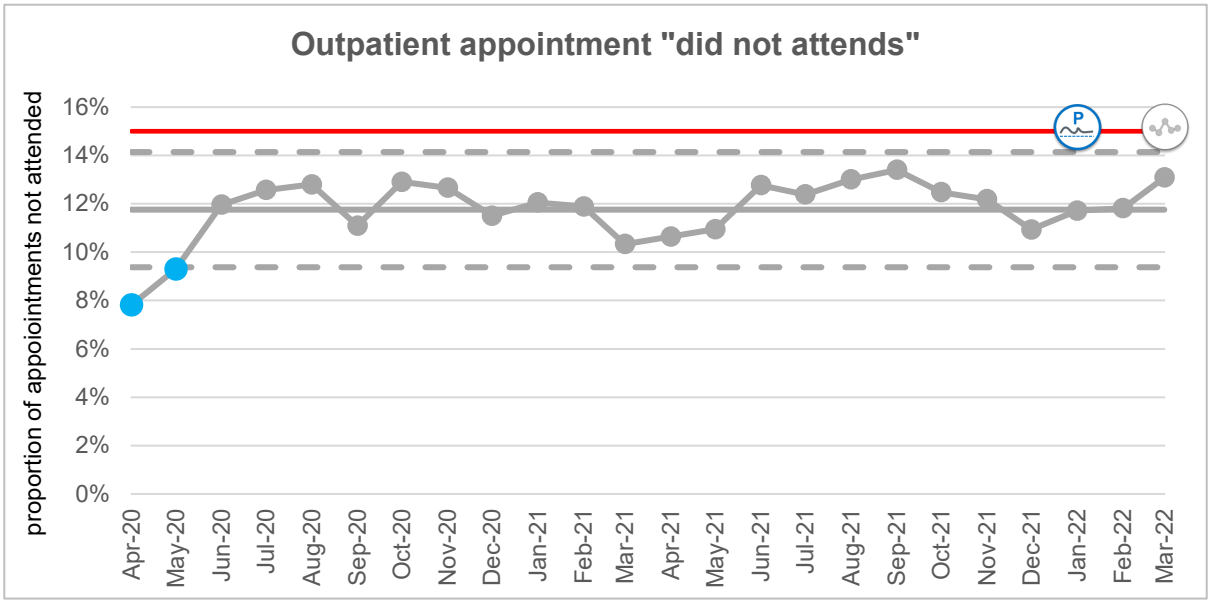
We have plans to further review the whole medical structure: what is working well, where the gaps are and where we need more support. Review of the referral pathways and website is ongoing. We hope to improve the experience for children, families, carers, and professionals who access our services.

15. Outpatient appointments cancelled by the Trust



The level of cancellations has been significantly low for the last 14 months and close to target for the last 2 months.

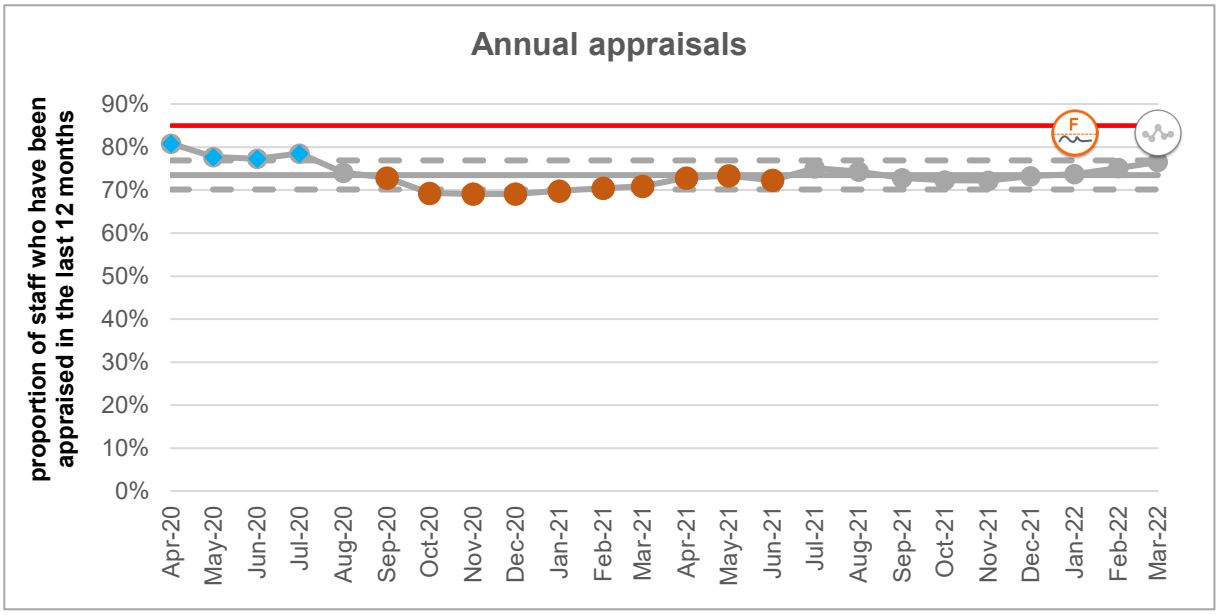
16. Outpatient appointment “did not attends”



The level of defaulted appointments has remained within common cause variation for the last 22 months and in the current process the trust target of 15% or lower is likely to be consistently achieved.

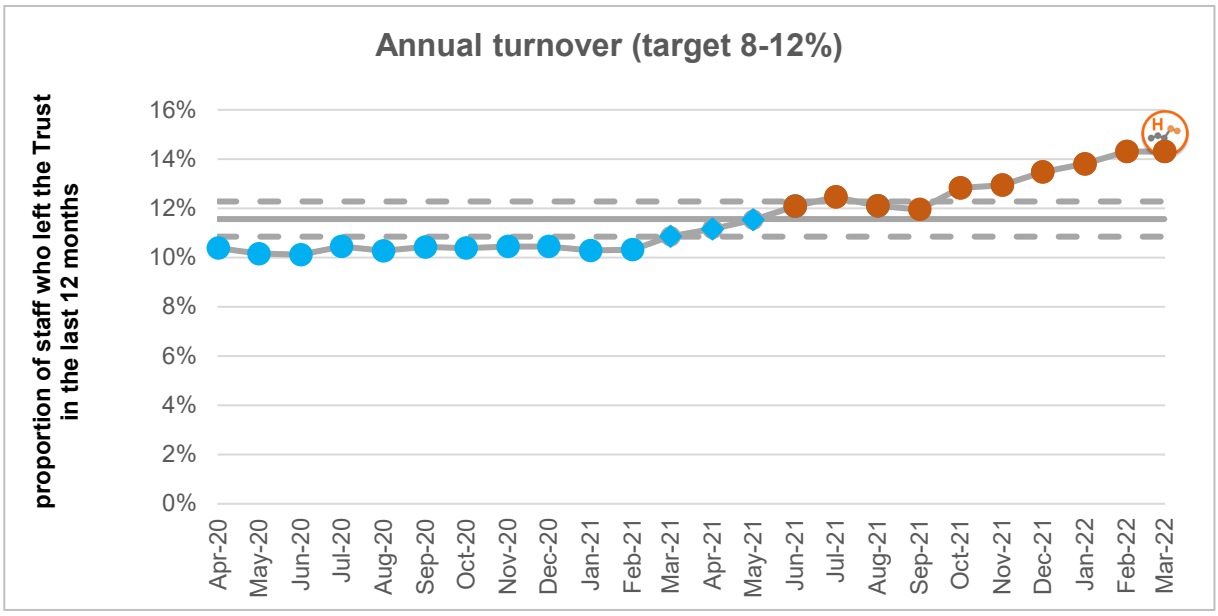
People

17. Annual appraisals



We recognise that the last 12 months have continued to present challenges for colleagues in responding to the pandemic whilst returning to a level of business as usual. This has had some impact on appraisal rates, particularly in corporate teams who have been working and delivering against very different objectives. As we finish the year with Operational Services currently at 82% and Corporate Services at 53%, we recognise that from April 2022 we need to reaffirm our expectation that all colleagues will have a meaningful appraisal conversation over the next 12 months. We have also been able to move in the last two months into a strong position with our people divisional leads who are now aligned to every division and will be able to recommence their roles in working with teams to support and drive appraisal compliance where we are moving against trajectory throughout the year.

18. Annual turnover



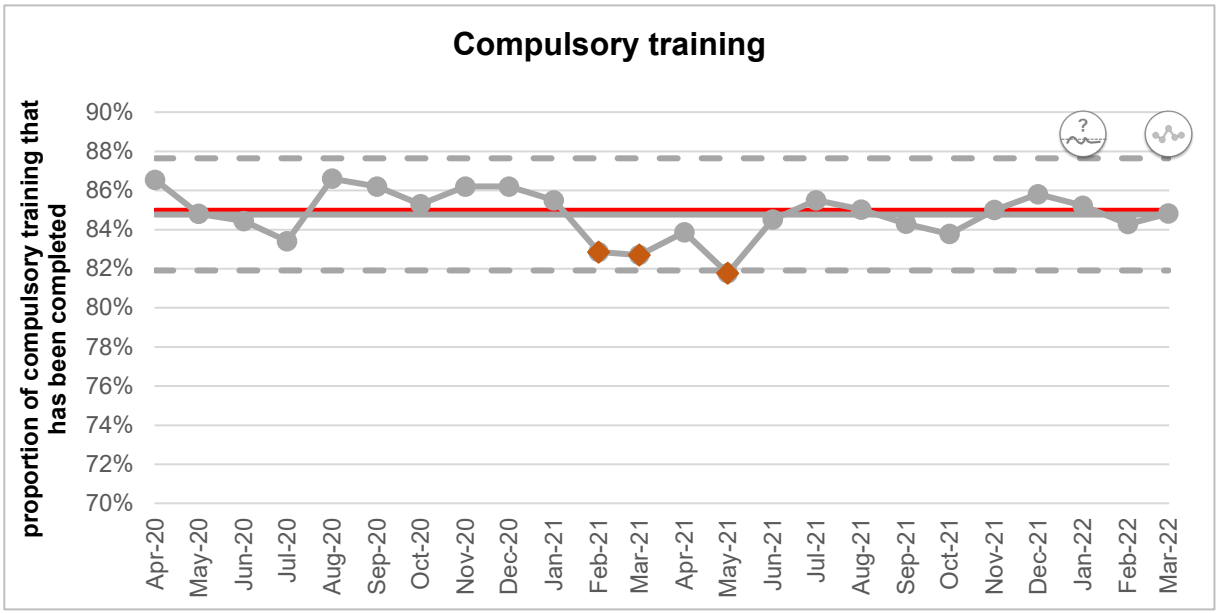
Turnover remains high and above the Trust target range of 8-12% for the last six months. We have commissioned two areas of focused work to support us to understand more about why colleagues are leaving the Trust. Firstly, a STAY survey which will be targeted at key areas where we know we

are losing more colleagues – these include colleagues reaching the 2-year period employment and teams and professions with higher levels of turnover. Secondly, we have recognised that the current exit interview process is not working as we have low numbers of leavers completing an exit interview. We are now developing our own system that will allow us to capture a much higher percentage of leavers in order for this intelligence to be used to develop the areas and actions needed to support retention.

Benchmarking

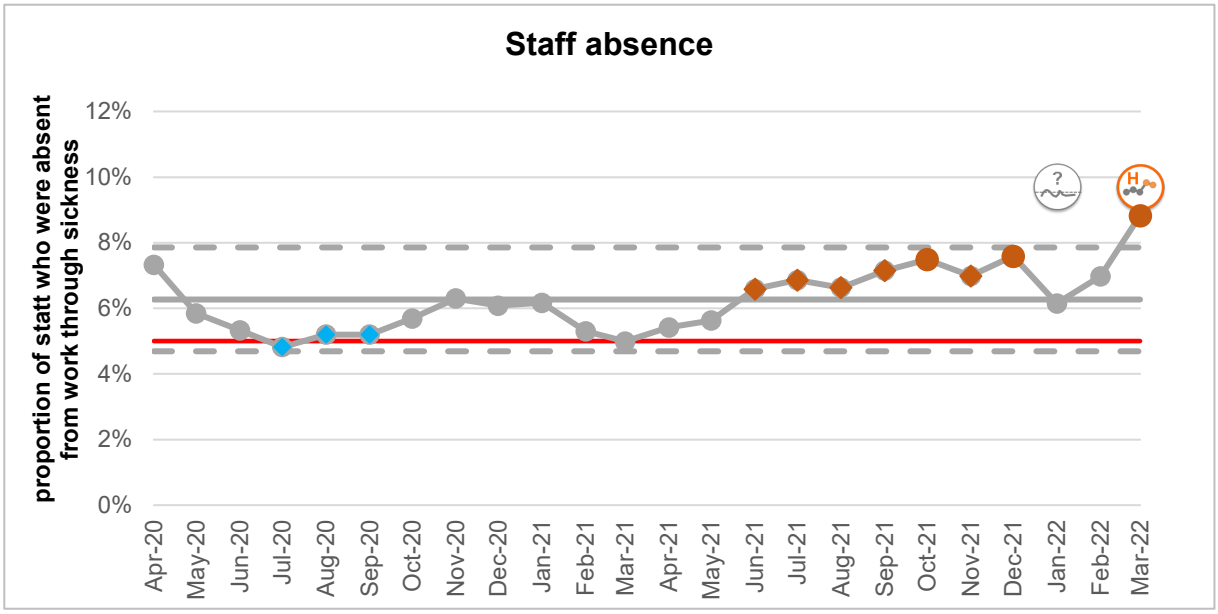
In the latest national NHS staff turnover benchmarking data, the Trust was ranked 10th highest mental health trust for stability of the workforce (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/december-2021).

19. Compulsory training



A recovery plan continues to improve training compliance. The full training requirement – compulsory training and role specific training – is over 75,000 attendances by our total workforce on 78 courses, with just over 18,000 individual attendances to be completed. Operational Services are currently above target at 87% compliant with compulsory training, and Corporate Services slightly lower at 76%. To support compliance, we have increased the availability of role specific clinical mandatory training. Operational teams are working closely with the training delivery team to look at ways to work differently in the delivery model including block training. The People and Inclusion team have also commissioned a review of all compulsory training and role competence requirements for all clinical and non clinical roles.

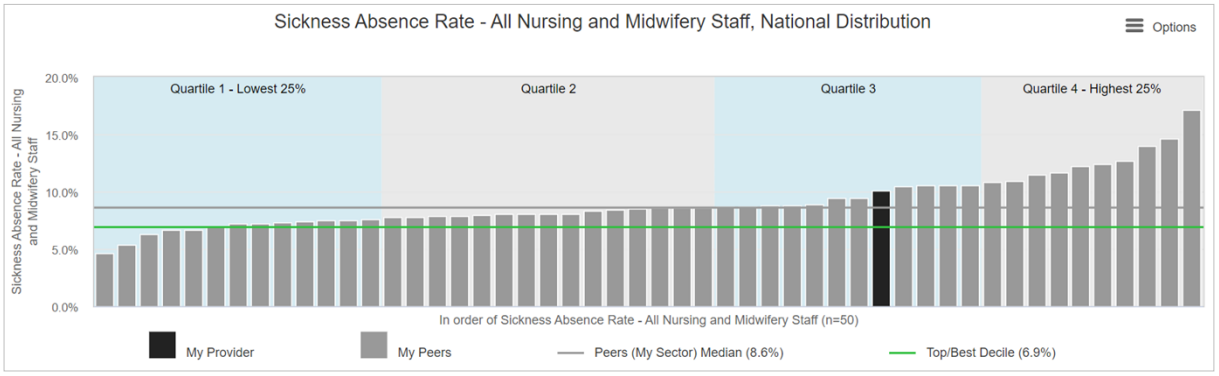
20. Staff absence

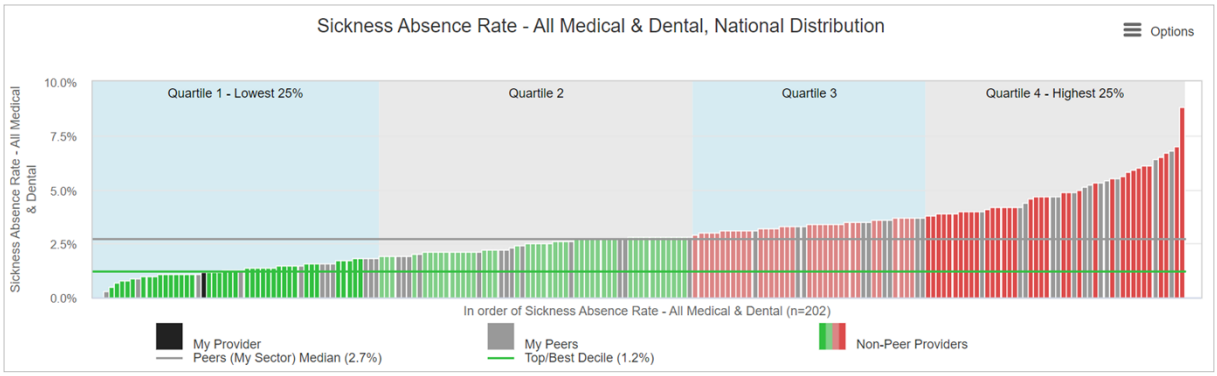


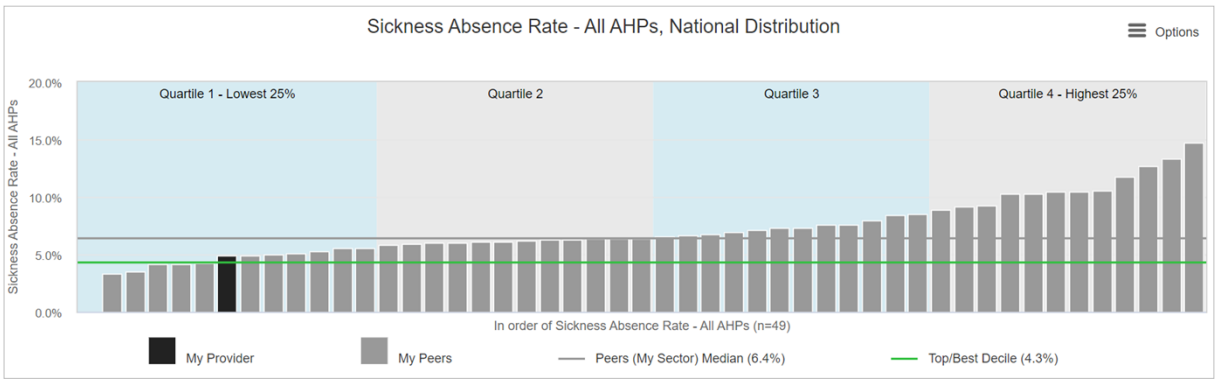
Corporate Services absence rate is 6.3%, and Operational Services is 9.4%. Sickness absence increased significantly in March with COVID-19 absence being the top reason for absence. Improvements are being made to the support provided by our external absence management provider GoodShape, to ensure we are maximising the opportunities this provides to support managers and colleagues over a period of absence. The return-to-work process is being reviewed to ensure this is a health and wellbeing focused conversation that is supportive and recorded as part of the employees return to work. The absence task and finish group are initially focusing on ensuring we get all the basics right and connect the support available for managers and colleagues over an absence period.

Benchmarking

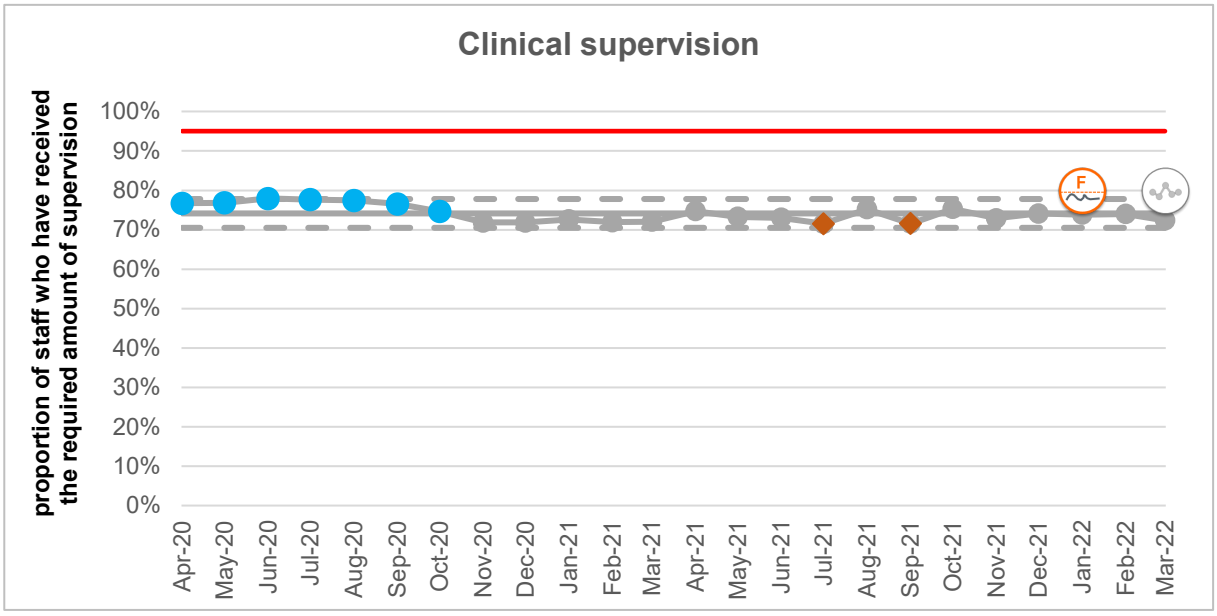
In the latest data (January 2022) our absence rate was above average for the nursing and midwifery staff group but was low compared with the peer group for the medical and dental and allied health professionals staff groups (https://model.nhs.uk/).



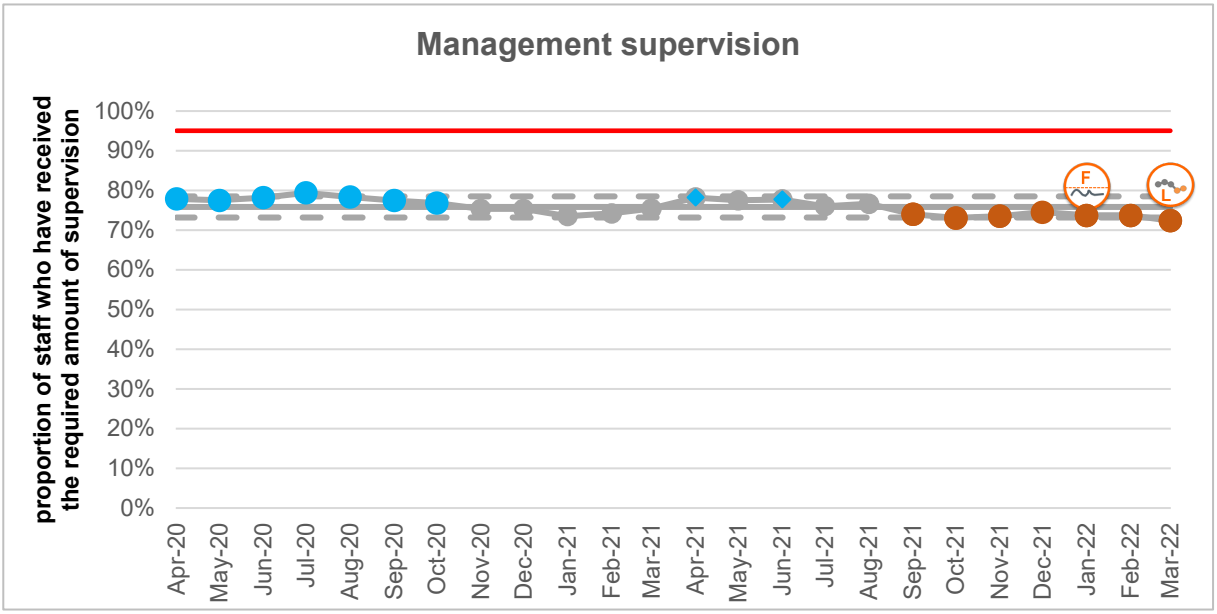




21. Clinical supervision

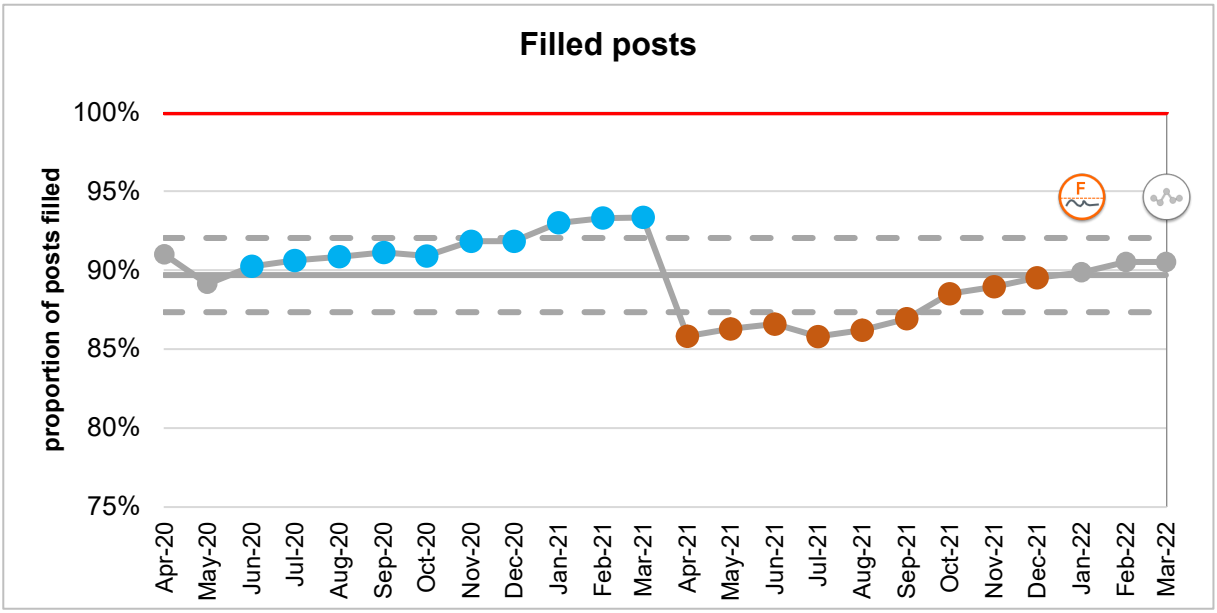


22. Management supervision



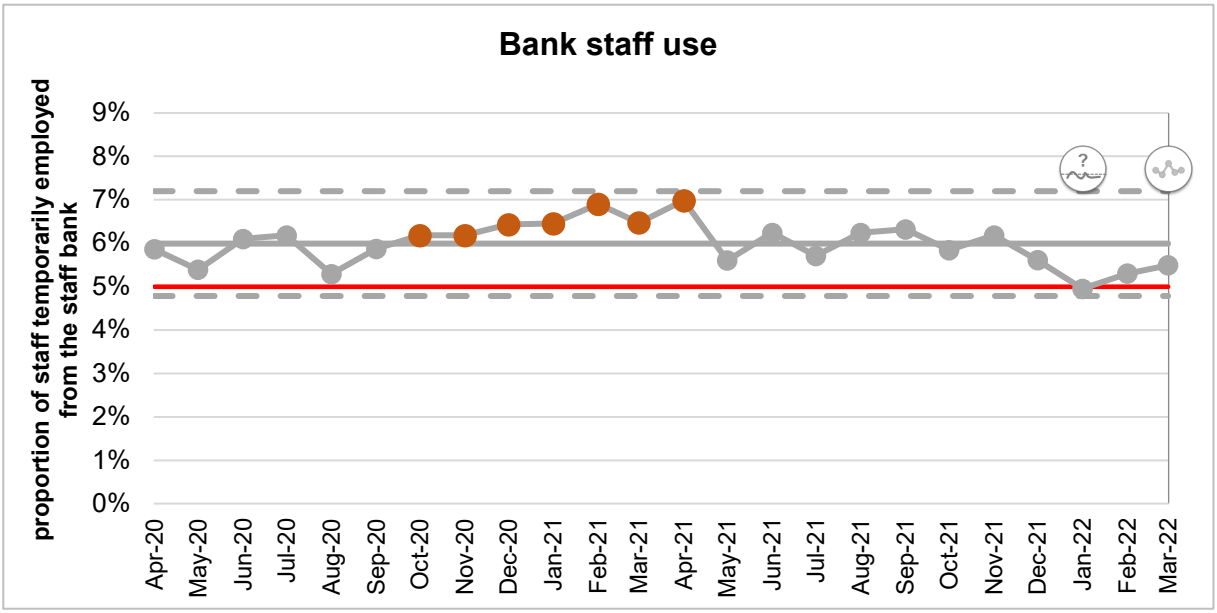
The levels of compliance with the clinical and management supervision targets have remained low since the start of the pandemic. As seen with compulsory training and appraisals, Operational Services are performing at a considerably higher level than Corporate Services for both types of supervision (management: 75% versus 57% and clinical: 74% versus 26%).

23. Proportion of posts filled



Recruitment fill rates continue to improve with the time to recruit now at 55 days, which is below the national NHS benchmark of 60 days. There has been a steady improvement in our vacancy rate as we continue to make improvements to recruitment practices and approaches including fast track recruitment, creative campaigns and advertisements and the roll out of DocuSign to reduce delays and unnecessary paperwork.

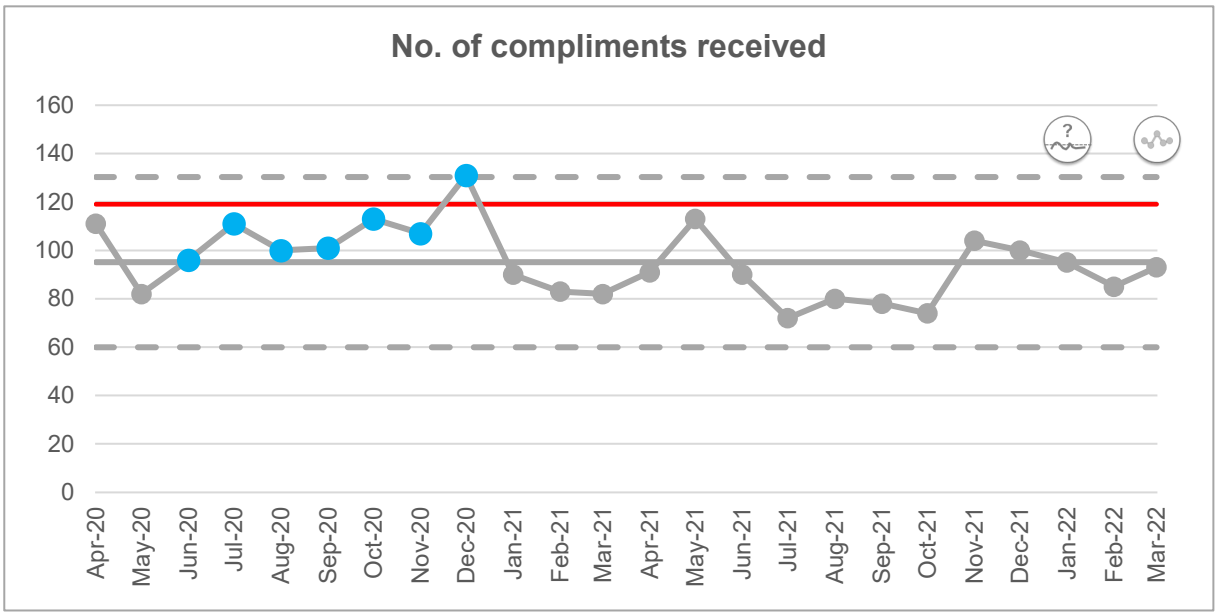
24. Bank staff



In the past 11 months bank staff usage has returned to common cause variation. The trend continues to improve where recruitment is now filling vacancies normally supported by bank staff.

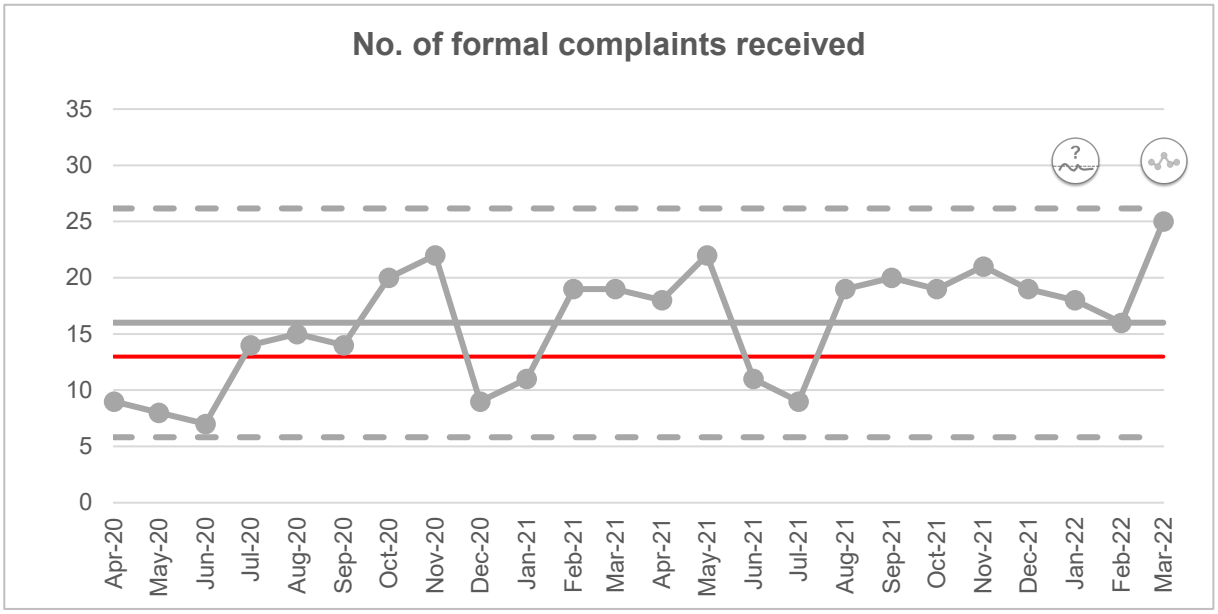
Quality

25. Compliments



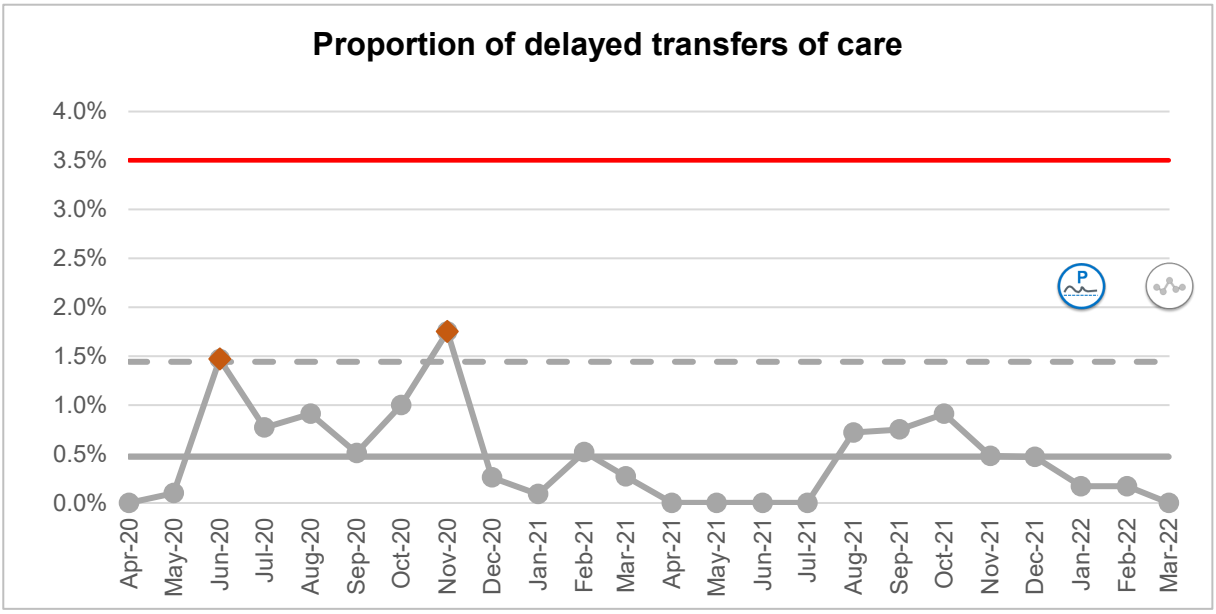
The number of compliments continues to remain below the expected level however, as face to face contact increases, so does the number of compliments received. This is due to compliments mostly being received verbally and then staff recording them. A Head of Nursing has now been allocated to lead on Trust-wide projects and their first project is the roll out of the electronic patient survey which will provide a further method of receiving compliments, complaints, and concerns. With an increase in accessibility, it is expected that a natural increase in compliments, complaints and concerns will occur.

26. Complaints



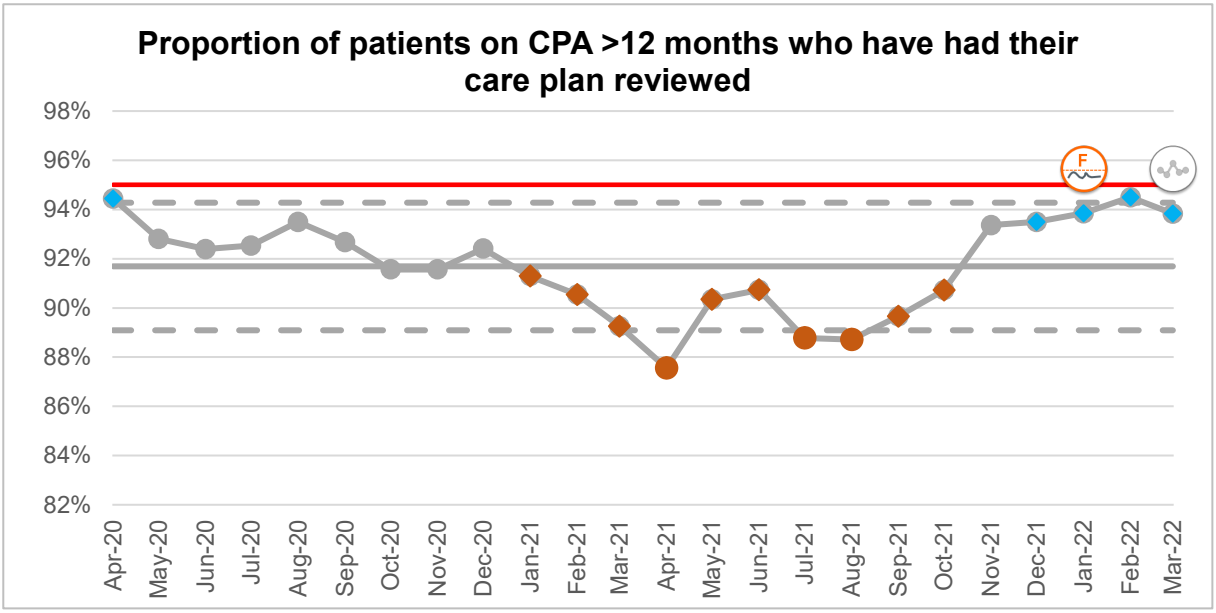
As face-to-face contact increases and services begin to stand back up, the number of complaints decreases. In reviewing data, a large number of complaints are in relation to reduced face to face contact and reduced access to services. As services continue to stand back up and the electronic patient survey is implemented the number of complaints is expected to continue to decrease.

27. Delayed transfers of care



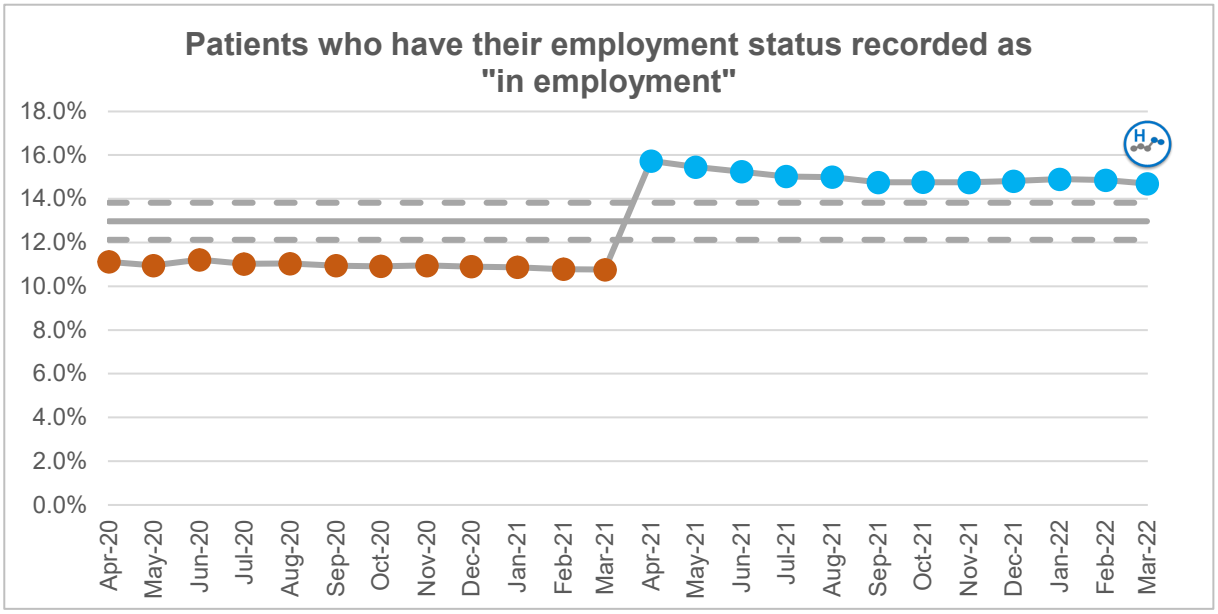
Since the multi-agency discharge events (MADE) were held, numbers of delayed transfers of care have reduced and now sit below the mean line. Work continues within the rapid review processes and clinical meetings.

28. Care plan reviews



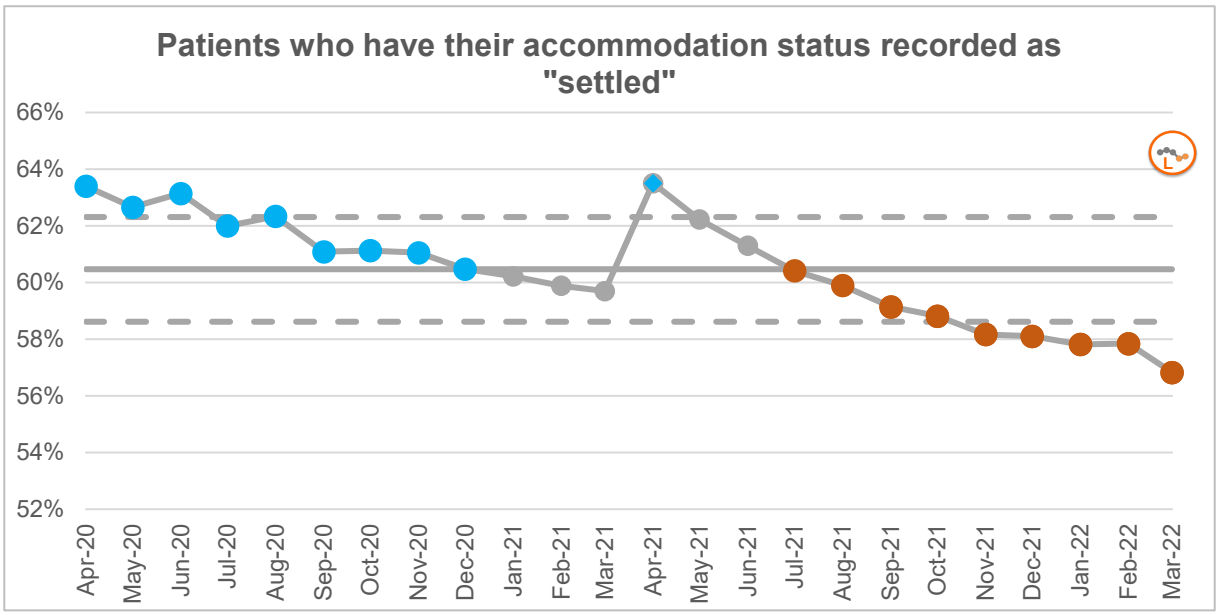
The proportion of patients whose care plans have been reviewed continues to be lower than usual. However, as can be seen there is a positive trajectory and improvements in the percentage of reviewed care plans. Work continues to improve this month by month and this is expected to continue as this is completed largely face to face. As we move over to SystmOne, processes are expected to improve further.

29. Patients in employment



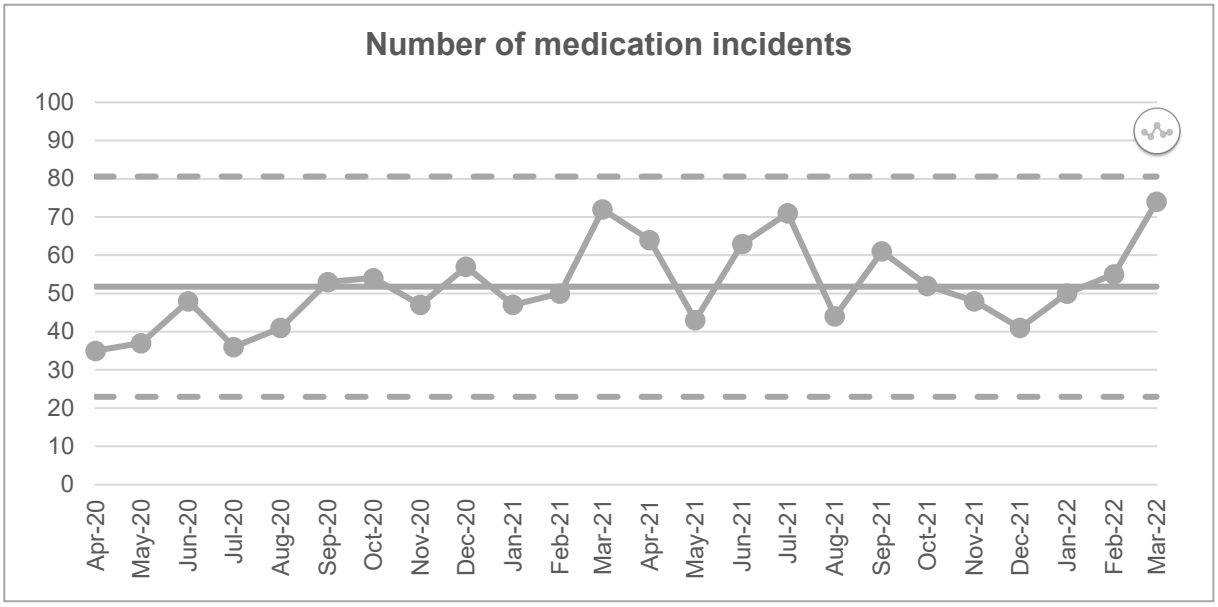
Around one third of patients have no employment status recorded. The Individual Placement Support (IPS) Service continues to have success in supporting people into employment even during the current pandemic and the service is currently expanding. The Trust has recently employed two experts by experience to focus on the implementation and management of Health Education England training in relation to peer support working and apprentices. As a result, those in employment or education is expected to improve in time. This aims to support people into employment, apprentice, or education.

30. Patients in settled accommodation



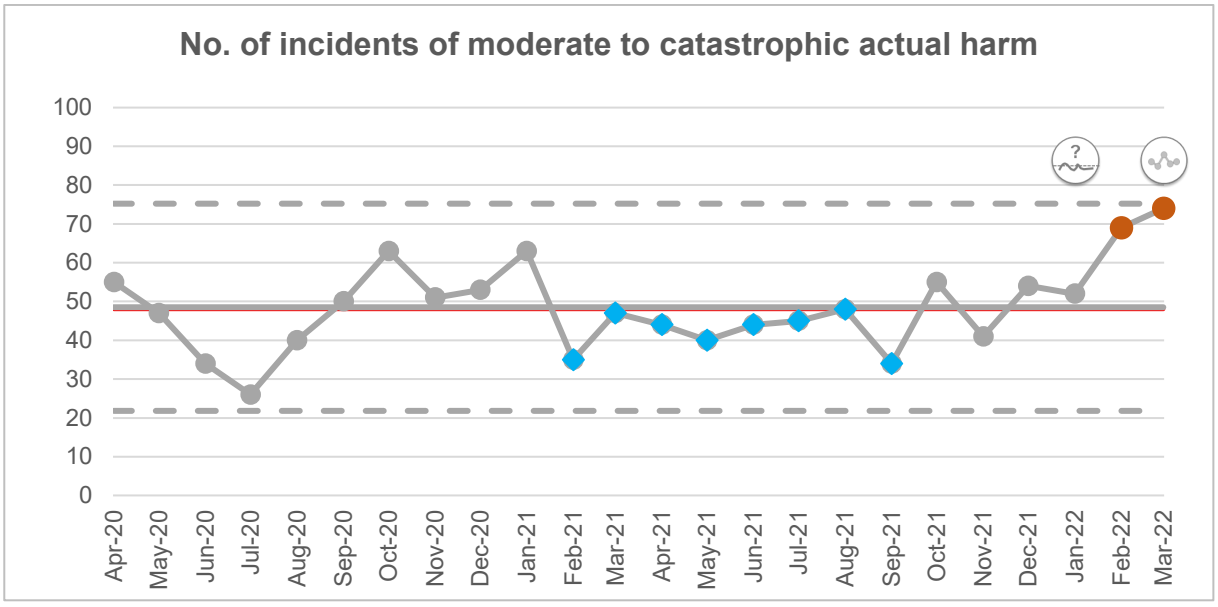
Around one third of patients have no accommodation status recorded.

31. Medication incidents



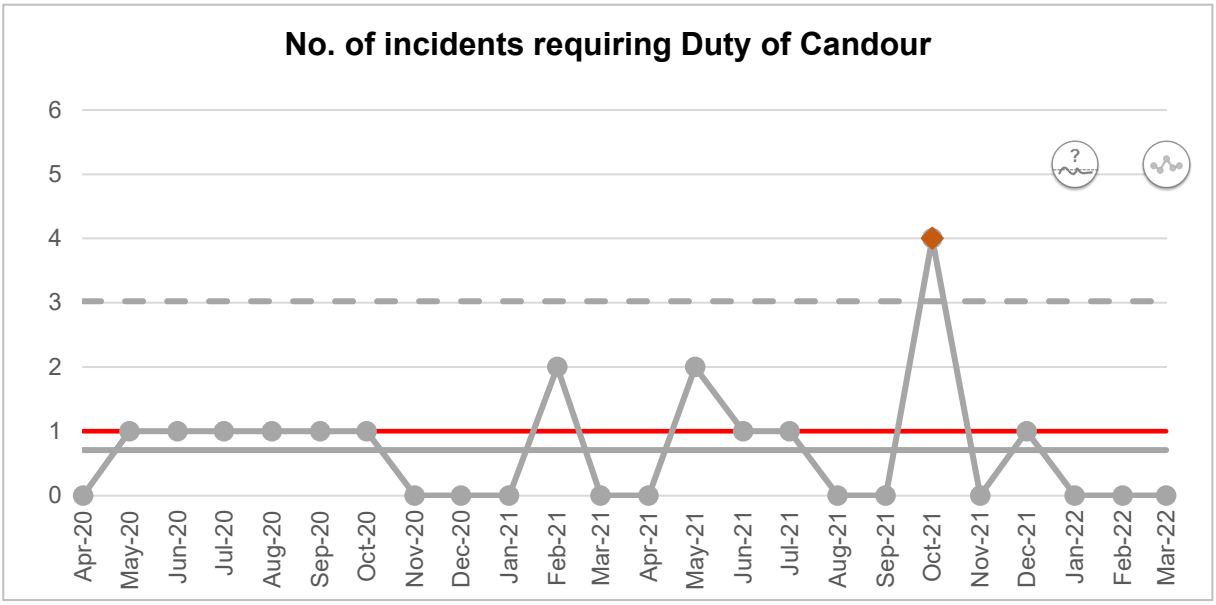
When looking into medication incidents, they take a variety of forms, from missed doses, wrong medication administration, missed fridge temperature recording, prescription error and non-location of medication. As a result, there are several factors that impact such as how busy the ward is, number of qualified staff and how the medication cabinet is organised. The medicines management operational subgroup are currently revising the medications error procedure, taking into account Trust values, and the Acute Inpatient Matrons and Head of Nursing are in the process of updating the relevant policies which will reduce the number of insignificant incidents. A report on incidents is also reviewed within the Monthly COAT meeting for each division.

32. Incidents of moderate to catastrophic actual harm



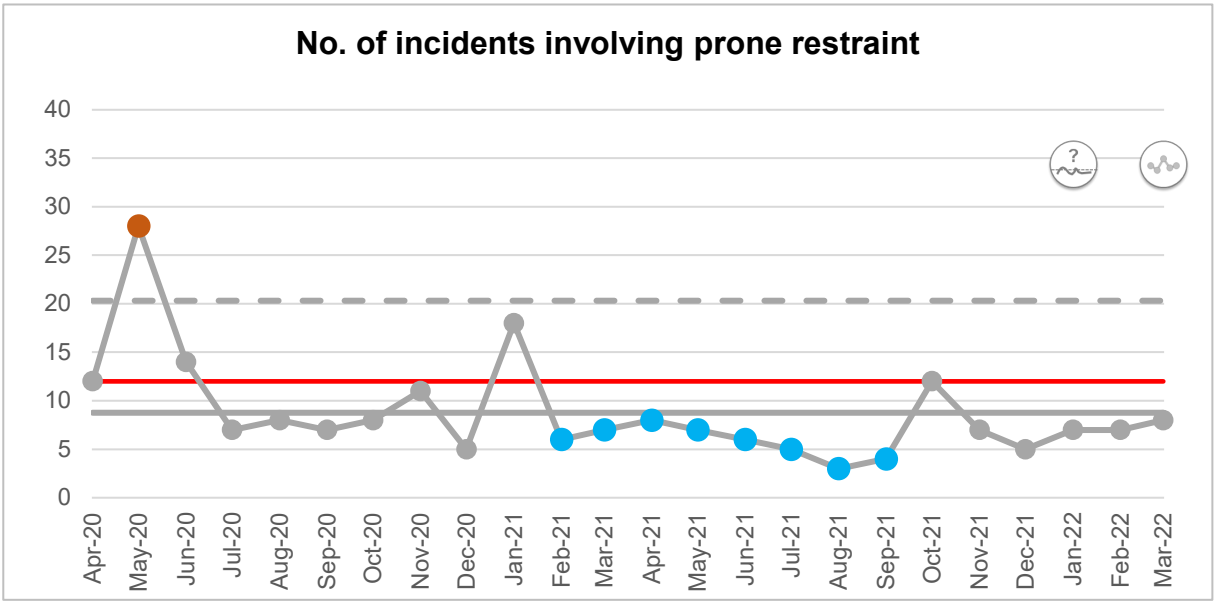
The number of reported incidents of moderate to catastrophic harm have remained within common cause variation throughout the reporting period. However, there has been a recent increase bringing the total above the mean line. This will continue to be monitored by the Heads of Nursing team on a quarterly basis and fed into the relevant COAT meetings.

33. Duty of Candour



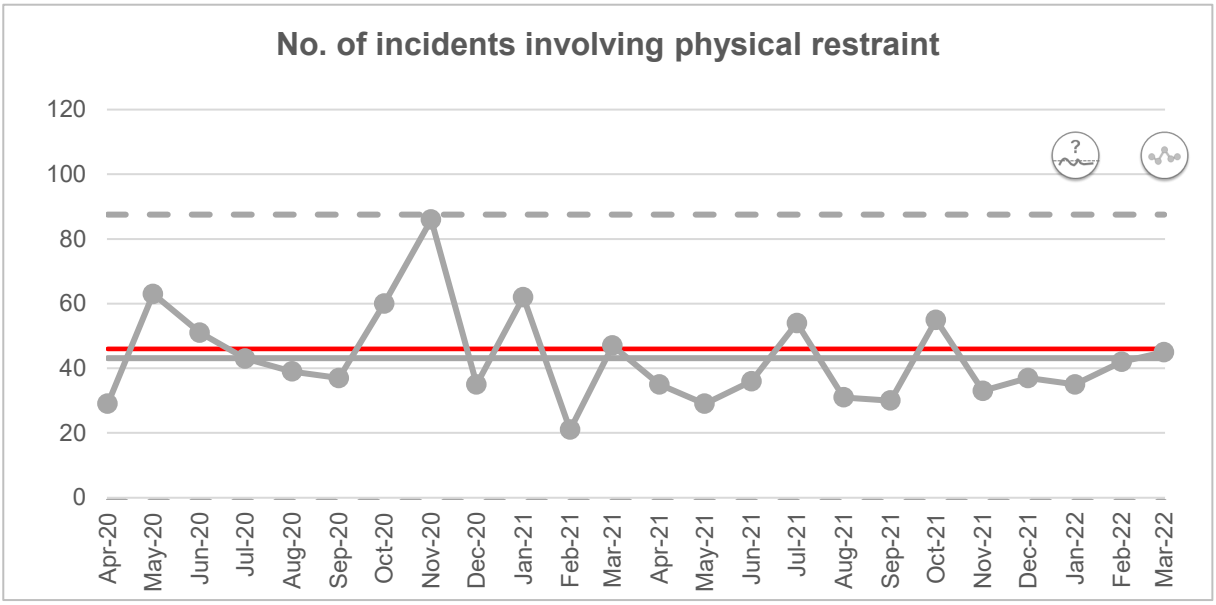
There have been zero instances of Duty of Candour in the last 3 months. This comes in line with reports being finished and signed off by the Executive Serious Incident Group, resulting in pockets of data increase. This pattern is expected as groups of reports are signed off and Duty of Candour raised. At times this can present high in certain months as they are all reported together rather than as soon as the report has been completed. Processes have been reviewed with the Head of Nursing team and the current DATIX reporting process has been updated to improve the real time reporting of Duty of Candour incidents.

34. Prone restraint



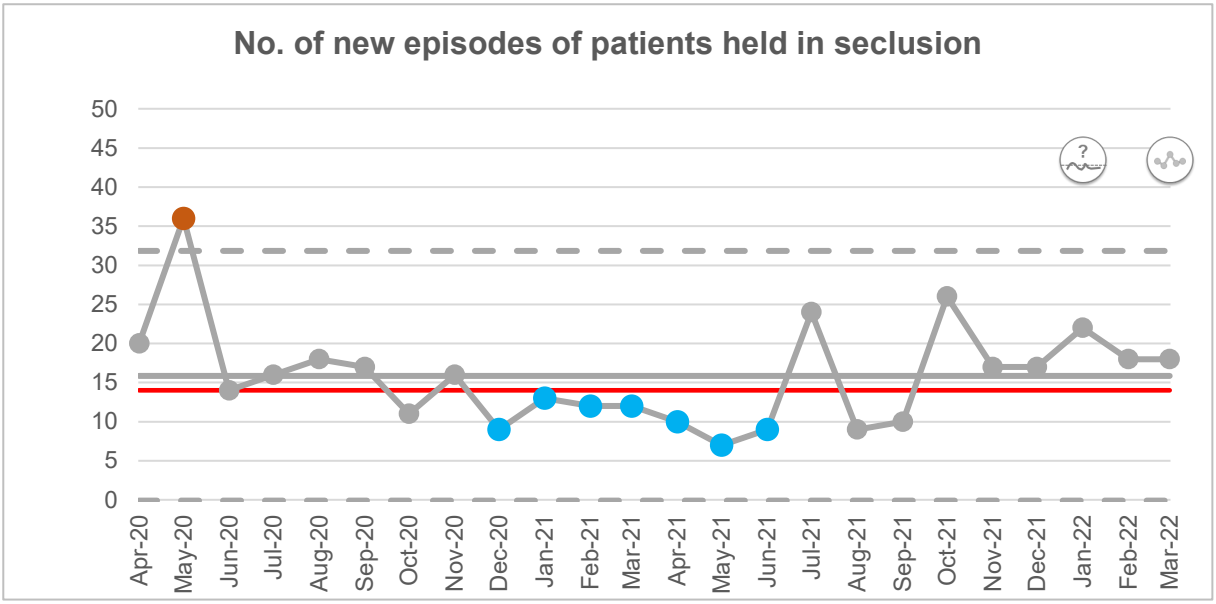
There are ongoing work streams to support the continuing need to reduce restrictive practice, including the introduction of body worn cameras, monitoring of restrictive practice within forums. Data analysis and review has shown that even where restraint and seclusion has increased, the use of prone restraint has continued to remain below the expected amount. Although some spikes in data have occurred in the last 6 months, we still remain low in numbers of prone restraint and much lower than the regional average per bed numbers.

35. Physical restraint



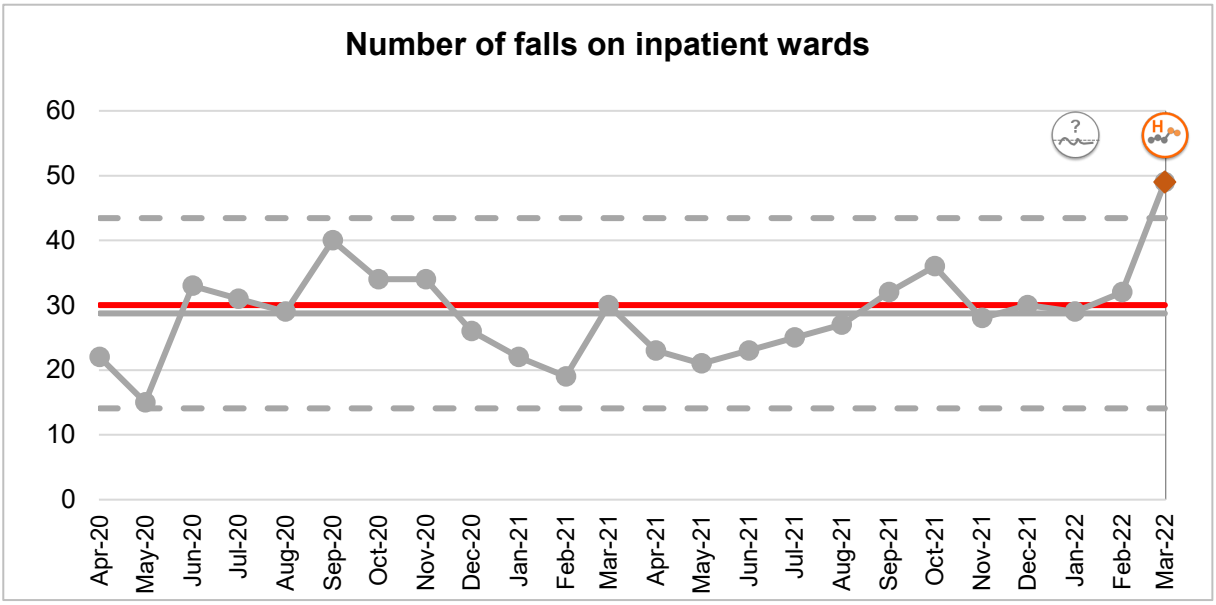
The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period. The changes in numbers are linked to the data above relating to prone restraint and below relating to seclusion. It is important to highlight that a common impacting factor to restrictive practice is increased use of bank staff, vacancies, increased sickness, staffing challenges and concerns relating to closed culture. A working group has been created to put together a working procedure for assessing closed cultures and what needs to be done where closed cultures are identified. This work aims to improve patient feedback along with reducing restrictive practice both in inpatient services and community services.

36. Seclusion



The use of seclusion has been above the common cause variation from October 2021. In further investigating this trend, there appears to be a link to a small number of patients who have been placed in seclusion on more than one occasion. This data will be monitored for patterns and further support needs for individual areas. Further auditing and investigation will be carried out by the new Head of Nursing for Acute and Assessment Services and will also include the links to Psychiatric Intensive Care Unit use.

37. Falls on inpatient wards

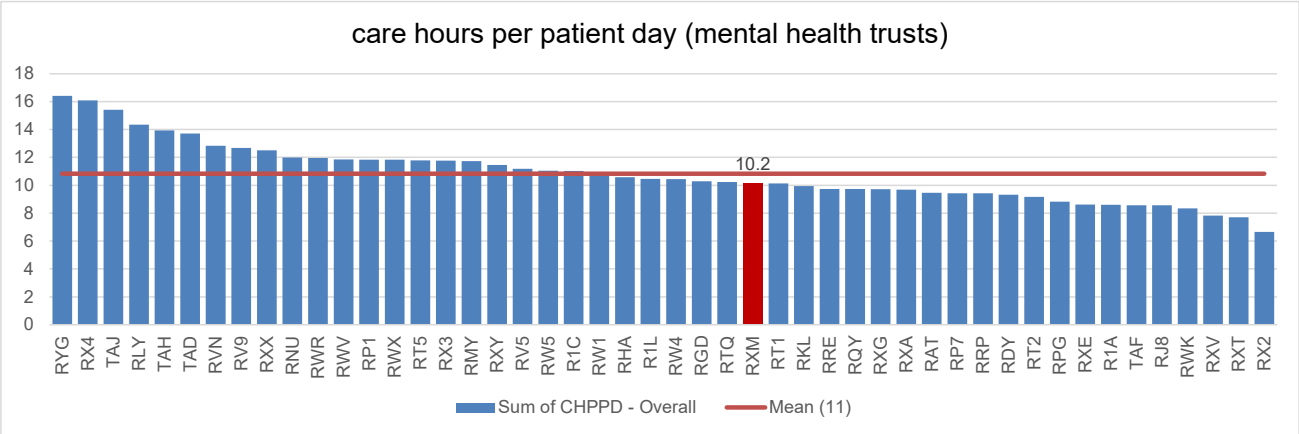


After an increase above the mean line in September incidents appear to have continued to increase with an abnormal spike in March 2022. A review of Falls has been commissioned along with the subsequent action plan and improvements. This will commence in April and is will be an ongoing project, working alongside teams to reduce incidents of Falls.

Care Hours Per Patient Day (CHPPD)

CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate a daily average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day. Work is underway to implement processes relating to staffing levels and how they are recorded in line with CHPPD and patient acuity. This will be in the form of the MHOST reporting system and SafeCare module within E-Roster.

The chart below shows how we compared in the latest published national data (December 21) when benchmarked against other mental health trusts. We were below average:

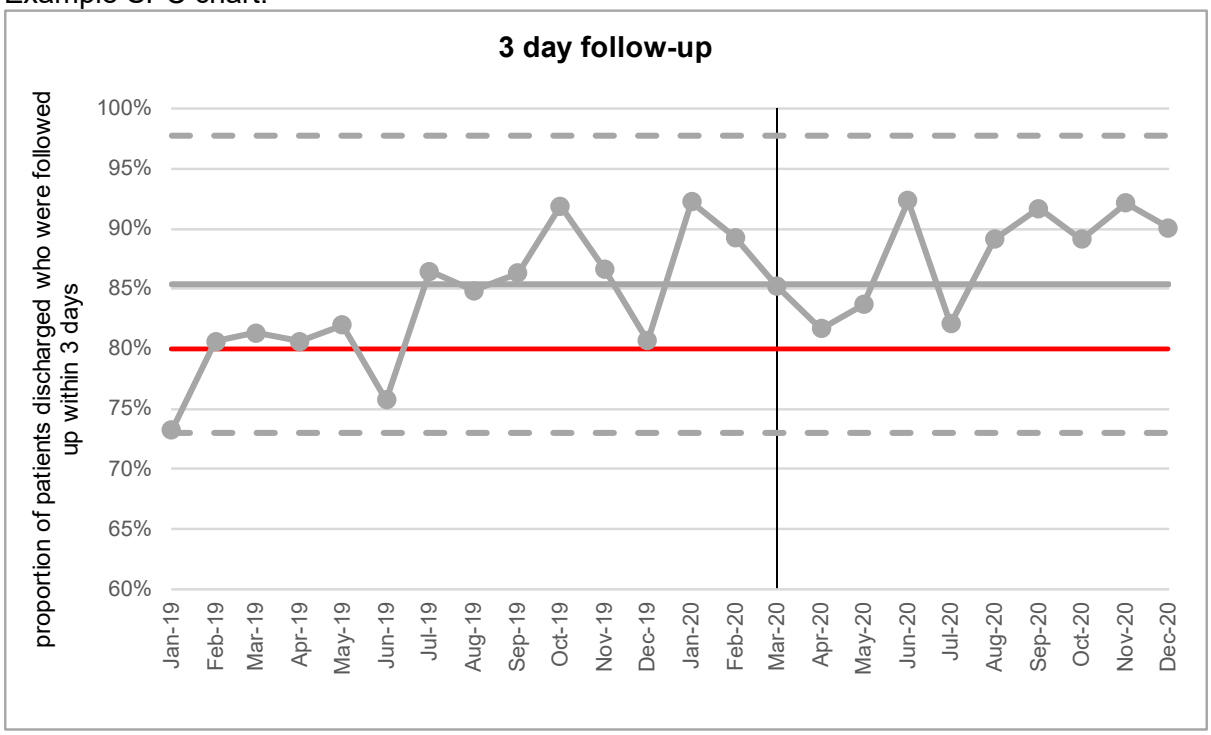


Data source: NHS England » Care hours per patient day (CHPPD) data

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



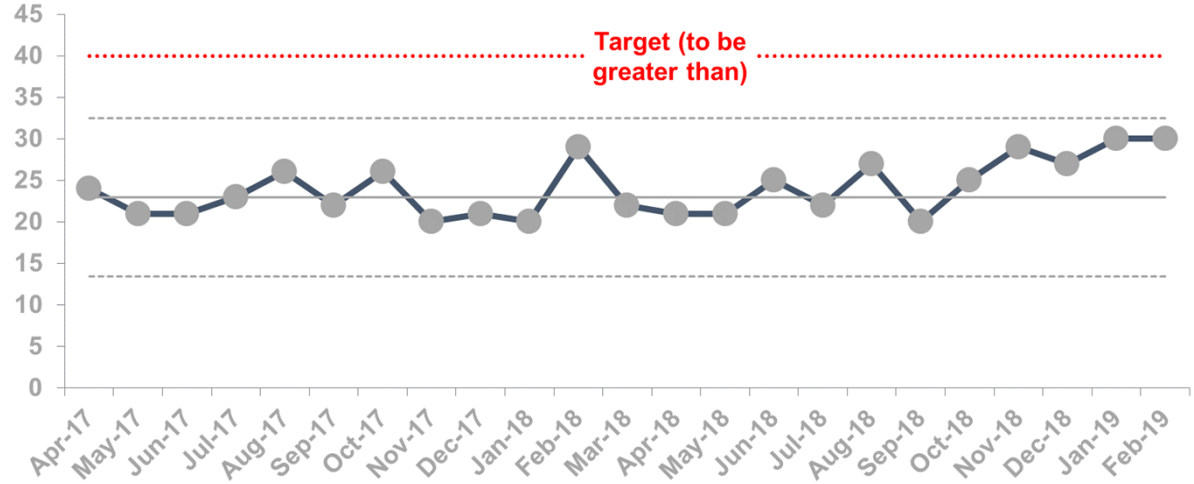
- The red line is the target.
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example.
- The solid grey line is the average (mean) of all the grey dots.
- The grey dotted lines are called process limits, or control limits.

Very simply, any grey dots sitting between the upper and lower grey dotted lines is normal performance for the process and is known as “common cause variation”.

The closer the two grey dotted lines are together, the less variation there is and therefore the more tightly controlled is the process.

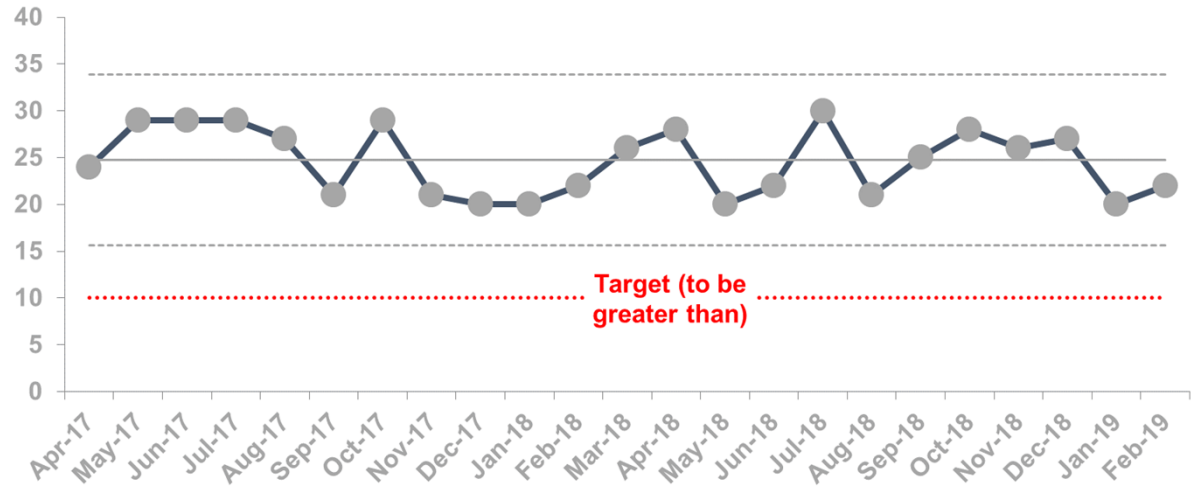
Things to look out for:

1. A process that is not working



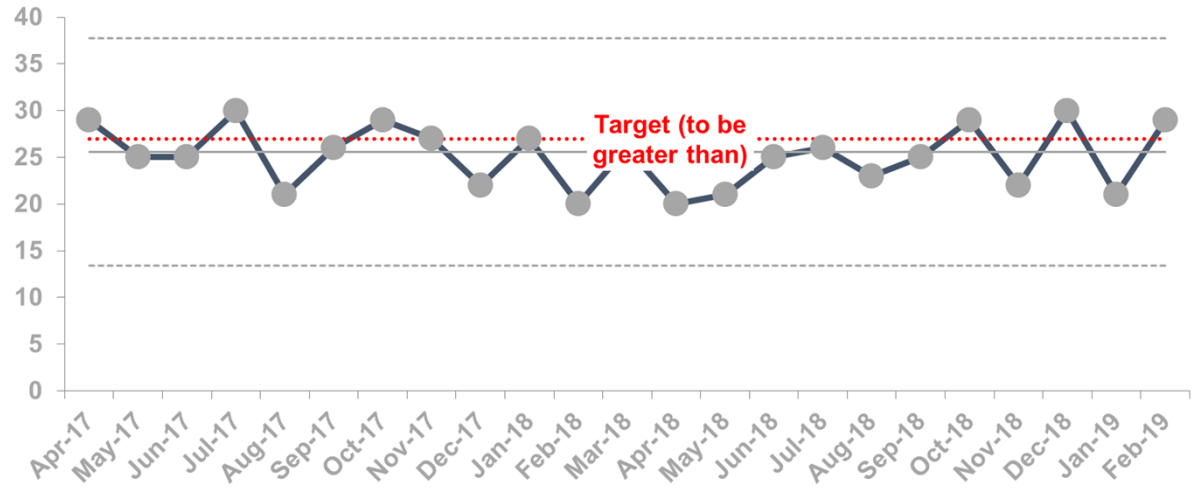
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process



The lower grey dotted line is above the target line. This gives assurance that the target will consistently be achieved, and that the system is effective.

3. An unreliable system

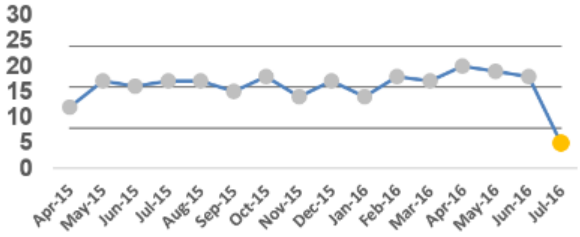
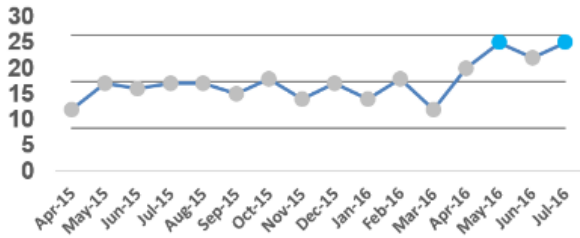
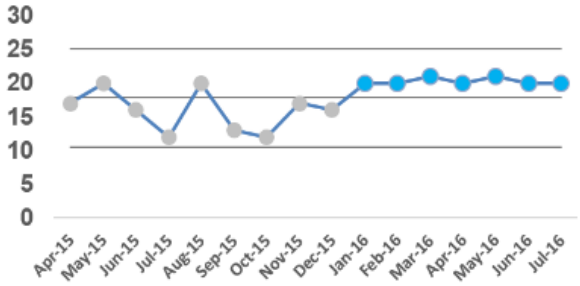
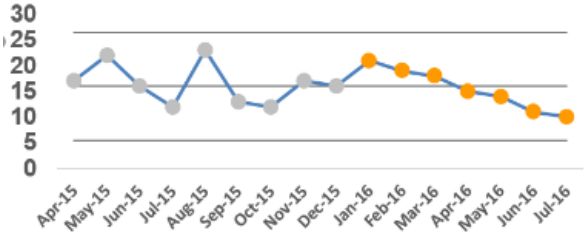


In this example the target line sits between the 2 grey dotted lines. As it is normal for the grey dots to fall anywhere between the 2 dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned if the target is to be consistently achieved.

4. Unusual patterns in the data

If there is anything unusual in the data, the grey dots will change colour. Orange means it is unusually worse than expected and blue means it is unusually better than expected. These unusual patterns should be looked into to establish why it is happening.

There are four scenarios where this can happen:

<table>
<tr>
<td>A single data point outside the process limits
 
</td>
<td>Two out of three points close to the process limits
 
</td>
</tr>
<tr>
<td>In this example the July 16 perfomance is significantly lower than expected and falls beneath the lower grey dotted line.</td>
<td>2 out of 3 points close to one of the grey dotted lines is statistically significant, in this case they are blue, indicating better than expected performance.</td>
</tr>
<tr>
<td>Shift of points above / below mean line
 
</td>
<td>Run of points in consecutive ascending / descending order
 
</td>
</tr>
<tr>
<td>A run of 7 points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 16 that has proven to be effective.</td>
<td>A run of 7 points in consecutive ascending or descending order is significant. In this example things are getting worse over time.</td>
</tr>
</table>

(Adapted from guidance kindly provided by Karen Hayllar, NHS England & NHS Improvement)

Appendix 2 – Data Quality Maturity Index Benchmarking Data

PROVIDER NAME	December-2021	November-2021	October-2021
National Average	**79.9**	**80.7**	**80.7**
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	98.1	98.1	98.1
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	98.0	98.0	98.1
GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	97.9	97.8	95.3
NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	97.9	97.7	97.4
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	97.4	97.7	98.0
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	97.4	97.3	97.0
CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	97.0	97.1	97.2
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	96.4	96.3	96.4
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	96.2	96.1	95.2
SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	96.2	96.4	96.7
NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	95.6	95.6	95.5
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	95.4	95.5	95.8
LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	95.3	95.3	95.2
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	95.3	95.1	95.2
ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	95.2	94.7	95.2
WEST LONDON NHS TRUST	94.9	95.0	95.0
EAST LONDON NHS FOUNDATION TRUST	94.7	94.5	93.8
SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	94.7	94.9	92.4
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	94.6	94.0	93.6
HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	94.5	95.1	94.7
KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	94.2	94.3	94.4
MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST	93.6	93.7	93.6
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	93.4	93.5	93.5
BRADFORD DISTRICT CARE NHS FOUNDATION TRUST	93.3	93.2	93.4
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	93.3	93.5	93.5
CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	93.0	92.9	93.2
PENNINE CARE NHS FOUNDATION TRUST	93.0	93.0	93.0
AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	92.6	92.6	92.4
LEICESTERSHIRE PARTNERSHIP NHS TRUST	92.4	91.4	91.4
WORCESTERSHIRE HEALTH AND CARE NHS TRUST	92.3	90.8	94.0
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	92.0	94.0	94.0
SOLENT NHS TRUST	91.5	91.4	91.5
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	91.2	91.4	91.9
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	91.1	91.1	91.3
BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	91.0	87.8	90.8
HUMBER TEACHING NHS FOUNDATION TRUST	91.0	94.3	93.8
OXLEAS NHS FOUNDATION TRUST	90.2	90.1	90.7
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	89.8	89.4	90.8
DEVON PARTNERSHIP NHS TRUST	89.6	89.0	88.5
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	89.2	89.6	89.7
SHEFFIELD HEALTH & SOCIAL CARE NHS FOUNDATION TRUST	88.9	88.9	88.6
LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST	88.1	88.3	88.4
SOUTHERN HEALTH NHS FOUNDATION TRUST	86.9	89.0	88.6
NORTH EAST LONDON NHS FOUNDATION TRUST	85.9	85.7	85.6
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	85.3	85.3	86.1
OXFORD HEALTH NHS FOUNDATION TRUST	81.5	81.8	81.7
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	76.5	76.2	83.1
GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST	60.5	87.9	88.0
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	51.0	50.9	50.3
MERSEY CARE NHS FOUNDATION TRUST	49.4	49.2	49.5

Data source: Data quality - NHS Digital

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 10 May 2022

Workforce Standards Formal Submission 2022

Purpose of Report

In October 2018, NHS Improvement (NHSI) wrote to all trusts asking them to review their workforce safeguards and implement some formal recommendations effective from 1 April 2019. The purpose of this report is for the Board to receive assurance that the Trust is formally assessing its compliance and outlines the work undertaken for 2021-22. In addition there is a self-assessment of the workforce safeguards for the year and this is discussed further by the People and Culture Committee to scrutinise and review all workforce information, systems and process of staff deployment, rostering and skill mix of the Trust's services.

At DHCFT we aim to provide safe, high-quality care to our patients, and our clinical staffing levels are continually assessed to ensure we meet this aim.

Executive Summary

The paper outlines all NHSI requirements and the Trust's compliance against each. Progress has been made against the actions set out in last year's report and all recommendations are now complete.

We will continue to refine the reporting and monitoring of these standards through the People and Culture Committee. There has been some disruption in committee reporting due to the pandemic emergency and the standing down of routine reporting in all areas. During this period the Incident Management Team (IMT) took oversight of safer staffing via the safer staffing cell. This includes emergency safer staffing reviews, formal assessments in the Quality and Safeguarding Committee and daily operational scrutiny of the services including over seven days per week. It also includes direct scrutiny and oversight by the clinical leads over a seven-day week period.

In 2022 the People and Culture Committee, Executive Leadership Team and People Delivery Groups will resume oversight and assurance. The delivery groups will initiate a more inquisitive exploration of safer staffing. This will include continually updating the Trust's integrated workforce information to provide the Board with assurance of our compliance against safer staffing in the integrated performance report.

The self-assessment outlines that the Trust was compliant in this emergency period and continues to be so.

The Quality and Safeguarding Committee is assured that the Trust is compliant with the majority of the standards and has maintained the required standards.

There are some gaps in controls:

- The workforce plan for 2021/22 is in final draft and has been scheduled for the next appropriate Board meeting.

- The achievement of suitably qualified and trained staff has areas of deficit due to gaps in full compliance of safety and mandatory training.

It has received staffing and caseload service specific reviews for services. This included emergency staffing and oversight.

The Quality and Safeguarding Committee also receives the National Quality Required Standards twice a year to review the safety aspects of this requirement which has occurred.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

- Mental health and other guidance is reviewed and is part of safer staffing reviews at Quality and Safeguarding Committee.
- Trusts must ensure the three components are used in their safe staffing processes, which include evidence-based tools (where they exist) from the Mental Health Guide and professional judgement adopted, led by the Assistant Director of Clinical Professional Practice and Heads of Nursing / AHP (Allied Health Professional). This will include a dashboard, CHPPD (care hours per patient day) and e-roster.
- We have some gaps in assurance, and therefore have limited assurance in a revised reporting section due to sustained deficits in training compliance and operational management of this deficit. Recovery plans are in place and will become fully achieved early in the financial year 2022.

Consultation

- As part of the safe staffing review, the Executive Director of Nursing and Executive Medical Director will confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

Governance or Legal Issues

- To base our assessment on the annual governance statement, in which Trusts will be required to confirm their staffing governance processes are safe and sustainable, this will be in development with the Annual Report process.
- To ensure compliance is met with https://www.cqc.org.uk/files/inspection-framework-nhs-trusts-foundation-trusts-trust-wide-well-led
- As part of the yearly assessment, the Trust will also seek assurance through the System Oversight Framework (SOF) in which a provider's performance is monitored against five themes. The NHS System Oversight Framework for 2021/22 replaces the NHS Oversight Framework for 2019/20, which brought together arrangements for provider and CCG oversight in a single document. In 2021/22, the NHS will continue to manage the impact of COVID-19 and provide the full range of non-COVID services within an evolving local, regional and national context within this revised framework.
- Mental Health Staffing Framework mh-staffing-v4.pdf (england.nhs.uk) Mental Health Optimal Staffing Tool (MHOST) Shelford Group: Mental Health Optimal Staffing Tool (MHOST) (10 May 2019) - Mental health - Patient Safety Learning - the hub (pslhub.org)
- The Royal College of Nursing published their Nursing Workforce Standards (2021), developed as part of their safe staffing campaigns. The standards summarise the expectations in other national guidance and reiterates the importance of the Chief Nurse being responsible for setting nurse staffing levels based on service demand and user needs and the requirement to report directly to the Trust board. Self-assessment undertaken by the Lead Nurse for Workforce Nursing show DHCFT is compliant with these standards.
- To comply with the requirement for Trusts to have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss the workforce plan in a Public Meeting.
- The Trust must ensure that it has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board monthly. Routine monitoring has returned to the People and Culture Committee and the integrated performance report of the Trust Board.

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

The risks are people related, so there are always adverse impacts (for example health). For the purposes of this paper it should be noted that the safeguards

referred to are to improve clinical and workforce risks and it is the risks of not implementing these safeguards which have been taken into account, rather than the risk of implementing the required monitoring.

Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve.

Recommendations

The Board of Directors is requested to:

1) Receive and accept the Safe Staffing Report and self-assessment for the financial year 2021/2022.
2) The board is asked to confirm a level of assurance that processes are in place to monitor inpatient and community staffing levels and that actions are in place to try to mitigate the risks to patient safety and care quality.

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

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

Jaki Lowe
Director of People and Inclusion

Amanda Wildgust
Assistant Director (People Operations)

Workforce Standards Formal Submission 2022

Nursing, AHP and Clinical Staffing

The Executive Chief Nurse has also completed a self-assessment shown at the end of this document to ensure that medical staffing is safe, effective and sustainable and taking into account other scheduled and unscheduled absences as indicated below.

Figure 1 also shows the CHPPD values for the wards by month at the end of this report.

Clinical Staff on Maternity Leave as at March 2022:

Absences due to maternity leave were factored into the safer staffing reviews to ensure continuity of patient care.

Staff Group	Headcount
Add Prof Scientific and Technic	2
Additional Clinical Services	9
Administrative and Clerical	6
Allied Health Professionals	9
Estates and Ancillary	1
Medical and Dental	1
Nursing and Midwifery Registered	19
Grand Total	47

And by banding:

Staff Group	AFC Banding	Headcount
Add Prof Scientific and Technic	Band 7	1
	Band 8 - Range B	1
Additional Clinical Services	Band 3	7
	Band 4	2
Administrative and Clerical	Band 3	3
	Band 4	2
	Band 5	1
Allied Health Professionals	Band 5	1
	Band 6	7
	Band 7	1
Estates and Ancillary	Band 2	1
Medical and Dental	Other	1
Nursing and Midwifery Registered	Band 5	2
	Band 6	14
	Band 7	2
	Band 8 - Range A	1
Grand Total		47

Data is not available by proposed maternity return date as it is up to the individual how long they wish to be off for up to the maximum permitted under NHS Terms and Conditions.

Sickness Absence

Again absences due to sickness leave were factored into the safer staffing reviews to ensure continuity of patient care.

The annual sickness absence (Apr 2021 to Mar 2022) by Staff Group was:

	Absence FTE %
Add Prof Scientific and Technic	5.16%
Additional Clinical Services	9.25%
Administrative and Clerical	4.24%
Allied Health Professionals	4.09%
Estates and Ancillary	7.97%
Medical and Dental	1.72%
Nursing and Midwifery Registered	6.72%
Students	2.43%
Grand Total	6.11%

Retention

Retention remains a priority for the Trust.

Work is ongoing to review the Trust's Retirement Policy and to promote the flexible retirement options available in the NHS pension scheme. System-wide work is proposed to improve access to flexible working opportunities is taking place, as is some focused work to improve recruitment practices as part of the EDI plan. The Trust's recruitment and induction processes are being reviewed and the online induction process is being streamlined to make it easier to follow and access.

The Trust staff bank operated in a shared service arrangement continues to offer flexible staffing and continuity of service in its operations to the Trust services. The trust bank fill rates are monitored regularly and signed off weekly by the senior operational team with oversight of the weekly fill rates by the Director of Nursing.

The Trust introduced an additional safer staffing intervention over the pandemic which included planned/site specific cover staffing. This is a set of staff with additional training, who are deployed at site level - 24 hours a day to be inserted into safer staffing skill mix to mitigate emergency staff gaps due to COVID. This model is called the bubble, (this is a local term, meaning to cushion the pressure of unplanned staffing). It has helped services navigate the pandemic period safely.

There is continued work to increase the pipeline of people entering nursing careers through alternative routes, as well as work to increase access to encourage career progression within the organisation.

The Trust wide Health, Safety and Security team review safer staffing with a safety lens. this group is a partner with the senior union representatives to scrutinise and review safer staffing and any learning. this group gives an additional level of scrutiny of safe staffing and learning events. There have been no major incidents in this financial year due to the bubble, bank and the operational teams proactive planning.

Conclusion

The Trust continues to closely monitor staffing levels and comply with the recommendations outlined in the Developing Workforce Safeguards Guidance. However, it has to be acknowledged that Covid 19 has presented significant challenges with regards to ensuring safe staffing across all disciplines. Noting the staffing information detailed in this report, alongside the robust escalation and mitigation of short and long-term staffing shortfalls, it can be concluded that the Trust has in place sufficient processes and oversight of its staffing arrangements to ensure safe staffing is prioritised as part of its routine activities.

Health and Wellbeing and Staff Engagement continue to be key areas of focus within the Trust, particularly as we support staff during the restoration and recovery phase.

Recommendation

The Board is asked to note the report.

Figure 1

Ward	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average 21-22
AUDREY HOUSE RESIDENTIAL REHABILITATION													
CHILD BEARING INPATIENT	28.00	21.91	26.64	21.19	33.04	42.08	21.50	21.31	38.28	34.63	23.80	29.05	28.45
CTC RESIDENTIAL REHABILITATION	6.20	5.51	5.11	5.01	4.10	3.97	4.14	4.82	4.87	4.10	4.16	3.69	4.64
ENHANCED CARE WARD	15.23	16.29	22.84	15.26	21.03	16.02	16.15	17.09	17.33	17.08	18.74	18.97	17.67
HARTINGTON UNIT - MORTON WARD ADULT	9.44	9.17	8.97	6.49	7.52	7.97	8.89	8.13	9.68	9.74	12.54	11.33	9.16
HARTINGTON UNIT - PLEASLEY WARD ADULT	10.20	8.79	8.81	7.89	7.50	7.19	8.19	8.31	8.73	7.68	9.05	7.65	8.33
HARTINGTON UNIT - TANSLEY WARD ADULT	11.33	11.20	9.31	8.06	7.79	7.27	7.72	9.10	8.62	8.36	8.25	7.90	8.74
KEDLESTON LOW SECURE UNIT	12.83	12.27	14.31	13.19	12.42	11.75	12.91	12.29	12.93	14.44	12.56	13.07	12.91
KINGSWAY CUBLEY COURT - FEMALE	23.52	18.46	8.24	12.26	11.64	12.14	9.20	10.87	13.26	13.57	11.95	11.38	13.04
KINGSWAY CUBLEY COURT - MALE	33.94	20.35	11.86	22.20	21.64	26.78	21.84	29.77	32.22	25.70	20.66	22.46	24.12
LONDON ROAD COMMUNITY HOSPITAL - WARD 1 OP / Tissington House	11.01	10.49	12.86	-	11.37	10.21	9.29	9.76	9.24	13.05	11.16	10.44	10.81
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	8.44	8.35	8.98	8.13	8.08	7.73	7.84	7.92	9.60	10.78	11.37	11.64	9.07
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	7.95	7.25	8.02	7.15	8.73	8.77	7.57	7.09	7.78	7.42	8.43	7.72	7.82
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	6.70	6.21	7.99	7.16	7.05	7.42	7.85	7.22	7.78	10.97	10.55	10.47	8.12
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	11.64	11.84	8.30	7.07	7.05	7.96	7.43	8.33	7.70	9.35	8.55	8.29	8.63
Total	11.11	10.37	9.76	9.97	9.32	9.20	9.06	9.61	10.17	10.57	10.48	10.24	9.99

For Audrey House, there were no patients in there this year. Ward 1 patients transitioned to Tissington House in July, hence the blank value for that cell.

The figures are all the CHPPD values for the ward and month. The total has been calculated based on the total number of care hours and patients, rather than being an average of the ward level totals. The Average 2021-22 Column is an average of each row equates to the ward average for the year and the total rows.

Clinical self-assessment against the recommendations:

The NHSI standard	Trust response	Current performance and gap in assurance
1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	Executive Director of Nursing and Patient Experience is Lead Director and NQB Mental Health and other guidance reviewed and part of safer staffing reviews at Quality Committee.	Assured and in place in 2021/22 Safer staffing reviews Reviews of emergency staffing have been maintained in the pandemic period
2. Trusts must ensure the three components (see below) are used in their safe staffing processes:	Compliant	Compliant
– evidence-based tools (where they exist)	Mental Health Guide	The Quality and Safeguarding Committee has reviewed the Mental Health Guidance, benchmarked against this information and the required recommendations and this is in place. The mental health model hospital data is used to triangulate, and the Trust remains within national standards.
– professional judgement	Led by Assistant Director of Clinical professional practice and Heads of Nursing / Allied Health Professional (AHP). It includes a dashboard / CHPPD* and E-roster dashboard. A full review of COVID-19 emergency staffing was undertaken and reviewed by the Quality and Safeguarding Committee. A workforce cell was established and reviewed emergency staffing and put in place full mitigation plans, and the use of redeployment.	Assured and in place for 2021/22 The trust has shared its model nationally of a three professionally qualified model of practice. (Two nurse registrants and a third registered professional model of practice). This model has received positive commentary on its use. In addition, in recent East and West Midlands skill mix benchmarking the Trust was compared/ highly favourably in its staff model

The NHSI standard	Trust response	Current performance and gap in assurance
	*See Figure 1 at end of report for monthly CHPPD figures.	
– outcomes.	Recommendations form clinical staff and Heads of profession are included in the skill mix review and have been implemented. This has occurred extensively throughout 2021/22.	Assured and in place for 2021/22
We will check this in our yearly assessment.	Available for assessment	
3. We will base our assessment on the Annual Governance Statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable. https://www.cqc.org.uk/files/inspection-framework-nhs-trusts-foundation-trusts-trust-wide-well-led	In development with Annual Report process, for submission.	The Well-led review in 2020, including reviewing our safe staffing and skill mix review. There were no concerns re: our establishment. The concerns were for continual improvement in reducing our vacancy rate in core hot spot areas, our Trust wide qualified vacancy rate is below the East midlands regional average. This has had some deterioration in 2022, with an extensive reduction in vacancy rate in hotspot areas with an end of year position of a Trust wide vacancy rate of 9%. We continue to deploy mitigation actions in our operational services to ensure the safety of our series in the acute service and we have made progress in 2021/22 to ensure safe staffing. This includes and additional staffing resource referred too locally as the “bubble” where additional staff are booked and then deployed at the beginning of a shift to areas of elevated activity, any unplanned shortages due to

The NHSI standard	Trust response	Current performance and gap in assurance
		COVID and to high intensity areas such as the 136 suite. This can be externally verified by CQC mental health act and transitional monitoring which reported on the acute service in 2021 *"the Trust had enough staff to deliver these services".*
4. We will review the Annual Governance Statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.	Revision to ensure all recommendation requirements are reviewed as per this guide and a standard operating framework for these required reports in a new model is implemented. COVID-19 arrangements have been in place and have impacted upon this work. This work has been achieved through the Incident Management Team, however in May 2021 a full return to integrated performance reporting on all aspects of safe staffing including fill rates should return to oversight and governance practice.	Assured and in place for 2021/22 through Incident Management Team. The 2021/22 Annual Governance Statement contains a statement of compliance with the standards.
5. As part of this yearly assessment we will also seek assurance through the Single Oversight Framework (SOF), in which a provider's performance is monitored against five themes.	Provided in integrated report, any further refinements as per recommendation 4, and was enacted in March 2019.	Assured and in place for 2021/2022 through Incident Management Team.
6. As part of the safe staffing review, the Executive Director of Nursing and Executive Medical Director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Available for Nursing and AHP in Quality and Safeguarding Committee papers. All service changes have a Quality Impact Assessment (QIA) and this has been externally assessed by the CQC in 2020 as meeting required standards.	Medical risks to delivery for safe staffing are reviewed Deep dive reports have been undertaken including benchmarking and detailed analysis

The NHSI standard	Trust response	Current performance and gap in assurance
	To ensure that medical staffing is safe, effective and sustainable: • Medical workforce monitoring for all grades including trainees in real time reports to medical workforce group every 2 weeks with exception reporting. Chaired by Executive Medical Director or his deputy with operational HR leads in attendance. • International and local recruitment (and retention) initiatives are maximised with liaison with the Royal College of Psychiatrists and GMC. There are regular local engagement events to maximise local recruitment. • There is a focus on CAMHS recruitment and retention following an exodus of substantive consultants to Nottinghamshire local services have been maintained primarily through the procurement of locums. • Gap in assurance – job plans to attract new substantive consultants have not yet been formulated. • Locum costs have spiralled. This is an area of improvement that we must continue to progress • Gap in assurance – national and regional locum pay caps have been breached and are subject to ongoing pay inflation. It has been agreed regionally not to use recruitment and	Guardian of safer working reports have been scrutinised by the Quality and Safeguarding Committee and received by Trust committees Assured and in place for 2021/22 The nursing workforce review of The Beeches required in 2021, was completed, and the Trust went at risk and over recruited against the skill mix. Further contractual discussions remain in place for the Beeches unit to review its final contracted safer staffing model for 2022. One residual risk that is not fully mitigated is the suitably qualified and trained staff. The Trust continues to have instability in mandatory training figures. At this time or report, this is not fully mitigated and requires further improvement planning by the People Services and Operational teams to rectify mandatory training compliance levels to the required standards. This remains a gap in control.

The NHSI standard	Trust response	Current performance and gap in assurance
	retention premiums but there is fierce competition from trusts using RRPs outside of the region to the North of the county and also one regional partner who did apply RRP's with significant impact upon our organisation staffing stability in one service. • Capital plan and the associated workforce plan includes medical staffing. • Review of medical leadership and medical structure is underway and is consistent with the proposed review of the operating management structure. • E-job planning software has been procured but cannot become fully operational without administrative support. Gap in assurance – need administrative support to become fully operational • All training posts compliant with national contracts with reports from Guardian of Safe Working to the Quality and Safeguarding Committee • Trust rated highly by GMC regarding medical training standards • Alternative cover arrangements for physical healthcare after hours in place and utilised in the event of absences of medical staff from rotas	

The NHSI standard	Trust response	Current performance and gap in assurance
	• A group formed to explore gender/diversity issues in medical workforce including the gender pay gap and suggestions have been proposed to the Medical Staff Committee and Local Negotiating Committee Approved Clinicians and prescribing roles. • Medical Director has presented workforce plan at People and Culture Committee. Recruitment and retention performance is in advance of regional average. • A training cohort of Multi-professional Approved Clinicians have commenced their training. This development has been very well received. • Non-medical prescribing continues to expand in the Trust under the leadership of our Consultant Nurse and Non-medical prescribing lead Lisa Thomas. Advanced Clinical practitioners - Two senior nurses are now at an advanced stage of ACP for Physical healthcare training, and one will be joining the in-patient workforce this year in this new model of practice	
7. Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders.	The workforce plan is due at the July Trust Board. The Executive Team in the pandemic period continued to activate some key new projects	Strategic Workforce Group has been impacted by the pandemic and has not fully overseen the delivery of the two-year plan.

The NHSI standard	Trust response	Current performance and gap in assurance
The Board should discuss the workforce plan in a public meeting.	Examples include 'grow your own' approaches and apprenticeships for Nursing Assistants and eligible administration staff to enter into Nursing Associate or Registered nurse training positions. Specific priority areas with future workforce gaps have included Learning Disability Nursing with this group qualifying in 2022 and all of the group choosing DHCFT and our sister Trust as their preferred employer at completion. Mental Health Nursing, these schemes have been identified for the predicted expansion in Autism and Learning Disability services in line with long term plan investments in 2023/ 24. In addition, the expansion of trust services including Psychiatric Intensive Care Unit (PICU) and community framework again in this time period. Investment in additional medical training posts to reduce future workforce gaps and the use of the workforce levy for national apprenticeship schemes continue in the organisation	The executive team have taken direct oversight and direct action in the pandemic period. In this next phase of recovery in 2022 the Director of People will reactivate the workforce development and delivery architecture to recommence standard operating procedures and People services governance and assurances.
8. They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board every month.	The Integrated Performance Report provides this information. Alongside this other service specific reports are provided to both Quality and Safeguarding and People and Culture Committees.	Assured and in place for 2021/22, governance streamlined in line with national requirements to reduce the burden to release capacity to manage the pandemic governance. Deep dive reports and CQC review transition monitoring reports all contain mental health model hospital data per service line.

The NHSI standard	Trust response	Current performance and gap in assurance
		The Executive Team have taken direct oversight and direct action in the pandemic period in the Incident management team and safer staffing reports returned to TOOL in 2021/22.
9. An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.	Available in Quality and Safeguarding Committee papers. This is reported to the Board through the Board Committee Assurance Summaries. There were no escalation issues to the Trust Board based upon these submissions.	The Executive Team have taken direct oversight and direct action in the pandemic period. This has been reviewed and signed off by the Executive Director of Nursing and Patient Experience and the Quality and Safeguarding Committee. The People and Culture Committee and Quality and Safeguarding Committee will continue to review a submission as a minimum twice per year and this is evidenced in its Board Assurance summary.
10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool	This is a statement – not a specific question to answer. We do not adapt any information.	Assured and in place for 2021/22
11. As stated in CQC's well-led framework guidance (2018) 6 and NQB's guidance7 any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review	We will refresh our QIA once we have the outcome of shift change consultation exercise. This did not occur in 2020/21. Additional supplementary staffing has been introduced including the staffing known locally as the bubble to manage unexpected large scale	Assured and in place for 2021/22

The NHSI standard	Trust response	Current performance and gap in assurance
	changes in staffing. No reductions in staffing have occurred within the year. Any new services have a new clinical safer staffing model review and this includes drawing upon clinical models and evidence. This year a proposed new model of older people's care was undertaken and included a full skill mix review of the proposal	
12. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.	Compliant. Executive Director of Nursing has a deployment and risk management plan for nursing associates.	Assured and in place for 2021/22. Example Nursing associate. New roles have been proposed in the region from new monies associated with the Long term plan if these are adopted a full QIA of the new roles will be undertaken.
13. Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	Staffing in high risk service areas is reviewed on a daily basis with a formal process and monitoring system, which includes dynamic risk assessment. This is performed locally by Managers and their teams, with oversight by the Nursing and Quality team in the Incident Management Team. Datix is used to record risk, with an assessment of risk part of this.	Assured and in place for 2021/22 Example acute care, Health visiting caseloads in the pandemic, and a new hub model of practice.
14. Should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and	Staffing risks are identified in inpatient areas via a daily assurance process, whereby current and future risks are reviewed, and actions taken to minimise risk. Staffing huddle/ Safe staffing cell/ Escalation to Ethics and Clinical Governance cell as required.	Assured and in place for 2021/22.

The NHSI standard	Trust response	Current performance and gap in assurance
teams, re-alignment, or a return to the original skill mix	When appropriate escalation to Directors for service closure decisions are made.	

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 10 May 2022

Learning from Deaths - Mortality Annual Report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period 1 April 2021 to 25 March 2022.

Executive Summary

Due to recent sickness within the mortality team, there is a backlog of non Datix reportable deaths that require reviewing against the red flags outlined in the Royal College of Psychiatrists Care Review Tool and the internal Trust Datix red flags. All deaths reported through the Incident Reporting and Investigation Policy and Procedure (Datix) continue to be reviewed.

All deaths directly relating to COVID-19 are reviewed through the Learning from Deaths procedure unless they also meet a Datix red flag, in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure.

- From 1 April 2021 to 25 March 2022 there have been seven deaths reported where the patient tested positive for COVID-19.
- The Trust received 1,981 death notifications of patients who had been in contact with our service in the last six months There is very little variation between male and female deaths; 980 male deaths were reported compared to 1,001 females.
- Two inpatient deaths were recorded, three patients died whilst on leave from an inpatient ward
- The Mortality Review Group reviewed 77 deaths through a Stage 2 Royal College of Psychiatrists Care Review Tool These reviews were undertaken by a multi-disciplinary team and it was established that of the 77 deaths reviewed, none were due to problems in care.
- The Trust has reported 26 Learning Disability deaths in the reporting timeframe and death of one patient with a diagnosis of autism
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	

Assurances

This report provides assurance that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

Consultation

Quality and Safeguarding Committee 12 April 2022.

Governance or Legal Issues

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance 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
- Duty of Candour (Regulation 20)

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

- 1 April 2021 to 25 March 2022 there is very little variation between male and female deaths; 980 male deaths were reported compared to 1,001 female.
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this Mortality Report as assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.

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

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

Louise Hamilton
Mortality Technician

1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths[1]'. 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.

To date the Trust has met all of the required guidelines.

The report presents the data for 1 April 2021 to 25 March 2022.

2. Current Position and Progress (including COVID-19 related reviews)

- The Trust is still waiting to ascertain if cause of death (COD) will be available through NHS digital. Currently COD is been ascertained through the coroner officers in Chesterfield and Derby but only a very small number of COD have been made available.

- Medic rotas for the north and south have been updated. 61 Case Note Review sessions were undertaken, where 77 incidents were reviewed. Unfortunately 34 sessions did not take place due to lack of medic availability and 7 sessions did not take place due to nurse availability.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed 18 March 2022.

- The monthly mortality review group meetings have resumed

- Due to sickness within the mortality team, there is a backlog of non Datix reportable deaths that require reviewing against the red flags outlined in the Royal College of Psychiatrists Care Review Tool and the internal Trust Datix red flags. All deaths reported through the Incident Reporting and Investigation Policy and Procedure (Datix) continue to be reviewed.

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

3. Data Summary of all Deaths

Note that inpatients and learning disability (LD) data is based upon whether the patient has an open inpatient or LD referral at time of death. The table below outlines information for 1 April 2021 to 25 March 2022.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Deaths Per Month	144	144	154	174	168	174	145	175	191	214	153	145
LD Referral Deaths	3	2	1	0	3	4	1	2	3	4	3	0

Correct as of 30 March 2022

From 1 April 2021 to 25 March 2022, the Trust received 1981 death notifications of patients who have been in contact with our services.

Of these deaths 980 patients were male, 1001 female, 1494 were white British and 26 Asian/Asian British Pakistani. The youngest age was 0 years, the oldest age recorded was 102.

The Trust has reported 26 Learning Disability deaths in the reporting timeframe and death of one patient with a diagnosis of autism

4. Review of Deaths

Total number of Deaths from 1 April 2021 to 25 March 2022 reported on Datix	167 “Unexpected deaths”; 7 COVID deaths 38 “Suspected deaths” 14 “Expected - end of life pathway”) NB some expected deaths have been rejected so these incidents are not included in the above figure 2 inpatient deaths 3 patients died whilst on leave from an acute inpatient ward
Incidents assigned for a review	176 incidents assigned to the operational incident group 5 did not meet the requirement 9 incidents are to be confirmed

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.
- *Death of a patient with Autism*
- *Death of a patients who had a diagnosis of psychosis within the last episode of care*

The last two red flags have been added to ensure that the Trust meets the Learning from Deaths guidance and recent changes to the LEDER reporting requiement of patients who have a diagnosis of autism.

5. Learning from Deaths Procedure

The mortality team, as well as reviewing identified deaths against the ‘red flags’ outlined in the Royal College of Psychiatrists Care Review Tool also review deaths against locally defined red flags**.**

From 24 June 2020 these locally defined red flags were:

- Patient taking an anti-psychotic medication
- Death of a patient with a learning disability
- Patients with chronic pain
- Patients only open to outpatient services
- Patients with COVID19 (this is a temporary flag)

From 5 August 2021 these locally defined red flags were:

- Patient diagnosed with a severe mental illness
- Patient only seen as outpatient
- Patient with long term physical condition
- Patient with long term chronic pain

Over the last 12 months the Patient Safety Team with support from NHSE Patient Safety team have been considering the current Trust identified Mortality red flags against the red flags identified in the Royal College of Psychiatrists Care Review Tool for mortality reviews. This tool was developed following the publication of the Learning from Deaths Guidance for Mental Health Trusts to use when undertaking mortality reviews. It has become clear that the Trust has overcommitted its resources in this area and a redesign of the Mortality (learning from deaths) process was required.

The red flags identified within the Care Review Tool were already met under the Trust Incident review process with the exception of psychosis within the last episode of care which has now been added as a Datix red flag.

The mandatory Flags for review under the Royal College of Psychiatrists Care Review Tool for mortality reviews are:

- All patients where family, carers or staff have raised concerns about the care provided

- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death or have been discharged within 6 months prior to their death

- All patients who were an in-patient in a mental health unit at the time of death or who had been discharged from in-patient care within the last month

- All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.

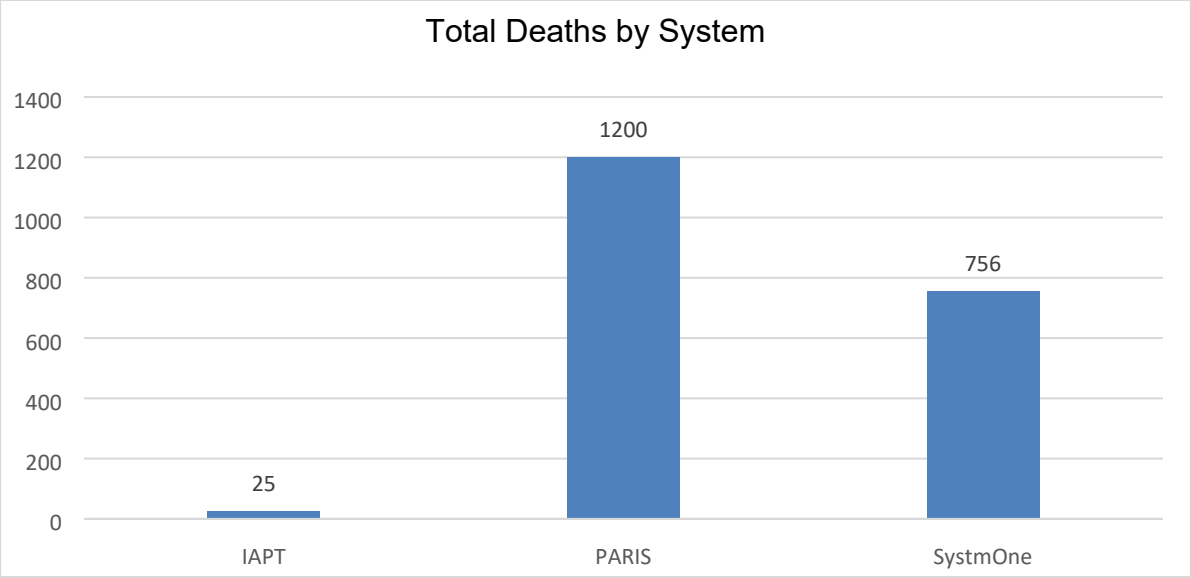
Those patient deaths which meet these ‘red flag’ criteria above should be subject to a review process if they are not already under the Incident process. At the stage of determining if a death meets the criteria for reporting as an incident, teams are required to review all deaths against the Trust Incident ‘Red Flags’.

A form is currently under development based on the section 1 of the Royal College of Psychiatrists Care Review Tool for Mortality Reviews which will sit within the Electronic Patient Record which confirms the consideration against the identified mandatory red flags. It is important to note that clinical teams already assess each death when determining if a DATIX incident is required. This will release capacity within the Patient Safety team and allow for greater return on the Case Record Review process.

For the period 1 April 2021 to 25 March 2022, the Mortality Review Group reviewed 77 deaths through a Stage 2 Case Note Review. These reviews were undertaken by a multi-disciplinary team and it was established that of the 77 deaths reviewed, 0 were not due to problems in care. Unfortunately, 34 sessions did not take place due to lack of medic availability and 7 sessions did not take place due to nurse availability. Unavailability of medics to attend these meetings remains a recurring problem.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 April 2021 to 25 March 2022



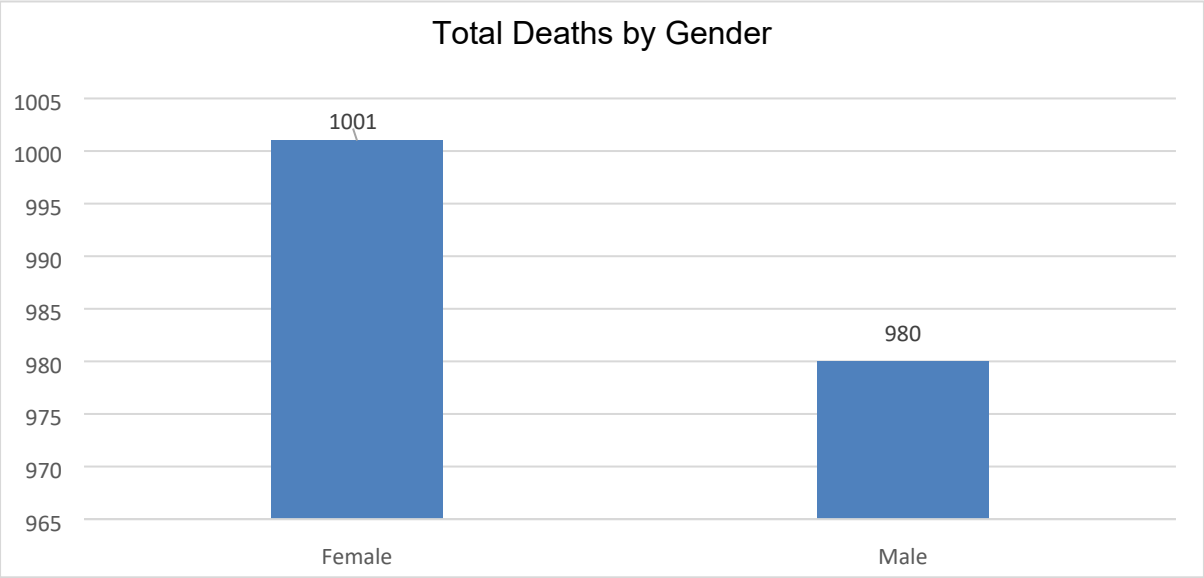
System	Number of Deaths
IAPT	25
SystmOne	756
PARIS	1200
Grand Total	**1981**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from PARIS. 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.

From the 1 April 2021 to 25 March 2022 there have been 7 deaths reported where the patient tested positive for COVID-19. Of these deaths 6 patients were male and 1 female. 5 males and 1 female were from a White British background and 1 male was from a British Pakistani background.

6.2 Deaths by Gender

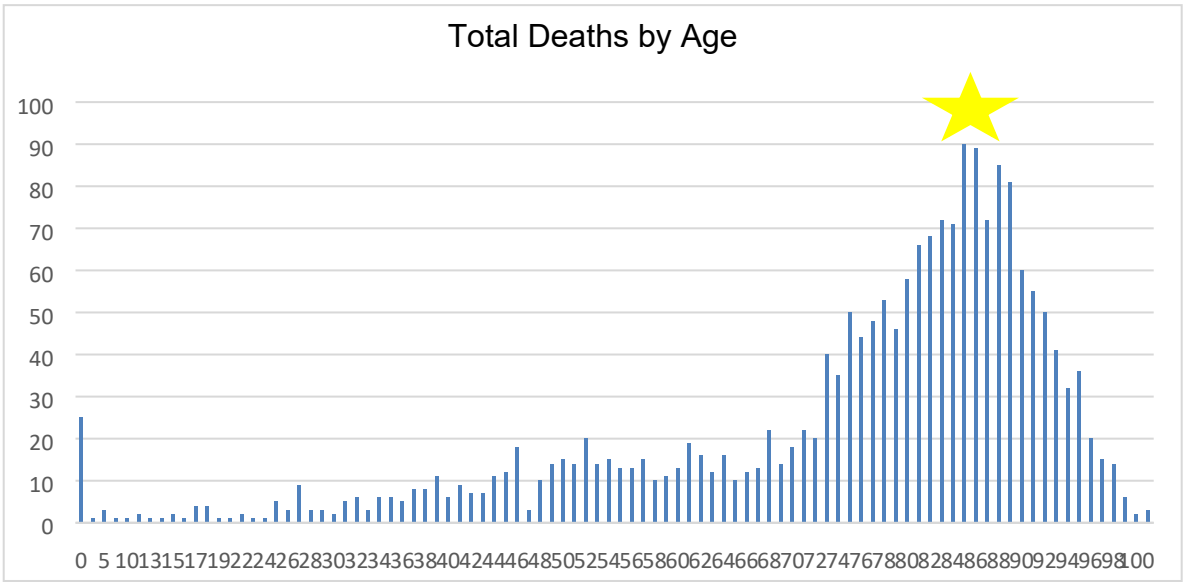
The data below shows the total number of deaths by gender 1 April 2021 to 25 March 2022. There is very little variation between male and female deaths; 1001 female deaths were reported compared to 980 males.



Gender	Number of Deaths
Male	980
Female	1001
Grand Total	**1981**

6.3 Death by Age Group

The youngest age was classed as 0, and the oldest age was 102 years. Most deaths occurred within the 85 to 89 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
LD Deaths	3	2	1	0	3	4	1	2	3	4	3	0
Autism	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	1

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. 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. Following a meeting with the Commissioning Manager for Learning Disabilities and Autism, further information has been made available, 13 patients who were referred for LeDer have had reviews and feedback has been made available. This will be shared with the teams and in the Mortality Review Group.

From 1 January 2022 the Trust has been required to report any death of a patient with autism to date one patient has been referred.

During 1 April 2021 to 25 March 2022, the Trust has recorded 26 Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

6.5 Death by Ethnicity

White British is the highest recorded ethnicity group with 1,494 recorded deaths, 255 deaths had no recorded ethnicity assigned, and 15 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
Asian or Asian British - Bangladeshi	1
Black or Black British - any other Black background	1
Asian or Asian British - any other Asian background	1
British	1
Mixed - White and Black African	1
Any other Black background	1
Indian	2
Mixed - White and Asian	2
Mixed - White and Black Caribbean	3
Black or Black British - African	4
Black or Black British - Caribbean	6
Mixed - any other mixed background	8
Asian or Asian British - Pakistani	11
Asian or Asian British - Indian	11
Not stated	15
White - Irish	15
White - any other White background	45
Other Ethnic Groups - any other ethnic group	104
Not known	255
White - British	1494
Grand Total	**1981**

6.6 Death by Religion

Christianity is the highest recorded religion group with 414 recorded deaths, 1097 deaths had no recorded religion assigned and 12 people refused to state their religion. The chart below outlines all religion groups.

Religion	Number of Deaths
Jewish	1
Anglican	1
Mixed religion	1
Humanist	1
Quaker religion	1
Islam	1
Christian Scientist religious	1
Not religious - old code	1
Spiritualist	1
Orthodox Christian religion	1
Congregationalist religion	1
Pagan	1
Catholic religion	1
Protestant	1
Hindu	2
Greek Orthodox	2
Atheist movement	2
Christian religion	2
Church of Scotland	2
Baptist	3
Not stated	3
Religion NOS	3
Buddhist	3
Atheist	4
Jehovah's Witness	4
Nonconformist	5
Catholic: not Roman Catholic	5
Sikh	5
Patient religion unknown	6
Religion (other Not Listed)	6
None	7
Muslim	8
Not given patient refused	12
Methodist	21
Roman Catholic	29
Church of England, follower of	59
Not religious	112
Unknown	141
Church of England	151
Christian	414
Blank	956
Grand Total	**1981**

6.7 Death by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 586 recorded deaths. 1,334 have no recorded information available. The chart below outlines all sexual orientation groups.

Sexual Orientation	Number of Deaths
Person asked and does not know	1
Sexual orientation unknown	1
Person declined to disclose	1
Bi-sexual	2
Homosexual	2
Gay or lesbian	4
Not appropriate to ask	10
Sexual orientation not given - patient refused	10
Not stated (declined)	14
Unknown	16
Heterosexual	279
Heterosexual or straight	307
(blank)	1334
Grand Total	**1981**

6.8 Death by Disability

The table below details the top 6 categories by disability. Gross motor disability was the highest recorded disability group with 63 recorded deaths.

Disability	Number of Deaths
Learning Disability	16
Other	18
Physical Disability	19
Behaviour and Emotional	35
Intellectual Functioning Disability	43
Gross Motor Disability	63

There were a total of 377 deaths with a disability assigned and the remainder 1604 were blank (had no assigned disability).

7. Recommendations and Learning

Below are examples of the recommendations that have been undertaken following the review of deaths. These recommendations are monitored by the Patient Safety Team and are allocated to a specific team, and individuals to be completed. This is not an exhaustive list.

- Pathway development in relation to the Crisis team and Hope and Resilience hub to improve discharge, information sharing and communication.

- The transition of the electronic patient record system from PARIS to SystmOne should be supported by: Clinical standards for risk assessment, formulation and mitigation. A Standard Operating Procedure to demonstrate how these standards should be applied and recorded in practice. A training package to inform and support staff in the application of these standards in practice. A single, accessible place on the EPR in which the assessment, formulation and mitigation of risk is recorded. A corresponding governance process.

- To develop guidance and procedure for managing the transfer of patients from Acute hospitals to Mental Health hospitals who are physically unwell through the review of the Trust Discharge Transitions Transfers and Leave Policy.

- Development of suitable alternative community providers or emergency accommodation for service users with a learning disability leading to reduce admissions to acute psychiatric units.

- A learning event to be undertaken to support and enhance medic knowledge and learning in relation to hyponatraemia. This event should be undertaken jointly with an Endocrinologist and be presented through the current Doctors training programme.

- The Trust to develop a process with partner agency (Social Care) for multi-disciplinary meetings to be held more frequently between services when patients have moved to new residential placement to ensure the care provider and patient has effective support during this transition.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 10 May 2022

National NHS Staff Survey Results 2021

Purpose of Report

The purpose of this paper is to update the Trust Board on the NHS Staff Survey – NHS England results, which show our position based on the 2021 all staff survey.

Executive Summary

This report for Derbyshire Healthcare NHS Foundation Trust contains results for themes and questions from the 2021 NHS Staff Survey.

The 2021 results within each theme and question are presented in the context of the best, average and worst results for similar organisations where appropriate. In line with the commitment in the 2020/21 People Plan, for 2021 the annual NHS Staff Survey has been redeveloped to align with the People Promise. First published in July 2020 as part of People Plan 2020/21: action for us all, the People Promise sets out in the words of our NHS people what we can expect from our leaders and from each other to make the NHS the workplace where people want to stay, to stay well, and where others want to join us. The people best placed to say when progress has been made towards achieving this are our NHS people. To track this, the People Promise has been integrated with the annual national NHS Staff Survey from 2021 to ensure colleagues' voices are heard.

The results are presented against the 7 areas of the NHS 'People Promise', with additional feedback for staff engagement and morale.

Key information:

- Derbyshire Healthcare NHS Foundation Trust is within the Combined Mental Health / Learning Disability and Community Trusts benchmarking group
- There are 51 organisations in this benchmarking group

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	x

3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	x

Assurances
From the 2021 NHS Staff Survey NHS England results we can see that:

- We are above average in all of the 9 themes when benchmarking against the 51 other Combined Mental Health/Learning Disability and Community Trusts for the 2021 NHS Staff Survey
- We are top in three of the themes across all of the 51 other trusts
- Regionally and across Derbyshire we remain one of the top trusts across all themes

Consultation

- To date high level results have been shared with the Executives at the Executive Leadership Team meeting.
- All information on our NHS Staff Survey results has been shared via the key Trust channels including a one page summary document, with appropriate stakeholders and governors now the embargo has been lifted on 30 March.

Governance or Legal Issues

- CQC analyse the NHS Staff Survey results
- Staff FFT questions are reported and benchmarked nationally.

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

- All staff are given the opportunity to complete the NHS Staff Survey every year
- We have raised nationally, and this has been recognised, the gap in a survey to the temporary workforce who are a key part of Derbyshire Healthcare
- Our NHS Staff Survey results are be broken down by protected characteristics and further analysis is done by the Equality, Diversity and Inclusion Team in conjunction with all Staff Network Groups once all of this data has been received

Recommendations
The Board of Directors is requested to receive and review the 2021 NHS Staff Survey – NHS England results.
It is recommended that significant assurance should be given at this point based on:

- the consistent response rate, during another challenging year
- we are above average in all themes and top in three

Once all reports are received, including free text comments the final focus areas will be confirmed and reporting via the People and Culture Committee with ongoing tracking of delivery against focus areas.

Report presented by: **Jaki Lowe**
Director of People and Inclusion

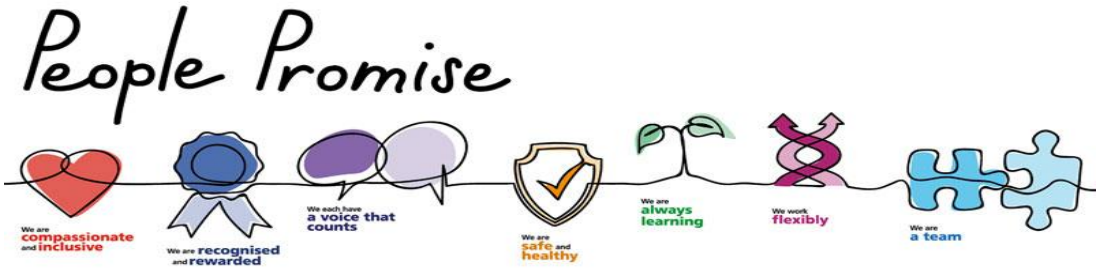
Report prepared by: **Rebecca Oakley**
Acting Deputy Director of People and Inclusion

2021 NHS National Staff Survey Results

Introduction

This report for Derbyshire Healthcare NHS Foundation Trust contains results for themes and questions from the 2021 NHS Staff Survey.

In line with the commitment in the 2020/21 People Plan, for 2021 the annual NHS Staff Survey has been redeveloped to align with the People Promise.



First published in July 2020 as part of People Plan 2020/21: action for us all, the People Promise sets out in the words of our NHS people what we can expect from our leaders and from each other to make the NHS the workplace where people want to stay, to stay well, and where others want to join us. The people best placed to say when progress has been made towards achieving this are our NHS people. To track this, the People Promise has been integrated with the annual national NHS Staff Survey from 2021 to ensure colleagues' voices are heard.

This means that it is not possible for all questions to provide historical data. To align to the NHS People Promise; 32 new questions have been added and others removed.

In addition to the survey structure and questions the eligibility criteria was extended to provide the opportunity for the following groups of staff to take part for the first time:

· Staff on long term sickness absence of more than 90 days

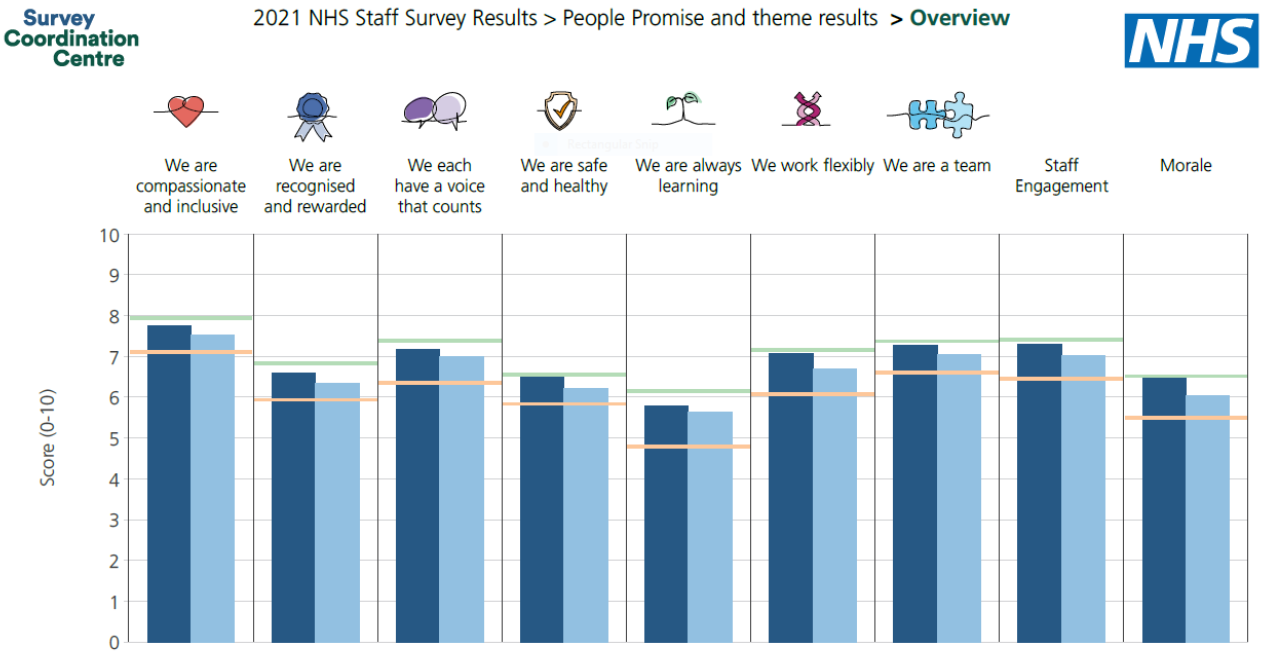
· Staff who have been on secondment at an organisation for more than 12 months

There is a recognition that bank staff are currently excluded from the survey and NHS England have announced plans to include in next year's survey.

Results overview

We achieved our highest ever response rate of 62%. This compares extremely well against our comparator organisations (51 other mental health trusts), where the median response rate was 52%.

The results are presented against the 7 areas of the NHS 'People Promise', with additional feedback for staff engagement and morale.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.9	6.8	7.4	6.6	6.1	7.1	7.4	7.4	6.5
Your org	7.8	6.6	7.2	6.6	5.8	7.1	7.3	7.3	6.5
Average	7.5	6.3	7.0	6.2	5.6	6.7	7.1	7.0	6.0
Worst	7.1	5.9	6.4	5.8	4.8	6.1	6.6	6.5	5.5
Responses	1,697	1,691	1,687	1,685	1,596	1,681	1,691	1,700	1,700

In summary of the 9 themes, compared to the other 51 organisations we are benchmarked against, we are:

- **Best in 3 – safe and healthy, work flexibly, morale**
- **Above average across all themes**

Staff Friends and Family Test (FFT) Scores

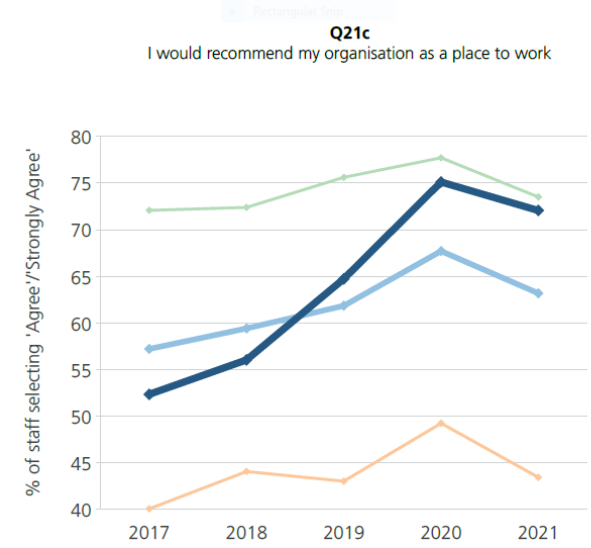
Percentage of staff who would recommend Derbyshire Healthcare as a place to work

- **2021 – 72%**
- 2020 – 75%
- 2019 – 64%

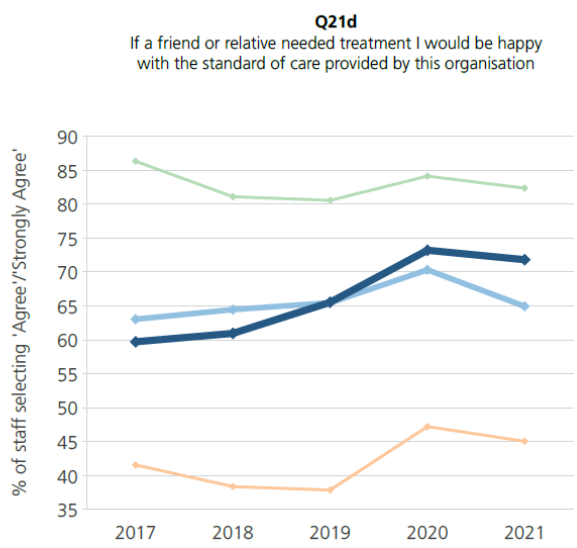
Percentage of staff who would be happy to recommend the standard of care/treatment provided by Derbyshire Healthcare if a friend or relative needed treatment

- **2021 – 71%**
- 2020 – 73%
- 2019 – 65%

The scores have lowered on both FFT questions by 3% and 2% retrospectively, however bearing in mind we are at the end of a second year into the COVID-19 pandemic, we should be looking at the results in context and at the huge strides which have been made over the last 5 years. It is evident a similar trend of a fall in the FFT questions from the comparison with other mental health trusts which saw on average over a 4% drop in the questions.



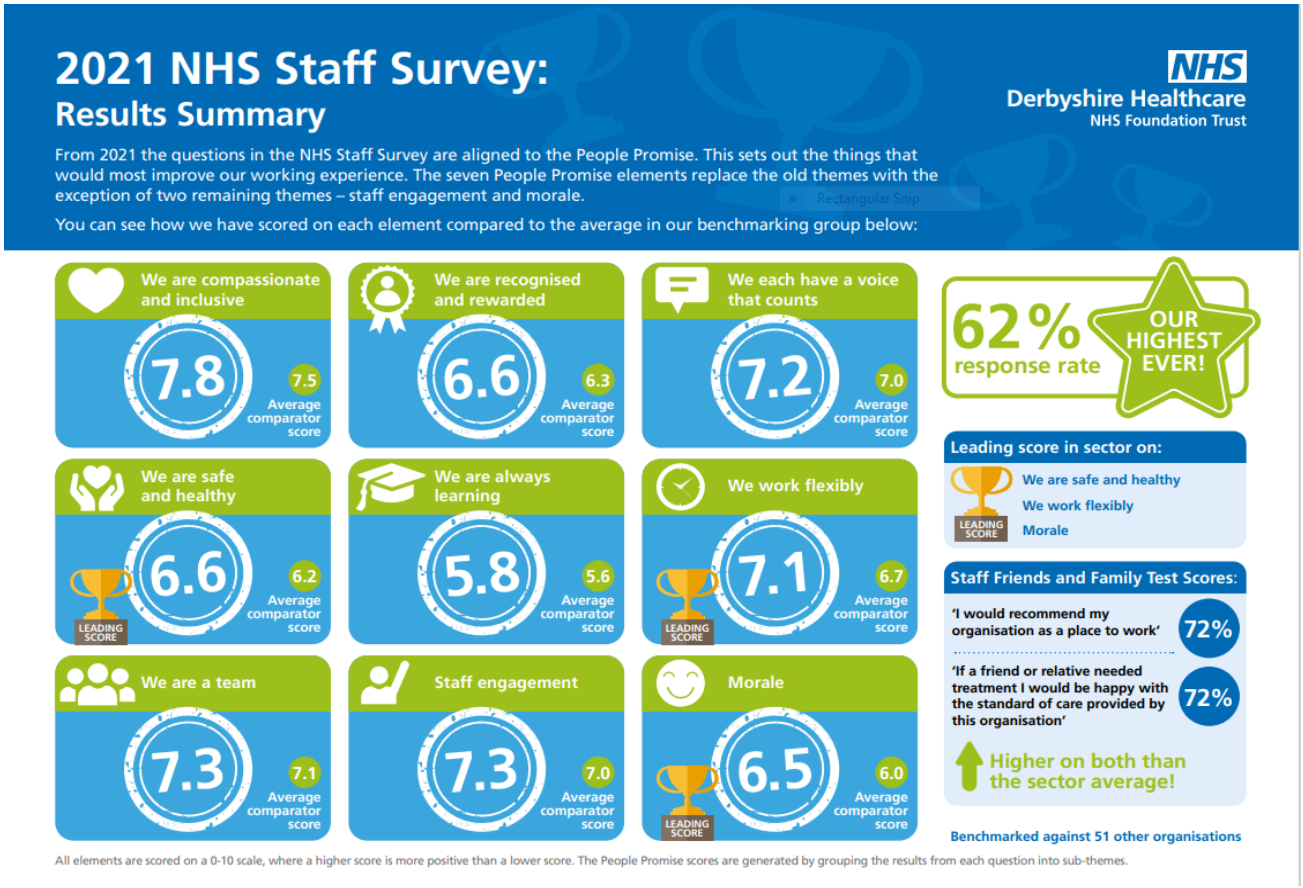
	2017	2018	2019	2020	2021
Best	72.1%	72.4%	75.6%	77.7%	73.5%
Your org	52.3%	56.0%	64.7%	75.1%	72.1%
Average	57.2%	59.4%	61.8%	67.7%	63.2%
Worst	40.1%	44.1%	43.0%	49.2%	43.4%
Responses	987	1,220	1,478	1,599	1,699



	2017	2018	2019	2020	2021
Best	86.3%	81.1%	80.6%	84.1%	82.4%
Your org	59.7%	60.9%	65.5%	73.2%	71.8%
Average	63.0%	64.5%	65.5%	70.3%	64.9%
Worst	41.5%	38.4%	37.8%	47.2%	45.0%
Responses	985	1,218	1,478	1,598	1,697

Sharing the results

We have devised the following infographic to summarise the key results to staff, this has been shared via the usual communication channels.



How do we compare to last year?

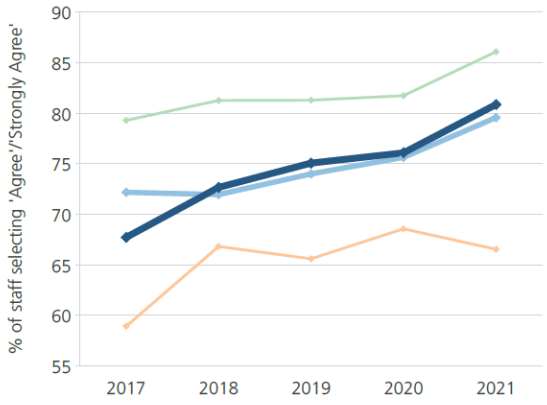
Compared to the 2020 survey, when looking at the 55 questions where we can compare to the previous year, we were statistically (change of over 4% either way):

- **Better** on 2 questions
- **Worse** on 4 questions

We were better on:

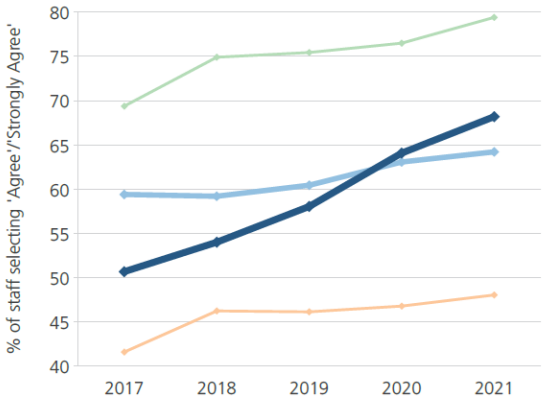
Question:	2020	2021	% change
17a. I would feel secure raising concerns about unsafe clinical practice.	76%	81%	5%
17b. I am confident that my organisation would address my concern.	63%	68%	5%

Q17a
I would feel secure raising concerns about unsafe clinical practice



	2017	2018	2019	2020	2021
Best	79.3%	81.3%	81.3%	81.7%	86.1%
Your org	67.7%	72.7%	75.1%	76.1%	80.9%
Average	72.2%	72.0%	74.0%	75.6%	79.6%
Worst	58.9%	66.8%	65.6%	68.6%	66.5%
Responses	992	1,230	1,481	1,593	1,689

Q17b
I am confident that my organisation would address my concern

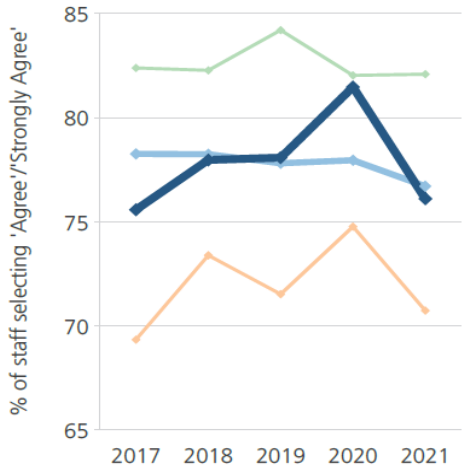


	2017	2018	2019	2020	2021
Best	69.4%	74.9%	75.4%	76.5%	79.4%
Your org	50.7%	54.0%	58.0%	64.1%	68.2%
Average	59.4%	59.2%	60.4%	63.1%	64.2%
Worst	41.6%	46.2%	46.1%	46.8%	48.0%
Responses	989	1,225	1,480	1,592	1,690

We were worse on:

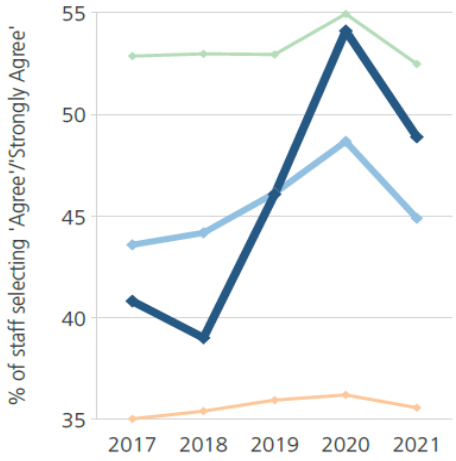
Question:	2020	2021	% change
3d. I am able to make suggestions to improve the work of my team / department.	81%	76%	5%
3g. I am able to meet all the conflicting demands on my time at work.	54%	49%	5%
3i. There are enough staff at this organisation for me to do my job properly.	51%	37%	14%
11d. In the last three months have you ever come to work despite not feeling well enough to perform your duties? **percentage of staff answering no, so more staff are coming in*	59%	52%	7%

Q3d
I am able to make suggestions to improve the work of my team / department



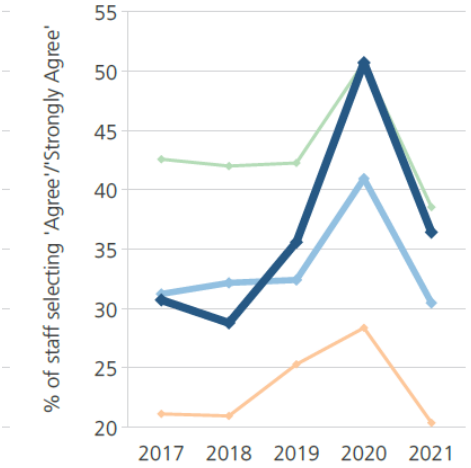
	2017	2018	2019	2020	2021
Best	82.4%	82.3%	84.2%	82.0%	82.1%
Your org	75.6%	78.0%	78.1%	81.5%	76.1%
Average	78.3%	78.2%	77.8%	77.9%	76.7%
Worst	69.3%	73.4%	71.5%	74.8%	70.7%
Responses	1,011	1,267	1,508	1,595	1,696

Q3g
I am able to meet all the conflicting demands on my time at work



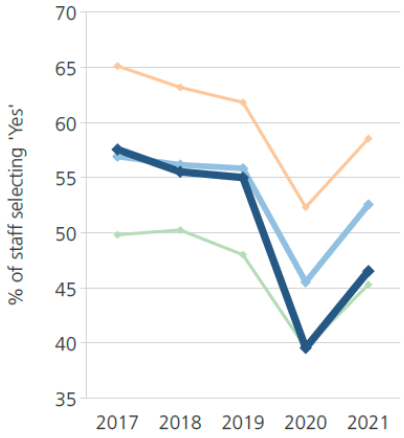
	2017	2018	2019	2020	2021
Best	52.9%	53.0%	52.9%	54.9%	52.5%
Your org	40.8%	39.0%	46.1%	54.1%	48.9%
Average	43.6%	44.2%	46.1%	48.7%	44.9%
Worst	35.0%	35.4%	35.9%	36.2%	35.6%
Responses	1,005	1,269	1,504	1,589	1,691

Q3i
There are enough staff at this organisation for me to do my job properly



	2017	2018	2019	2020	2021
Best	42.6%	42.0%	42.3%	50.7%	38.6%
Your org	30.7%	28.8%	35.6%	50.7%	36.4%
Average	31.2%	32.2%	32.4%	40.9%	30.5%
Worst	21.1%	21.0%	25.3%	28.4%	20.4%
Responses	1,009	1,269	1,505	1,593	1,696

Q11d
In the last three months have you ever come to work despite not feeling well enough to perform your duties?



	2017	2018	2019	2020	2021
Worst	65.1%	63.2%	61.8%	52.3%	58.5%
Your org	57.6%	55.5%	55.0%	39.6%	46.5%
Average	56.9%	56.2%	55.8%	45.5%	52.6%
Best	49.8%	50.3%	48.0%	39.6%	45.3%
Responses	999	1,237	1,497	1,595	1,692

How do we compare across the region?

Summary across Regions

Region	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
East of England	7.1	5.8	6.6	5.8	5.1	6.0	6.5	6.7	5.7
London	7.2	5.9	6.7	5.9	5.5	6.0	6.7	7.0	5.7
Midlands	7.2	5.8	6.7	5.9	5.3	6.0	6.6	6.8	5.8
North East and Yorkshire	7.3	5.9	6.7	6.0	5.3	6.0	6.6	6.8	5.8
North West	7.3	5.9	6.7	6.0	5.1	6.0	6.6	6.8	5.8
South East	7.3	6.0	6.8	6.0	5.4	6.2	6.7	6.9	5.8
South West	7.3	5.9	6.7	5.9	5.2	6.1	6.7	6.9	5.8
Difference across Regions	**0.2**	**0.2**	**0.2**	**0.2**	**0.4**	**0.2**	**0.2**	**0.3**	**0.1**
National Scores	**7.2**	**5.9**	**6.7**	**6.0**	**5.3**	**6.0**	**6.6**	**6.8**	**5.8**

Mental Health & Learning Disability and Mental Health, Learning Disability and Community Trusts

Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts	Promise 1: We are compassionate and inclusive	Promise 2: We are recognised and rewarded	Promise 3: We each have a voice that counts	Promise 4: We are safe and healthy	Promise 5: We are always learning	Promise 6: We work flexibly	Promise 7: We are a team	Staff Engagement	Morale	BENCHMARKING AVERAGE		
National Benchmarking Minimum	7.1	5.9	6.4	5.8	4.8	6.1	6.6	6.5	5.5			
National Benchmarking Maximum	7.9	6.8	7.4	6.6	6.1	7.1	7.4	7.4	6.5	ABOVE	SAME	BELOW
National Benchmarking Average	7.5	6.3	7.0	6.2	5.6	6.7	7.1	7.0	6.0			
Derbyshire Healthcare NHS Foundation Trust	7.8	6.6	7.2	6.6	5.8	7.1	7.3	7.3	6.5	9	0	0
Lincolnshire Partnership NHS Foundation Trust	7.8	6.8	7.3	6.5	6.0	6.9	7.3	7.3	6.5	9	0	0
North Staffordshire Combined Healthcare NHS Trust	7.8	6.8	7.3	6.5	6.1	7.1	7.4	7.4	6.5	9	0	0
Midlands Partnership NHS Foundation Trust	7.7	6.6	7.3	6.5	6.0	6.7	7.2	7.3	6.3	8	1	0
Northamptonshire Healthcare NHS Foundation Trust	7.7	6.5	7.3	6.4	5.8	6.9	7.1	7.3	6.3	8	1	0
Leicestershire Partnership NHS Trust	7.5	6.3	7.0	6.2	5.7	6.8	7.0	7.0	6.0	2	6	1
Coventry and Warwickshire Partnership NHS Trust	7.5	6.3	6.9	6.2	5.6	6.7	7.0	7.0	6.0	0	7	2
Herefordshire and Worcestershire Health and Care NHS Trust	7.5	6.3	7.0	6.2	5.5	6.6	6.9	7.0	6.0	0	6	3
Black Country Healthcare NHS Foundation Trust	7.4	6.3	6.9	6.2	5.4	6.7	6.9	6.9	6.0	0	4	5
Birmingham and Solihull Mental Health NHS Foundation Trust	7.2	6.1	6.8	6.1	5.6	6.4	6.9	7.0	6.0	0	3	6
Nottinghamshire Healthcare NHS Foundation Trust	7.4	6.2	6.8	6.2	5.4	6.6	6.9	6.9	6.0	0	2	7
Above Benchmark Average	5	5	5	5	6	5	4	5	5			
Same as Benchmark Average	3	4	2	5	2	3	1	4	6			
Below Benchmark Average	3	2	4	1	3	3	6	2	0			
Midlands Minimum	7.2	6.1	6.8	6.1	5.4	6.4	6.9	6.9	6.0			
Midlands Maximum	7.8	6.8	7.3	6.6	6.1	7.1	7.4	7.4	6.5			

We are one of only 3 Trusts to score above average across all nine categories across the region in comparison to other mental health and learning disbaility trusts.

Simlarly the table below highlights the engagement and morale scores and despite a small decrease from 2020, we remain in the top of the trusts for both categories.

Community Trusts and Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts Note: Each organisational type cannot be compared so Mental Health and Learning and Disability Trusts cannot be compared to Community Trusts or Combined Trusts.	Staff Engagement			Morale		
	2021	2020	Difference Range = 0 to 0.3	2021	2020	Difference Range = 0 to 0.4
Birmingham and Solihull Mental Health NHS Foundation Trust	7.0	7.1	-0.1	6.0	6.2	-0.2
Birmingham Community Healthcare NHS Foundation Trust	6.7	6.9	-0.2	5.6	5.9	-0.3
Black Country Healthcare NHS Foundation Trust	6.9	7.1	-0.2	6.0	6.1	-0.1
Coventry and Warwickshire Partnership NHS Trust	7.0	7.0	0	6.0	6.2	-0.2
Derbyshire Community Health Services NHS Foundation Trust	7.3	7.4	-0.1	6.3	6.5	-0.2
Derbyshire Healthcare NHS Foundation Trust	7.3	7.4	-0.1	6.5	6.7	-0.2
Dudley Integrated Health and Care Trust	7.0			6.2		
Herefordshire and Worcestershire Health and Care NHS Trust	7.0	7.1	-0.1	6.0	6.2	-0.2
Leicestershire Partnership NHS Trust	7.0	7.0	0	6.0	6.0	0
Lincolnshire Community Health Services NHS Trust	7.2	7.5	-0.3	6.1	6.4	-0.3
Lincolnshire Partnership NHS Foundation Trust	7.3	7.4	-0.1	6.5	6.6	-0.1
Midlands Partnership NHS Foundation Trust	7.3	7.3	0	6.3	6.5	-0.2
North Staffordshire Combined Healthcare NHS Trust	7.4	7.4	0	6.5	6.5	0
Northamptonshire Healthcare NHS Foundation Trust	7.3	7.5	-0.2	6.3	6.5	-0.2
Nottinghamshire Healthcare NHS Foundation Trust	6.9	7.1	-0.2	6.0	6.3	-0.3
Shropshire Community Health NHS Trust	7.1	7.2	-0.1	5.8	6.2	-0.4

How do we compare across Joined Up Care Derbyshire:

Joined Up Care Derbyshire	Promise 1: We are compassionate and inclusive	Promise 2: We are recognised and rewarded	Promise 3: We each have a voice that counts	Promise 4: We are safe and healthy	Promise 5: We are always learning	Promise 6: We work flexibly	Promise 7: We are a team	Staff Engagement	Morale	BENCHMARKING AVERAGE ABOVE	SAME	BELOW
Chesterfield Royal Hospital NHS Foundation Trust	7.7	6.3	7.1	6.1	6.0	6.5	7.0	7.2	6.1	9	0	0
Derbyshire Community Health Services NHS Foundation Trust	7.8	6.5	7.3	6.4	5.9	6.8	7.1	7.3	6.3	9	0	0
Derbyshire Healthcare NHS Foundation Trust	7.8	6.6	7.2	6.6	5.8	7.1	7.3	7.3	6.5	9	0	0
University Hospitals of Derby and Burton NHS Foundation Trust	7.2	5.8	6.7	5.9	5.1	6.0	6.5	6.9	5.8	3	4	2

Celebrating the achievements

Our results are strong and compare positively against our comparator organisations. Where there are downward trends from last year, the majority of these are in line with other organisations and a reflection of the continued difficult circumstances we've all been working and living through.

The key areas emerging from the feedback, which is of particular cause for celebration are:

- Strong positive feedback in all questions relating to people feeling comfortable in raising concerns and feeling confident that these concerns (including about safe clinical practice) will be heard and acted upon. Equally, people are confident that patient concerns are acted upon. All questions relating to this area have increased consistently and significantly since 2017.
- Reporting a big increase from 2017 to now (from 51.6%), 64.5% of respondents stated that people feel Derbyshire Healthcare acts fairly with regard to career

progression / promotion, regardless of ethnic background, religion, sexual orientation, disability or age.
- Colleagues reported the highest positive response rate in the sector to the questions 'I achieve a good balance between my work life and home life' (64.9%) and 'I have a choice in deciding how to do my work' (70.9%)
- While both the engagement and morale scores have decreased since 2020, they are both above our 2019 scores and significantly above our comparator median, with us equalling the leading score for 'morale'.

Areas to focus on:

While we do have strong results, there are some areas we need to interrogate further as the data flags emerging concerns around:

- Involvement in changes and improvements within work area / team / department, and the ability to make changes to work
- Staffing levels – this may be due to the challenges in recruitment were being felt over the period of the survey being completed, whilst we have now moved to a better position on recruitment, we need to use team level data (when available) to triangulate this question against vacancies and safer staffing intelligence
- Whilst we scored well on the safe and healthy theme, we also know that we have had increased staff coming into work despite not feeling well enough. Again being able to look at this question at team level will support further work and ensure we focus on supporting colleagues with their health and wellbeing

On the questions related to discrimination, bullying and harassment and violence and aggression, although we score favourably compared with our comparators, we still have some reports of physical violence from colleagues (22 respondents) and managers (10 respondents). There were also reports of harassment, bullying or abuse at work from managers (119) and colleagues (237). We need to interrogate all this data further once we receive more detailed information to look for any trends or 'hot spots', triangulating with intelligence from FTSU, Datix and employee relations.

Next steps

- Results have been released later than usual this year and we are still awaiting further reports that will allow a deeper focus on key themes, trends and team level analysis
- Further reports are expecting early May
- NHS Coordination Centre free text comments are expected May
- Deep dive reports on WRES and WDES and protected characteristic data are also due May
- Once all reports received engagement at team level and support to leaders will be a key focus to ensure leaders understand, share and work with teams to develop their own focus areas.
- Recognise that we haven't been able to focus on developing work on the response rate since the last survey due to COVID and Mandatory Vaccination

work however it is important that we return to this – we have colleagues who we haven't heard from and we need to understand why and what their thoughts are

- Reporting progress will be via the People and Culture Committee.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 10 May 2022

Quality Report – 'Caring'

Purpose of Report

This paper provides the [Trust Board with a focused report on 'Caring' as part of the wider expanded quality reporting relating to CQC (Care Quality Commission) domains and NHS Improvement requirements. It is written to aid strategic discussion on how best to improve our outcomes for those who use our services.

Executive Summary

Caring covers a wide range of measures. This is a summary of the areas and the Trust's current levels of performance and the future direction of travel.

The key lines of enquiry for caring are presented with benchmarking evidence, independent evidence from surveys or externally verified information from the CQC.

The report shows evidence that the Trust has achieved strong compliance and internal and external assurance. This is demonstrated by the retention of the Trust's wide overall 'good' rating in this area.

At the last Trust wide inspection, nine core services all were rated good and two services were rated. Our objective in 2021/22 was to maintain this performance.

The Trust has achieved solid community survey benchmark information and feedback on all of its services up until the pandemic period, with some deterioration.

Since the last caring report was submitted to the Board in June 2020, the Trust's strategy has been revisited and now includes more specific focus on patient experience and the introduction of a shared governance model for patients with the Carers Forum as a mirror image to the Staff Forum which has been very well received and is growing.

The 'Equal' forum is fully operational and implementing the best practice evidence in co-production and emerging models of shared governance.

The Trust has reached a strong performance in benchmarking, in responsiveness and is performing just above the national average. This has deteriorated when compared to previous exceptional performance. The organisation has additionally made solid headway in the Family and Friends Test Trust wide feedback. There are, however, some areas of further additional attention to ensure consistency and performance in the standards we have grown to expect from Derbyshire Healthcare services.

The aspiration to offer good services as defined by the Trust and by our Health Regulator in this domain of caring has been achieved and maintained.

Solid performance in Acute Mental Health care CQC Mental Health visits and above average performance is noted in the very recent acute care in-patient survey and should be commended.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	

Assurances

- The consideration of the use of caring has positive assurances which are well evidenced.
- In the last report, gaps in controls in quality improvement were references, the Trust has an active Quality improvement strategy and implementation plan.

Consultation

The content of the reports has been collected from the Quality and Safeguarding Committee information, Divisional Achievement reviews and Trust information.

Governance or Legal Issues

The NHS is founded on a common set of principles and values that bind together the communities and the people it serves – patients and public – and the staff who work for it. The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions.

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

This paper explores the domain of caring at a whole Trust level, rather than by patient or staff groups who may have protected characteristics.

However, the Board will be aware that there are known equality, diversity and inclusion issues that will adversely affect some of the measures. For example, the ability to access services and have them adapted to fit your needs will directly impact upon these groups.

The Trust is working hard to improve these factors, but there is work still to do to ensure services are able to meet current or emerging national access targets.

Recommendations

The Board of Directors is requested to:

1) Consider and confirm the levels of assurance as rated by the CQC as 'good.' Furthermore, consider the current priorities for quality improvement in the domain of Caring and achievements in this area
2) Confirm the level of assurance obtained on the areas presented. It is suggested that significant assurance continues to be achieved. A gap in control is specifically noted with regard to dormitory accommodation.

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

Quality Report – Caring

Policy and regulatory context

The formal legal duties under this domain are as follows:

Caring covers a wide range of measures. The key lines of enquiry (KLOE) for caring are:

KLOE C1- Kindness, Respect and Compassion

The measures for this area are the Trust's training in equality and diversity and patient feedback on caring as per our community and in-patient survey and any questionnaires or service visits in our comprehensive inspection.

In addition, CQC (2020) patients and carers said

"Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. There was good engagement with patients and carers in the transformational plans for clinical services."

"Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs."

"Physical needs were important as mental health needs."

"Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided."

"They ensured that patients had access to advocates when needed."

"Staff informed and involved families and carers appropriately."

"Staff ensured that people's communication needs were understood, sought best practice and learnt from it."

"The Trust had created a website that enabled the patient or family to access information in another language this website was accessed via the patient's mobile phone via a quick response code."

In 2022, this pattern has continued and our DEED scheme every week is overflowing with service user and carer feedback on Trust services.

I have chosen some particular extracts to demonstrate the lived experience of our services. The number of service user and family feedback through the DEED scheme is increasing. This is a sustained change and is a great insight into our culture changes and how valued the feedback form people who experience our services is to our people working within our organisation.

Registered Nurse, Midway and Dovedale Day Services
Service User Feedback

"*After an appointment today the patient and their spouse asked to leave their compliments to say how 'absolutely lovely' Lauren had been. Their written feedback reads: "We had a meeting today with Lauren. She was very helpful, kind, patient and informative. We felt she really empathised with us.'"*

Individual Peer Support Worker, Work Your Way team
Service User Feedback

"*Michael has been working with a client who sent in some lovely feedback: Today was probably the best day out of the list of good days I've had with Michael. Prior to today's meeting, I told Michael I had found a job to apply for and the desire to return to work was getting much stronger as I felt more confident with the various coping mechanisms that he's taught me. I told him I needed to make a new CV and he suggested that I made a CV for today's meeting and we apply for the job together. The really cool aspect of this was that he said we should apply as a test to see if I really did feel ready. The reason he said this was because I told him that it was impossible to know how I'd feel until I did something. It's okay thinking you're ready to go back but going back could be too soon and it's a massive worry about how that could affect me. It just felt like a really clever step to transition across. I just want to say a massive thank you to Michael – without him I wouldn't be as far along as I am now. I genuinely felt quite emotional today applying for the job. To be in a place to want to work and to be thinking this way and applying feels incredible, and Michael has played a big part in helping me get there! Wonderful chap, wonderful service! Thank you, thank you, thank you.'"*

Recreational Worker, The Hub, Hartington Unit
Service User Nomination

"Julie is a truly amazing person; she is trustworthy and has never judged me no matter what I did. With your support and guidance, Julie, I'm leaving with a positive future. I wish I could show you how much you have helped me and how much you have increased my self-esteem. You have saved my life and I'm sure you have saved many others and continue to do so. Don't ever stop being you. I feel everyone needs a Julie in their life, you truly are a real-life angel."

Health Care Assistant, Morton Ward, Hartington Unit
Service User Nomination

"During a shift with a number of staff who were quite new to the ward, Chris ensured that the ward was working as it should be and found the time to spend quality time with patients."

This is not only through our DEED schemes, in two CQC inspection visits in 2022. The feedback was.

The Enhanced Care Ward
Patient feedback

"*Patients spoke positively about the ward staff; they described the staff as caring, helpful and approachable. They felt there was enough staff on the ward to meet their needs."*

"Patients spoke positively about the range of activities on offer. They told us about how the occupational therapist and recreational worker supported them with learning new skills and relearning skills."

"Patients told us they could maintain contact with family and carers. Family and carers visits took place face to face. Patients also had access to their own mobile phone and the internet. The trust provided free Wi-Fi access."

"Patients spoke positively about the food. They told us they had access to snacks and hot and cold drinks throughout the day."

Carer feedback

"*The carer was overwhelmingly positive about the care and treatment. They described staff as 'brilliant', 'excellent' and 'really understood the patient's specific needs."*

"They knew how to contact the ward. They visited the patient on the ward and staff exercised flexibility with visiting times."

"They have attended meetings and involved in decisions including discharge planning. They described the Doctor as 'brilliant' and 'explained treatment fully."

Ward 33

Patient feedback

"Patients were overwhelmingly positive about the ward staff. They described the staff as 'amazing' 'good' and 'helpful'. Some patients felt the ward was sometimes short-staffed, and this meant there were delays in accessing the laundry room for example."

"Patients sleeping in dormitories told us they had privacy curtains and felt safe. They did not raise any concerns about their sleeping arrangements."

"Patients were complimentary about the food. They felt there was plenty of choice and portions sizes were good."

"Patients told us there was a range of activities on offer and enjoyed using the recreational room on the ward. This contained art material, access to karaoke and other activities."

"Patients were aware of who their named nurses were and told us they had regular one-to-one sessions. They told us they were involved in developing their care plans and received copies."

"Patients knew who their responsible Clinician was and told us they attended their ward rounds. They felt the Doctor listened."

"Patients were aware of what medication had been prescribed. They told us they had been involved in discussions about their medication."

"Patients could maintain contact with their friends and family. They had access to their own mobile phones and could meet family and friends on the ward."

Carer feedback

"Carers knew how to contact the ward. They described staff as responsive, helpful and approachable. One carer described the ward environment as 'warm and nurturing.'"

"Staff provided regular updates to carers."

"Carers were able to visit patients face to face on the ward and keep in touch by telephone."

"Carers felt included and involved in care and treatment decisions. They were invited to meetings including discharge meetings."

This information correlates with the National Benchmarking information on the Trust's services, which, at this time remains with solid performance.

Our Community Mental Health Survey 2021

Our in-patient survey (2021/22)

The survey is a small sample but shows solid improvement across the Board. With one area of significant concern.

INTRODUCTION TO THE WARD

Q01. When you arrived on the ward, did staff make you feel welcome?	RXM - 2021		2021 All	
* Yes	35	85%	384	82%
* No	6	15%	87	18%
Can't remember	13	24%	105	18%
Missing	1		11	

Q02. When you arrived on the ward, did you feel that the staff knew about you and any previous care you had received?	RXM - 2021		2021 All	
* Yes, definitely	12	25%	127	26%
* Yes, to some extent	14	29%	198	41%
* No	22	46%	156	32%
Don't know / can't remember	7	13%	94	16%
Missing	0		12	

Q03. When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine of the ward, such as times of meals and visiting times?	RXM - 2021		2021 All	
Yes	24	44%	219	39%
Yes, to some extent	19	35%	171	30%
No	12	22%	172	31%
Missing	0		25	

INTRODUCTION TO THE WARD

Q04. Were you able to keep in touch with your family and friends during your stay?	RXM - 2021		2021 All	
* Yes, always	33	63%	294	54%
* Yes, Sometimes	18	35%	214	40%
* No, never	1	2%	32	6%
I did not need / want to keep in touch	2	4%	22	4%
Don't know / can't remember	1	2%	8	1%
Missing	0		17	

Q05. Did you get enough help from staff to keep in touch with your family and friends?	RXM - 2021		2021 All	
* Yes, always	26	57%	235	47%
* Yes, Sometimes	13	28%	190	38%
* No, never	7	15%	80	16%
I did not need / want to keep in touch	5	9%	44	8%
Don't know / can't remember	4	7%	22	4%
Missing	0		16	

There are areas of concern that are important to note to take into account within the Trust strategy and in future planning.

Although excellent feedback on food, sleeping at night and disturbance is a significant issue for our organisation.

In October 2020, the Government pledged to:

To remove the outdated dormitories, as part of the Government's record investment in NHS infrastructure. Announcing the first 21 NHS Trusts that will receive funding to replace out-of-date mental health dormitories with single en-suite rooms, to help improve care for mental health inpatients across the country.

The Government went on to state the eradication of dormitories will improve the individual care that can be given to patients, allowing them to reduce the length of their stay in the facility. It will also have benefits for patient safety including through better infection control and by reducing the risk of incidents involving patients or staff.

This new funding delivers on the Government's commitment to accelerate investment in health infrastructure and to level up access to Mental Health services, so that every inpatient can receive treatment in an appropriate setting.

As the Board and the public is aware, Derbyshire Healthcare, unfortunately has one of the highest levels of dormitory stock in the country and we continue to work in implementing our Estates strategy and our commitment to transform our Estate through the eradication of dormitory wards in Acute care.

As an organisation, we have achieved the successful completion of Ward 1 to the Tissington service at Kingsway, which reduced our dormitory wards.

We continue to work towards full dormitory eradication for our community and to rectify this finding in our in-patient survey.

INTRODUCTION TO THE WARD

Q06. Were you ever prevented from sleeping at night by any of the following?	RXM - 2021		2021 All	
Noise from other patients	34	62%	282	48%
Missing	21		365	
Noise from staff	20	36%	156	27%
Missing	35		431	
Hospital lighting	18	33%	180	31%
Missing	37		407	
Something else	11	20%	109	19%
Missing	44		478	
None of these	12	22%	182	31%
Missing	43		405	

Q07. Were you offered food that met any dietary needs or requirements you had?	RXM - 2021		2021 All	
* *Yes, always*	*28*	*76%*	*226*	*61%*
* *Yes, Sometimes*	*4*	*11%*	*96*	*26%*
* *No, never*	*5*	*14%*	*49*	*13%*
I did not have any dietary needs or requirements	18	33%	185	33%
I did not have any hospital food	0	0%	9	2%
Missing	0		22	

As we are aware, it is not only Trust Board members who champion these issues.

The CQC has warned that "patients and carers have an overwhelmingly negative opinion of shared sleeping arrangements. They are concerned about disturbed sleep, lack of privacy, risk to personal safety and of theft of possessions."

The Care Regulator made clear in a report in 2018 that "in the 21st century, patients, many of whom have not agreed to admission, should not be expected to share sleeping accommodation with strangers, some of whom may be agitated."

The CQC and the Trust Board are also joined by experts who undertook a review of Modernising the Mental Health Act

Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983 December 2018

The Government and the NHS should commit in the forthcoming Spending Review to a major multi-year capital investment programme to modernise the NHS Mental Health Estate.

- *All existing dormitory accommodation should be updated without delay to allow patients the privacy of their own room.*

- *The definition of single sex accommodation should be tightened up to ensure a genuinely single sex environment with separate access to any shared daytime space*

NHS Benchmarking on Overall Patient Experience

This is a reduced level of performance for our organisation. However, it is still within acceptable levels, if not at our previous level of exceptional performance in this area, where we were functioning at the third highest in the country.

Organisationally we will seek to recover our position as we exit the pandemic period.

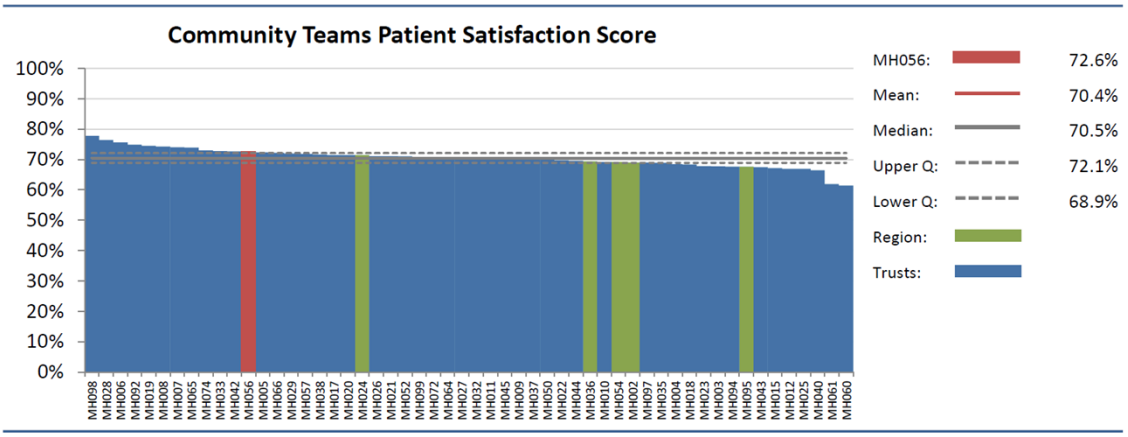


Figure 85

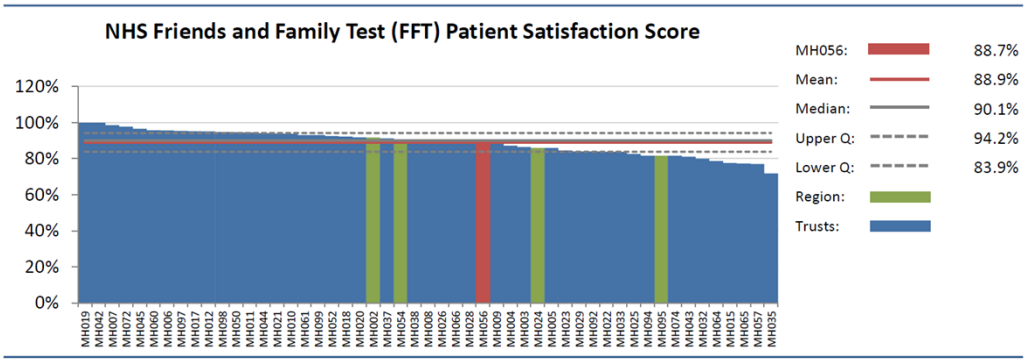


Figure 86

Other new developments related to feedback and Patient Experience

Introduction of CHAT Health

CHAT Health is a secure and confidential text messaging service for parents and young people across Derby City as part of our 0-19 service offer. It allows people to easily get in touch with a healthcare professional for advice and support. Those making contact do not have to give a name, if they do not want to, but are still able to send a message to get advice or to chat with a healthcare professional about any worries. We have implemented CHAT Health to improve access to Health Visitors and school Nurses, with the aim of addressing some of the health inequalities relating to young males and diverse groups within our communities accessing our primary care services. As CHAT Health is open to the public and the person does not need to be under any DHCFT services, texts from the public are sent relating to physical and mental health, parental / infant health as well as other topics.

We can then signpost people to the right information or provide a follow up via a 1-1 appointment if needed. This provides a positive approach to accessibility and bridging the gap of inequalities.

The feedback is very positive and remains a highly response and valued support service.

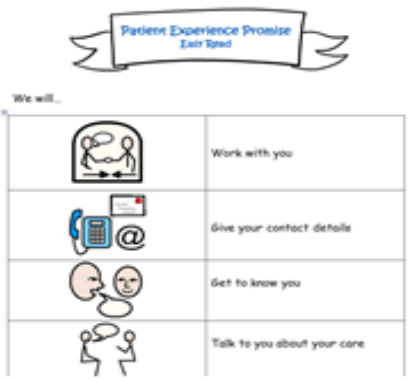
Organisation/Service	Launch Date	Number of Service Users (000's)	Number of Conversations Opened	Number of Conversations Opened (per 000 SUs)	Number of Messages Received
Leicestershire Partnership NHS Trust	Mar-2014	197	819	4.16	3522
Derbyshire Healthcare NHS Foundation Trust	Jul-2020	58	202	3.48	822
South Warwickshire NHS Foundation Trust	May-2016	76	156	2.05	597
Cambridgeshire Community Services NHS Trust	May-2015	472	851	1.8	3647
Nottingham City Care Partnership	Apr-2020	64	111	1.73	573
Devon County Council	Apr-2018	135	230	1.7	584
Local	Apr-2019	99	128	1.29	539
Sussex Community NHS Trust	Apr-2016	52	57	1.1	149
Midlands Partnership NHS Foundation Trust	Sep-2021	243	166	0.68	648
Nottinghamshire Healthcare NHS Foundation Trust	Jul-2016	171	100	0.58	636
Bolton NHS Foundation Trust	Sep-2019	73	23	0.32	92

Embedding of the Mental Health Helpline

The Mental Health Helpline continues to be very active and well regarded. The introduction of the Helpline during the pandemic has supported the increase in patient acuity and activity. The Mental Health Helpline provides an additional tool for people to access alongside clinical care teams over the 24-hour, 7 day a week period and provides access to a variety of professionals. This service has supported people into services as well as reduce the waiting time people face in discussing their concerns and in turn prevent crisis occurring. Furthermore, for those already in our care, it has provided another service for them to access out of hours when their care team may not be available.

Overall, the Trust is rated as “good”. The feedback from the CQC was very positive “there was good management of complaints and there was an increase in compliments.” “There were clear responsibilities at every level in the Trust for the management, investigation and response to complaints.”

We have developed and delivered new Patient and Carer promises to set standards of what to expect. These have been positively received.



Development of Patient and Carer Promises

Making a positive difference

Patient Experience

The Patient Experience Strategy was published in 2020 and has been reviewed by the Quality and Safeguarding Committee in 2021/22. Significant progress continues and areas of improvement include:

- The EQUAL developments including feedback through 'Bright Ideas' leading to investments in ward-based activity
- Texting and feedback service
- Pathway specific tools such as Helpline
- The community mental health survey
- Up-take and impact of Family and Friends Test

These are important areas to note and areas we have specifically required to improve due to feedback.

Community Mental Health Survey and Electronic Patient Survey

To ensure that we understand the experiences and satisfaction of people who receive care and treatment in our community mental health services, we take part in the annual national Mental Health Community Service User Survey. The community survey is compulsory for all Mental Health Trusts and is conducted by external providers on behalf of the CQC. The Trust commissions an organisation called 'Quality Health', who undertake surveys on behalf of the majority of Trusts in England. In 2021, the Trust has also decided to opt into the Mental Health Inpatient Service User Survey. Although this is not a contractual obligation, it was felt this would be a good opportunity to gain feedback on our inpatient services to further develop them.

These national surveys are used to find out about the experience of service users receiving care and treatment from all healthcare organisations and Mental Healthcare providers. Our results were published in November 2021.

Responses were received from 374 people who received community mental health services from our Trust. There was a decrease in sample size in comparison to last year by 20. Questions are grouped under headings with a score and comparison given for the overall heading and then individually for sub-headings. All the headings (blue sections) can be found in the table below, together with some of the sub-section scores (white sections); the complete table can be found on the CQC website.

Key:

Better:	The Trust is better for that particular question compared to most other Trusts that took part in the survey
About the same:	The Trust is performing about the same for that particular question as most other Trusts that took part in the survey
Worse:	The Trust did not perform as well for that particular question compared to most other Trusts that took part in the survey

For all sections, the Trust is performing about the same as most other Trusts that took part in the survey. However, scores higher in three questions. For five individual score, the Trust is scoring worse than most other Trusts.

Top & Bottom Five Questions

This section of the report summarises your organisation's highest and lowest scoring results for the current year across the entire survey.

	Top 5 Questions	Score
12.	Do you know how to contact this person if you have a concern about your care?	97.4%
13.	How well does this person organise the care and services you need?	85.7%
26.	In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines?	80.9%
37.	Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	80.9%
18.	Did you feel that decisions were made together by you and the person you saw during this discussion?	80.6%

	Bottom 5 Questions	Score
38.	Aside from in this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?	13.1%
34.	In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?	31.9%
33.	In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	39.4%
32.	In the last 12 months, did NHS mental health services support you with your physical health needs?	41.5%
3.	In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	55.1%

Your Care and Treatment

The scores in this section have largely remained the same from the previous years. This section focuses on people using our service feeling that they have had the right amount of contact. With the challenges of the COVID-19 pandemic, face-to-face contact has been reduced until recently. As a result of this, it is positive for the results to remain similar to the previous year.

	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2021		
					Number of Respondents	Score	RAG Rating
3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	47.6%	55.1%	62.7%	65.3%	344	55.1%	
4. In the last 12 months, were care and services available when you needed them?	57.9%	64.4%	71.4%	76.2%	323	67.8%	
5. Were you informed how the care and treatment you were receiving would change due to the coronavirus pandemic?	52.7%	62.3%	68.2%	72.5%	308	65.9%	

Your Health and Social Care Workers

The score for this section has remained the same since last year. Questions in this section ask about having enough time with the person leading their care, that person having enough of an understanding of their needs and their treatment history.

	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2021		
					Number of Respondents	Score	RAG Rating
7. Were you given enough time to discuss your needs and treatment?	62.9%	68.1%	74.8%	79.3%	337	71.2%	
8. Did the person or people you saw understand how your mental health needs affect other areas of your life?	59.3%	65.9%	71.9%	75.9%	332	65.9%	
9. Did the person or people you saw appear to be aware of your treatment history?	58.5%	66.6%	72.3%	78.3%	326	68.7%	

Organising Your Care

The score for this section has increased since last year. This section explores if a person knows who oversees organising their care, how well they do that and do they know how to contact them.

	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2021		
					Number of Respondents	Score	RAG Rating
10. Have you been told who is in charge of organising your care and services?	61.7%	68.1%	76.9%	91.0%	281	69.7%	
12. Do you know how to contact this person if you have a concern about your care?	93.9%	95.5%	97.9%	99.0%	190	97.4%	
13. How well does this person organise the care and services you need?	77.9%	80.6%	84.9%	88.1%	196	85.7%	

Planning Your Care

Overall, this section has remained the same since last year. This section asks about someone's engagement in planning their own care. This is an area that the Trust is focused on improving within the upcoming year, linked to the changes in CPA, move to SystmOne and developments within the community Mental Health Framework and Living Well Project.

	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2021		
					Number of Respondents	Score	RAG Rating
14. Have you agreed with someone from NHS mental health services what care you will receive?	51.0%	56.5%	62.9%	70.5%	347	58.3%	
15. Were you involved as much as you wanted to be in agreeing what care you will receive?	66.6%	70.6%	74.5%	80.1%	257	71.3%	
16. Does this agreement on what care you will receive take into account your needs in other areas of your life?	59.6%	64.2%	69.7%	72.0%	250	66.1%	

Reviewing Your Care

This section has had a decrease overall. This drop in direct contact with an NHS member of staff is directly linked to the COVID-19 Pandemic. As face-to-face contact begins to increase and return to normal this is expected to improve.

	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2021		
					Number of Respondents	Score	RAG Rating
17. In the last 12 months, have you had a specific meeting with someone from NHS mental health services to discuss how your care is working?	58.5%	63.4%	72.2%	76.0%	337	59.2%	
18. Did you feel that decisions were made together by you and the person you saw during this discussion?	70.7%	74.8%	81.1%	84.0%	193	80.6%	

Crisis Care

This section has reduced in score since last year for “would you know who to contact?” However, it has improved for receiving the help needed. With the introduction and further roll out of the Mental Health Helpline, there has been increased accessibility to services.

However, with this comes irregularity in the people who service users have contact with. The Helpline does, however, provide a wide range of Multi-Disciplinary workers and so widens the availability of the appropriate support for the service user.

	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2021		
					Number of Respondents	Score	RAG Rating
19. Would you know who to contact out of office hours within the NHS if you have a crisis?	60.2%	68.4%	79.0%	86.7%	302	65.6%	
20. Thinking about the last time you tried to contact this person or team, did you get the help needed?	51.1%	61.8%	69.5%	74.4%	145	71.0%	

Medicines

This section has improved since last year. It explores if people have been involved in decision making regarding their medicines, have they had side effects explained and have they had their medicines reviewed**?**

	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2021		
					Number of Respondents	Score	RAG Rating
22. Has the purpose of your medicines ever been discussed with you?	72.6%	75.4%	80.2%	82.9%	294	79.0%	
23. Have the possible side effects of your medicines ever been discussed with you?	51.8%	55.3%	61.2%	67.6%	291	60.4%	
26. In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines?	66.7%	71.8%	79.4%	86.0%	240	80.9%	

NHS Therapies

This section has generally remained 'About the Same' as other Trusts. This section asks questions about being involved in decisions about which therapy to access and explanations of the therapy.

	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2021		
					Number of Respondents	Score	RAG Rating
28. Were these NHS talking therapies explained to you in a way you could understand?	73.6%	77.7%	83.0%	89.5%	84	80.3%	
29. Were you involved as much as you wanted to be in deciding what NHS talking therapies to use?	59.2%	65.5%	72.7%	85.4%	81	71.1%	

Support and Wellbeing

This section explores people's feelings regarding how well supported they are with their physical health and employment. This has generally declined within the last year and presents as the area with the most negative feedback. Developments within the Trust to improve the offer of training or employment is underway as the Trust works alongside IMROC and HEE to support service users into education in preparedness for employment.

	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2021		
					Number of Respondents	Score	RAG Rating
32. In the last 12 months, did NHS mental health services support you with your physical health needs?	35.8%	42.1%	51.9%	58.3%	170	41.5%	
33. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	26.7%	36.7%	43.8%	49.4%	171	39.4%	
34. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?	22.9%	34.5%	44.6%	54.5%	72	31.9%	
35. Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?	54.2%	61.0%	68.5%	74.6%	239	63.0%	

Overall Experience

This section has largely remained the same. However, presents a drop in relation to service user and carer feedback. The implementation of the electron patient survey as well as further developments into face-to-face feedback are expected to improve this section through the year.

	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2021		
					Number of Respondents	Score	RAG Rating
36. Overall experience?(Scale score from 0-10. 0 = "I had a very poor experience", 10 = "I had a very good experience").	59.7%	66.6%	71.2%	74.8%	341	68.5%	
37. Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	76.8%	80.7%	85.2%	88.7%	354	80.9%	
38. In the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?	12.3%	14.7%	23.3%	32.1%	300	13.1%	

Compliments, Complaints and Concerns

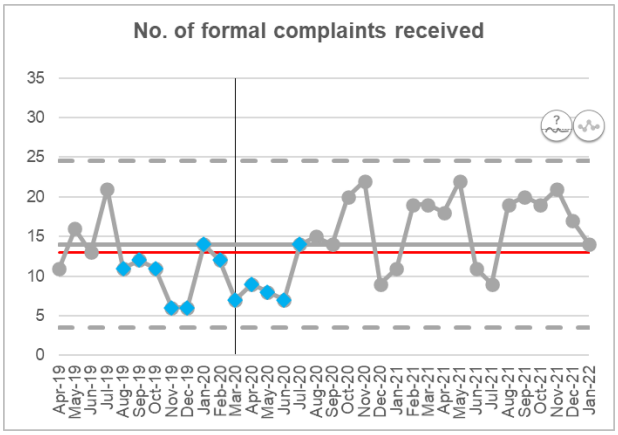
The Trust's Patient Experience Team is the central point of contact for people to provide feedback and raise concerns about the services provided by the Trust. The team sits within the Nursing and Patient Experience directorate. The team's aim is to provide a swift response to concerns or queries raised and to ensure a thorough investigation takes place when required, with complainants receiving comprehensive written responses including being informed of any actions taken.

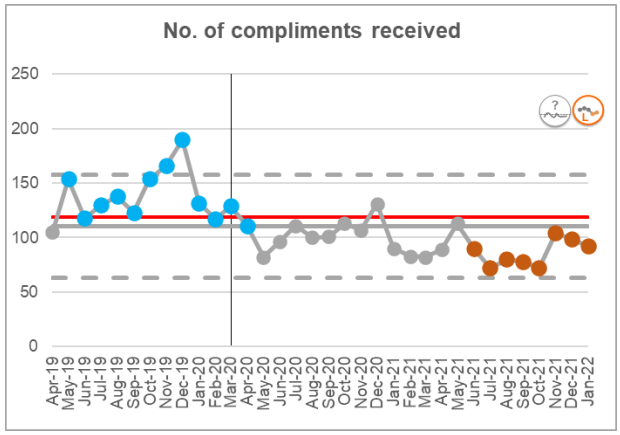
2021-2022 has been a challenging year, due to the COVID-19 pandemic, with pressure experienced by all teams across the Trust. The Patient Experience Team worked with operational teams and people contacting their service to ensure that the best outcomes have been achieved in the timely manner. Our progress throughout the year is monitored and reported on in quarterly reports to the Patient Experience Committee and Quality Committee.

Comparison of Contacts Through the Year

	2019-20	**2020-21**	**2021-22**
Complaints	140	167	175
Compliments	1659	1207	893
Concerns	581	482	443
Enquiries	59	743	1171
Total	**2439**	**2599**	**2682**

Complaints are issues that need investigating and require a formal written response from the Trust. Investigations are co-ordinated through the Patient Experience Team. Concerns can be resolved locally and require a less formal response. This can be through the Patient Experience Team or directly by staff at ward or team, level within our services. The number of recorded enquiries has risen significantly during 2020/21. A high number were related to the COVID-19 pandemic, including vaccinations and other issues not managed by our Trust.





Parliamentary and Health Service Ombudsman

During the year, the Trust discussed five cases with the Parliamentary and Health Service Ombudsman. In four of the cases, no further action was required. One required further response. However, this was dealt with and resolved at the time.

Comparison of Concerns, Complaints and Compliments by Top Issues Raised

The most common form of concern raised in 2021-2022 was in relation to the availability of services /activities/therapies, which was the same issue highlighted in 2019-20. During 2021-22, this reflected the closure/changes to services during the COVID-19 pandemic. Issues regarding care planning were the most common reason for making a complaint in 2019/20 and in 2020/21 and in 2021/22.

Top 3 issues raised in Concerns	
2019-20	260
Availability of Services / Activities / Therapies	110
Care planning	88
Appointments (e.g. delays and cancellations)	62
2020-21	245
Availability of Services / Activities / Therapies	104
Care planning	87
Other	54
2021-22	266
Availability of Services / Activities / Therapies	108
Care planning	107
Other	51
Total	**771**

Top 3 issues raised in Complaints	
2019-20	70
Care planning	33
Abruptness / Rudeness / Unprofessionalism	19
Information provided	18
2020-21	133
Care planning	70
Abruptness / Rudeness / Unprofessionalism	39
Availability of Services / Activities / Therapies	24
2021-22	164
Care planning	84
Availability of Services / Activities / Therapies	41
Abruptness / Rudeness / Unprofessionalism	39
Total	**367**

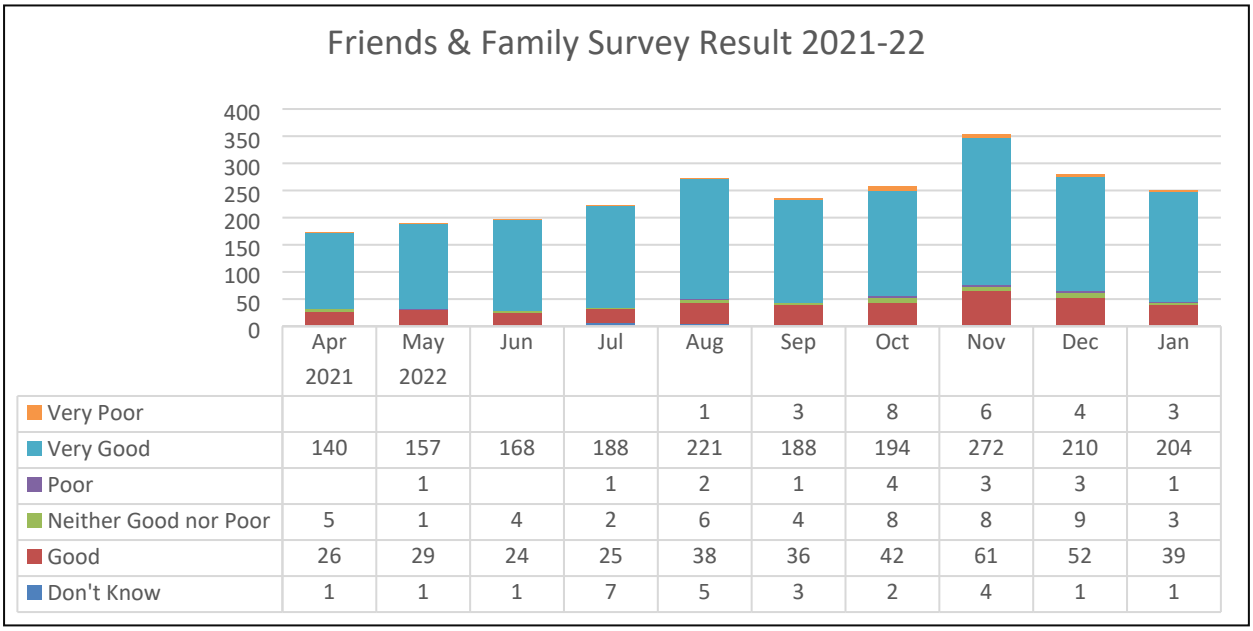
Compliments

Themes from the 4179 compliments received reflect people's gratitude for the care provided and appreciation of the support and help given, with the highest identified point being general gratitude. There has been a drop in compliments from 2019 to 2022. However, in further evaluation, this appears to be linked to the reduced number of face-to-face contacts during the COVID-19 pandemic. A large proportion of compliments are received face-to-face and so moving to electronic technology for appointments resulted in a decline in feedback. An electronic patient survey has been created and is in the process of roll out across the trust to tackle this alongside the move toward face-to-face contact being stood back up.

	2019-2020	2020-21	2021-22
Care	1033	669	539
Compassion	718	494	398
Empathy	517	338	290
Environment	305	145	125
Facilities	255	121	101
General gratitude	1060	873	633
Information/Advice	665	372	317
Kindness	846	558	472
Listening	699	444	367
Responsiveness	619	449	320
Support/Help	1036	799	585
Other - see description	82	70	32
Total	7835	5332	4179

Friends and Family Test

The Friends and Family Test asks people, if they would recommend the services, they have used to others who are close to them if they were also in need of similar care and treatment. It offers a range of responses to choose from, and when combined with supplementary follow-up questions, provides an indicator of good and poor patient experience. The results of the Friends and Family Test are published each month by NHS England, and we have also incorporated the expectation of feedback where possible from the Friends and Family test into the revised Quality visit model.



	Apr 2021	May 2022	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Very Poor					1	3	8	6	4	3
Very Good	140	157	168	188	221	188	194	272	210	204
Poor		1		1	2	1	4	3	3	1
Neither Good nor Poor	5	1	4	2	6	4	8	8	9	3
Good	26	29	24	25	38	36	42	61	52	39
Don't Know	1	1	1	7	5	3	2	4	1	1

During the year, work to increase the Friends and Family Test feedback was put on hold due to the COVID-19 pandemic but re-started again during 2021-22 through the development and on-going rollout of the electronic patient survey platform. This aims to provide another level of feedback options for service users and carers to allow for more oversight of services, allowing our EQUAL forum and Clinical Operation Assurance teams to review regular data and improve services through our Quality Improvement Strategy.

KLOE C2 - Involving people in decisions about their care

We were previously rated it as 'Good' because:

- There was good carer's involvement and carers assessment in place.
- Staff knew their patients and patients gave positive feedback on the quality of care.

Previously, the Trust noted that not all patients were involved in their care plans or given copies of their care plans in the acute care service. Since 2020, we have significantly improved this performance.

In recent CQC mental health visits in 2022 and on audits, care planning has significantly improved, both in completion and quality.

Ward 33

"Patients were aware of who their named Nurses were and told us they had regular one-to-one sessions. They told us they were involved in developing their care plans and received copies."

The Trust has co-produced a Patient Experience Strategy. This was designed drawing upon the evidence in safe wards and the concept of mutual expectations and implemented a patient experience promise which has been redesigned to be pathway specific. This, in reality, is an accessible version for Learning Disability and wider Trust services and a Children and Young person version in final design.

The EQUAL People and Carers Forum is live and influencing the Trust and wider partners. The EQUAL forum have set the agenda and defined the areas they wished to received assurance on, which have included autism, psychiatry, community working age adults care, stability in psychiatry, physical health care checks and new areas are crisis responsiveness and community mental health care responsiveness to text messages from people who use our services.

The model of 'Bright Ideas'. People based 'Bright Ideas' is implemented and feedback of this model and impact is very positive.

KLOE C3 - Privacy and Dignity

We have good indicators in our Community Mental Health, Mental Health helpline feedback and improvements in our acute in-patient survey.

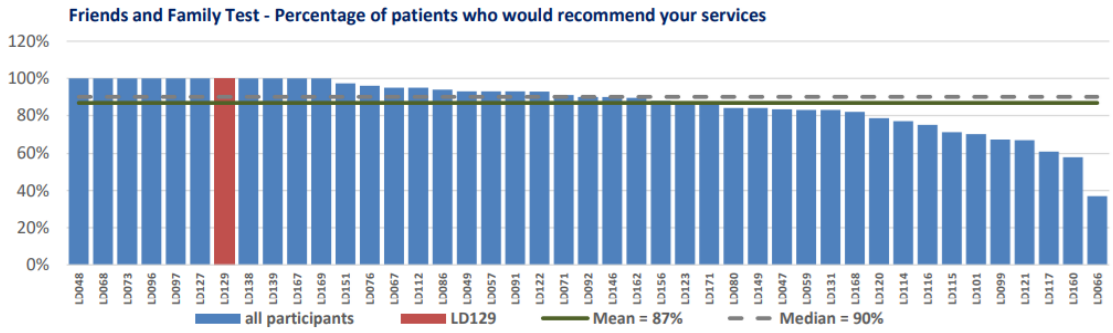
The specific measures in this area are listed as an appraisal of whether there is strong evidence in place to confirm compliance.

Incidents of breaches of confidentiality (strong evidence), compliance with data protection requirements - Staff training in IG (Information Governance) (strong evidence).

Healthwatch feedback (strong evidence and noted as a responsive organisation, number of complaints and compliments (strong evidence and patient privacy and confidentiality (strong evidence).

Learning Disability services for Derbyshire Healthcare – Percentage of patients that recommend your service against all other Learning Disability organisations. (strong evidence).

Source: NHS Staff Survey 2021



Source: NHS Friends and Family Test - test data 2020/21

In 2022 Feedback from Healthwatch Derbyshire (HWD) was:

HWD gathers experiences from patients and members of the public using a variety of methods including Engagement Officers, supported by volunteers, social media and direct feedback to HWD via telephone, website, emails, and letters.

Patient experience is fed through to Health and Care organisations throughout the year to give an independent account of what is working well, and what could be improved. Anyone who shares an experience with HWD can request a response and we encourage organisations to consider responses carefully and indicate where learning has taken place as a result of someone's experience.

When requested, the Trust (Derbyshire Healthcare NHS Foundation Trust) replies to these comments thoroughly and with rigour, setting out learning and the next steps that will follow.

During the period April 2021 - March 2022, a total of ten comments were received about the Trust. Seven of these comments related to Mental Health services and difficulties in accessing support. There was one comment from a family member of a patient, praising staff for their caring nature and giving exact information to family.

HWD also welcomes the use of the electronic patient survey platform, as a further option for gaining feedback via the Friends and Family Test, thus providing additional methods of collecting feedback in ways that are accessible to service users and carers.

HWD recognises that going forward from the Covid-19 pandemic, as services move into the recovery phase, we will have to adapt to the environment around us and adjust our methods of engaging and collecting patient feedback accordingly. This will be of importance moving forward and we will continue to provide independent feedback to the Trust to assist in shaping services in the future.

We look forward to continuing positive working relationships with the Trust in 2022/23. Healthwatch Derbyshire.

One learning from the survey was to improve our service to assist individuals back into employment and since this survey, we have been successful in securing a national bid to invest in an individual placement support service which enables individuals to recover through occupation and to employment. This service has become operational in 2019 and our feedback system has gone live in 2022.

Key improvement areas:

- Re-design and refocus Trust strategy on eradication of dormitory bed stock
- Full recovery of patient experience outcomes.

Carolyn Green
Director of Nursing and Patient Experience

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 10 May 2022

Board Assurance Framework (BAF)
Issue 1, 2022/23

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the third issue of the BAF for 2022/23.

Executive Summary

Each Director Lead has thoroughly reviewed the risks allocated to them and has also considered any new risks to the strategic directives of the Trust for 2022/23. The same nine risks remain in the BAF against the Trust strategic objectives as were identified in 2021/22.

In Issue 4 2021/22 there were two actions to close gaps in controls that were RAGged as Blue (complete) and between Issue 4 2021/22 and Issue 1 2022/23, presented to ELT, there are a further six actions that have been RAGged blue, all completed by year-end 2021/22. These actions remain in this issue of the BAF but are stricken through – this is so that progress is visible, but as they are not actions required to meet gaps in control against the strategic objectives of 2022/23 they will be removed by Issue 2.

Since ELT reviewed Issue 1 on 12.04.22, Risk 1a has been further updated. One action was RAGged blue by the action lead, this relates to training compliance and learning from CQC actions. However, in the last few weeks training compliance has reduced again and so the Director Lead has adjusted the action status accordingly. This was included in the version submitted to the Audit and Risk Committee.

Risk 3a has been fully revised by the Director Lead (and in consultation with Finance and Performance Committee colleagues). The risk rating remains the same but additional assurances on controls (internal and external) have been identified and the key gaps in control and associated actions have been completely updated to reflect the status of risk against the 2022/23 Trust strategic objectives.

The system-based risk (2022-23 MS1) remains and is presented separately from the risks to the Trust strategic objectives.

All changes/updates to this issue of the BAF, compared with Issue 4 2021/22, are indicated by blue text.

Operational Risks
There are five Trust-wide operational risks rated as high or extreme linked to the Trust strategic objectives. One operational risk (ID 22677) was previously listed under Risk 1a but this has been moved to Risk MS1 as it relates directly to the system-based risk. The ratings have not changed on the operational risks since Issue 4 2021/22.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	x
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	x
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	x

Assurances

This paper details the current 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

- Chief Executive
- Executive Directors
- Non-Executive Directors
- Trust Secretary
- Operational risk owners
- Deputy Directors of Operations and Operational Leads

Formal Reviews:

- Executive Leadership Team, Issue 1.1 on 2 April 2022
- Audit and Risk Committee, Issue 1.2 on 28 April 2022

Governance or Legal Issues

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

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

Specific elements within each BAF risk and associated actions are addressed by the relevant lead Executive Director in taking forward.

Recommendations

The Board of Directors is requested to:

1) **Approve** this first issue of the BAF for 2022/23 and the 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) Continue to receive updates in line with the forward plan for the Trust Board.

Report presented by: **Justine Fitzjohn**
Trust Secretary

Report prepared by: **Kel Sims**
Risk and Assurance Manager

Board Assurance Framework 2022-23 – Issue 1.3 Board 10 May 2022

PART ONE – RISKS TO DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST'S STRATEGIC OBJECTIVES

Ref	Principal Risk	Director Lead	Rating (Likelihood x Impact)	Responsible Committee
Strategic Objective 1 - To provide GREAT care in all services				
22-23 1a	There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board	Director of Nursing (DON)/Medical Director (MD)	**HIGH (4x4)**	Quality and Safeguarding Committee
22-23 1b	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and Psychiatric Intensive Care Unit (PICU) and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements	Chief Operating Officer (COO)	**HIGH (4x4)**	Finance and Performance Committee
22-23 1c	There is a risk that the Trust fails to maintain continuity of access to information to support effective patient care	Director of Business Improvement and Transformation (DBIT)	**MODERATE (3x4)**	Finance and Performance Committee
22-23 1d	There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage, i.e. cyber-attack, equipment failure	Chief Operating Officer (COO)	**MODERATE (3x4)**	Finance and Performance Committee
Strategic Objective 2 - To be a GREAT place to work				
22-23 2a	There is a risk that we do not sustain a healthy vibrant culture and conditions to make Derbyshire Healthcare Foundation Trust (DHCFT) a place where people want to work, thrive and to grow their careers	Director of People and Inclusion (DPI)	**HIGH (3x5)**	People and Culture Committee
22-23 2b	There is a risk of continued inequalities affecting health and well-being of staff	Director of People and Inclusion (DPI)	**HIGH (4x4)**	Trust Board
Strategic Objective 3 - To make BEST use of our money				
22-23 3a	There is a risk that the Trust fails to deliver its revenue and capital financial plans	Director of Finance (DOF)	**EXTREME (4x5)**	Finance and Performance Committee
22-23 3b	There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation	Director of Business Improvement and Transformation (DBIT)	**HIGH (4x4)**	Finance and Performance Committee
22-23 3c	Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change on senior managers from across the system may impact negatively on the cohesiveness of the Derbyshire health and care system	Director of Business Improvement and Transformation (DBIT)	**HIGH (4x4)**	Trust Board

Board Assurance Framework 2022-23 – Issue 1.3 Board 10 May 2022

Strategic Objective 1 - To provide GREAT care in all services

There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board

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

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas
b) Risk of substantial increase in clinical demand in some services and COVID-19 related mental health surge
c) Changing demographics of population and substantial impacts of inequality within the deprived wards of the city and county
d) Intermittent lack of compliance with Care Quality Commission (CQC) standards specifically the safety domain
e) Lack of embedded outcome measures at service level
f) Known links between Serious Mental Illness (SMI) and other co-morbidities, and increased risk factors in population including inequality/ intersectionality
g) Lack of compliance with physical healthcare monitoring in primary and secondary care
h) Restoration and recovery of access standards in autism and memory assessment services, due to COVID-19 pandemic
i) New and emerging risks related to waves of COVID-19, excess deaths associated with winter, impact of substantial economic downturn
j) Increased safeguarding and domestic violence related investigations as a result of harm to our patients and their families related to the impact of lockdown
k) Lack of appropriate environment to support high quality care, i.e. single gender dormitories and PICU
l) Lack of capacity to meet population demand for community forensic team
m) Deterioration in national enquiry into homicide – November 2021, above median
n) Local NHS Trusts will offer Recruitment and Retention Premium to Consultant Psychiatrists in specialist services and other clinical staff due to competitive practices that destabilises Trust clinical services and leads to a deterioration in waiting time and potentially in safety

BAF Ref: 22-23 1a	**Director Lead**: Carolyn Green (DON) / Dr John Sykes (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⇔	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; investment in COVID-secure environments and cleaning

Detective – Quality dashboard reporting; quality visit programme/virtual clinical service contact visits; incident, complaints and risk investigation; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron

compliance visits
Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; clinical sub committees of the Quality and Safeguarding Committee
Corrective – Board committee structures and processes ensuring escalation of quality issues; six monthly skill mix review; CQC action plans; learning from incidents, complaints and risks; actions following clinical and compliance audits; workforce issues escalation procedures; reporting to commissioners on compliance with quality standards; learning from other Trust experiences and national learning

Assurances on controls (internal)	Positive assurances on controls (external)
Quality and Trust dashboards Scrutiny of Quality Account (pre-submission) by committees Programme of physical healthcare and other clinical audits and associated plans COVID Board Assurance Framework reported to NHS England Positive and Safe self-assessment reported to the East Midlands Head of Nursing and Matron compliance visits	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) 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 CQC comprehensive review 2020 Trust is rated Good; two core services rated outstanding, two rated as require improvement Identified Trust fully compliant with National Quality Board (NQB) Learning from Deaths guidance 2020/21 Internal audits: Risk management; data security and protection 2020/21 Estates and Facilities Management internal audit (limited assurance) Transitional Monitoring Meetings with CQC (bi-monthly), no conditions

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Summary of progress on action	Action on track
Embedded learning from CQC regulatory actions, particularly in relation to improvement of training governance	Review operational governance of training compliance [ACTION OWNER: DPI] Develop and implement improvement plan to ensure sustained compliance with mandatory training [ACTION OWNERS: DPI/COO]	Embedded compliance with mandatory training and compliance rates. Reported to People and Culture Committee (PCC) Lack of recurrence of common themes regarding training compliance. Reported to PCC and to be led by the operational leadership teams	~~14.03.22~~ ~~31.05.22~~ 31.08.22	New reporting mechanism commenced May 2021 with Positive and Safe and Immediate Life Support (ILS) training compliance reporting to Board ILS / Basic Life Support (BLS) / Safeguarding Adults / Children / Positive and Safe: All available. Next training recovery	~~AMBER Changed to BLUE~~ Changed back to AMBER

				areas defined and being implemented in line with the Trust roadmap Implications of pandemic and stop and start training significantly impacting on steady flow of compliance. ILS and BLS back in recovery. Plan in place There are gaps in Mental Capacity Act training, compliance is 83% at April 2022 – To be monitored for three months ~~Residual unmitigated risk: Manual handling training compliance. This is currently at 72% and until it reaches the 75% threshold and a sustainable training plan it is not achieved~~ As at 23.03.22 manual handling training compliance is 80% compliance ~~– Action complete~~	
The Trust has not embedded a robust system of operational management and educational governance and has not learnt lessons from the 2016 and 2020 inspections	Review operational governance of training compliance [ACTION OWNER: DPI & COO]	The Trust continues to have significant instability in training compliance and oversight of safety training. The Trust management team need to move to a proactive oversight, projections of high-risk areas of safety training and	30.06.22		AMBER

		advance management of risk. Publication of ILS/ PSTS training as core risk areas in the Trust Board reporting until stability is achieved. Sign off of the outstanding CQC actions (5 overdue actions as at 04.04.22)			
Inability to complete physical health checks for patients whose consultations remain undertaken virtually	Improvement plan to be developed and implemented to ensure required physical health care checks are completed [ACTION OWNER: MD]	Compliance with physical healthcare checks, reported in the Quality Dashboard A 360 audit has been commissioned to review whether these improvements are embedded	~~14.03.22~~ 30.06.22	Revised metrics included in Quality Dashboard reported to Quality and Safeguarding Committee. Maintenance to be monitored though dashboard data Remain under monitoring – Consistent approach formulated for physical assessments to be completed face to face prioritised by need. Full progression of improvements has been impeded by the January COVID wave Successful bid to region to implement a coaching and self-report pilot model of health care to improve compliance and patient empowerment	AMBER
Implementation of revised priority actions for 'Good Care' which support the Trust strategy	Redesign improvement plans to align to revised building blocks which support the Trust Strategy [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule detailed in quality dashboard	~~31.03.22~~ 31.05.22	Indicators are within agreed tolerance including revised requirements as outlined in the COVID recovery roadmap~~. Modest~~	AMBER

				~~community survey results and positive staff survey results for 2021~~ Very positive staff survey (2022) in learning, morale which all positive indicators for clinical stability and safer services Health protection unit in place and active Quality dashboard embedded	
~~Insufficient investment in Community Forensic Rehabilitation Team~~	~~Significant investment (est. £1m+) required by Clinical Commissioning Group (CCG) to meet demand as outlined in new national specification~~ ~~Learning from mental health homicide reviews and formal recommendation for Trust to review capacity of the community forensic team [ACTION OWNERS: COO/DBIT]~~	~~Agreed funding allocation~~	~~31.03.22~~ 30.06.22	~~Escalated to CCG, in principle agreement in investment in August 2021. Clinical team developing information and analysis as they await the commissioner's final decision~~ ~~Expansion of the team agreed by the System Delivery Board in September 2021. Service is progressing with phased recruitment January-March 2022~~ ~~Some success in recruitment which will continue into new financial year 2022~~ ~~Homicide review will be published in February 2022 with learning completed bar one action which was escalated,~~	~~GREEN Changed to BLUE~~

				~~delayed and now resolved~~	
Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment services Waiting time has increased over COVID-19 period, exacerbated by underlying demand	Investment required by CCG to meet assessment and treatment demands [ACTION OWNERS: COO/DBIT]	Agreed funding allocation has occurred, recruitment to posts is active	~~31.03.22~~ 30.06.22	Mental Health and Learning Disability and Autism Board (MHLD AB) agreed investment in principle into autism services. Proposal ratified Recruitment to Derbyshire Community Health Services (DCHS) - North Autism Intensive Support Team (IST) and South Autism IST service has commenced Recruitment has begun for the Specialist Autism Team (SAT), with success in the South service Reduction in autism assessment waiting list required. Increased investment required – ~~Not~~ Scheduled ~~until~~ April 2022 in line with new National Autism Strategy Likely that waiting time will increase due to current staff absence. System exploration for waiting list initiative potential from private sector organisations. MHLD AB agreed a review and design of a new neuro diversity diagnostic pathway. Investment	AMBER

				included in 2022/23 system operational plan	
Monitoring of changes and patterns in population need in relation in the potential deterioration and other negative impacts due COVID-19	Continued monitoring and focus by the operations team and Divisional Achievement Reviews (DARs) [ACTION OWNERS: COO/MD/DON]	Monitoring of waiting list targets and implementation of mitigating actions. Reporting through DARs DON continues arm's length monitoring of monthly NHS benchmarking which continue to not follow the national trend Backlog in serious incident investigations has a recovery plan but is under significant stress and requires additional investment to mitigate this risk	~~31.03.22~~ 31.12.22	Safety standards remain in place for urgent referrals. Limited evidence of COVID related surge in demand. Robust oversight in place Community mental health team (working age) not having increase in referrals. Acuity and activity in existing patients is significant. Monitoring and team support in place Capacity against projected demand for non-inpatient contact and the inpatient demand is being reviewed. The Trust is feeding this work into the Strategic Operational Resilience Group (SORG) DARs up and running again. Referrals and wait lists discussed and changes post-covid included. Ongoing, continue to monitor changes in patterns and population requirements for the next year Additional staffing and investment to the serious incident team has been given and may require	~~AMBER~~ Changed to GREEN

				additional investment to stabilise further, management and executive action by TOOL	
Six service areas assessed as 'Requires Improvement' by CQC in relation to safety	Develop and implement an improvement plan to enable all six service areas to reach 'Good' for safety in relation to the CQC standards [ACTION OWNER: DON]	CQC inspection and assessment	~~(31.03.22)~~ 30.06.22	Significant improvement in all services. Plan to meet training compliance by 31.05.21 was achieved Residual CQC actions still require further attention to embed and sustain improvements – There are currently ~~15~~ 6 open actions for the acute and community service. The focus is training compliance	AMBER
Gap in operating standards for acute and community mental health services	Enhanced monitoring of acute and community mental health services by the Nursing and Quality Directorate [ACTION OWNER: DON] Implement Royal College of Psychiatrists (RCP) Standards across Acute Services [ACTION OWNERS: MD/DON/COO] Implement 2019 Community Mental Health Framework [ACTION OWNER: DBIT]	Improvement in operating standards compliance. To be confirmed by external CQC inspection and assessment of at least 'Good' Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Achievement Reviews and Quality Account Implemented Mental Health Community Framework to Quality and Safeguarding Committee	~~31.03.22~~ 30.06.22 (31.03.24) ~~(31.03.22)~~ (31.05.22)	Increased performance management scrutiny and unannounced site visits have been undertaken with compliance checks Standards compliance work continues. Gaps in Accreditation for Inpatient Mental Health Services (AIMS) due to accommodation requirements. New estates plan will meet standards when complete. Plan for investment agreed with NHSE April 2021. Reported to Quality and Safeguarding Committee May 2021 Active recruitment now underway and named	AMBER

				specific pilot areas in roll-out Design of new fully integrated model completed. Implementation delayed by Voluntary, Community and Social Enterprise (VCSE) procurement processes, now resolved Sites for year-two roll-out agreed as Derbyshire Dales, Chesterfield and North East Derbyshire/Bolsover. Go-live expected in High Peak and Derby City. The go-live of the model will be reviewed end of April	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times - Getting it Right First Time (GIRFT) reviews - Patient Safety Incident Response Framework (PSIRF) implementation - Commissioning for Quality and Innovation (CQUIN) Framework - National Institute for Health and Care Excellence (NICE) guidelines	Develop and implement an improvement plan to enable all governance improvement plans to be implemented [ACTION OWNERS: MD/DON/COO/DBIT]	Compliance with suite of metrics and reporting schedule	~~(31.03.22)~~ (30.06.22)	Trust's COVID recovery roadmap outlines timescales for standing up of core clinical governance developments, commenced June 2021 PSIRF implementation continues – New processes in place and approval of revised incident policy. Staff training on PSIRF to recommence ~~is yet to be launched due to impact of January COVID wave. This roll out has been paused until DIPC authorises~~	AMBER

				CQUIN progress to be included in DARs from 2022 NICE guideline mapping recommenced September 2021 Getting it Right First Time (GIRFT) reviews were held in July 2021, action plan received. Response ~~drafted by operational and clinical group with action plan in development~~ received by Quality and Safeguarding Committee and significant progress and assurance on approach noted Reduction in waiting times included in DARs. Work continues until the gap is significantly reduced ~~Extra support is required in Psychology and resources are being planned~~	
Implementation of three new quality priorities for: - Reducing violence - Sexual safety - Learning from COVID-19 pandemic	Develop and implement an improvement plan to enable all quality priorities to be implemented [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule	~~(31.03.22)~~ (31.05.22)	Reducing violence - Body worn camera investment has commenced Sexual safety – Improvement work (dashboard, preceptorship training and protocols) all commenced Learning from COVID -	GREEN

				Review of learning commissioned and IMT event delivered September 2021. Review of findings in development for a formal learning report Design and feedback ~~will be~~ incorporated into the Quality Account	
~~Lack of Quality Improvement (QI) strategy and implementation plan may result in failure to achieve most effective quality improvement and reduce the quality of patient care~~	~~Develop and implement a QI strategy [ACTION OWNERS: DBIT]~~	~~Develop and implement an improvement plan in line with required standards for Well Led~~	~~(31.03.22)~~	~~QI Strategy submitted to Quality and Safeguarding Committee. Strategy and implementation plan in place and progressing. QI training for leaders has commenced (for sign off) and Finance and Performance Committee (for information) in November 2021. The implementation plan was signed off by ELT in December 2021 and is in implementation phase~~	~~AMBER Changed to BLUE~~

Related operational high/extreme risks on the Corporate Risk Register:

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
3009	Learning Disabilities Services	Demand for Autism Spectrum Disorder (ASD) assessment Service far outstrips contracted activity	04.11.21: Temporary funding for a specialist doctor is allowing stabilisation of the prescribing caseload and some assessment and follow up work. Demand outstrips capacity – Working with CCG to develop a long-term plan. Business case in draft 02.02.22: This remains a significant concern within Derbyshire and the demand continues to rise. The team is still not commissioned to provide the number of assessments which are required for the region. 22.03.22: The team is still not commissioned to provide the number of assessments which are required for the region. Demand continues to outstrip capacity. Complaints and concerns have been raised	01.01.16	28.10.22	HIGH
21586	Community Care Services (Older People)	Wait times breaching CCG contract	24.11.21: There are currently approximately 1600 patients on the MAS waiting list. In the North of the county, it is a 12 week wait for initial assessment and in the South a 20 week wait. All patients accepted into the service are being supported through the Waiting Well Policy 23.03.22: MAS wait times remain high at around 20 weeks for South and 16 for North. There are approx. 1000 waiting for initial assessment and 1000 people waiting a diagnosis. It is anticipated that referral rates will continue to rise; demand outstrips capacity. Trajectories indicate with current capacity the wait times will remain high	12.12.18	23.05.22	HIGH
22154	Community Paediatrics Teams	Neurodevelopmental (ND) Assessment Pathway – operational delivery and capacity risks	01.06.21: Internal review shows Attention Deficit Hyperactivity Disorder (ADHD) diagnosis and management is the greatest risk. Short term funding also to be used to employ a short-term Specialty Doctor to help with the prescribing and oversight of this group 22.10.21: Engaged in demand and capacity modelling with the CCG. Estates impacting delivery. Specialty doctor recruited for 12 months 22.03.22: Business case submitted to CCG / JUCD MHLDA Board. Limited funding agreed for an additional technician and a specialty doctor to create additional capacity. This is an interim settlement. Cross provider working group established and first meeting April 2022 – Aim to create better flow service delivery	05.10.20	29.07.22	HIGH

21739	Operational Services	Emergency Preparedness, Resilience and Response (EPRR) Risks within Derbyshire	The incident management team response to the pandemic proactively managed disruptions in a safe, responsive way 10.11.21: Risks locally still remain the same as there are external factors as well as internal ones. Any changes in national and regional risk registers and guidance will result in early review of this risk 28.03.22 The risk remains, we are actively responding to COVID-19 pandemic	23.07.19	31.05.22	**HIGH**

Board Assurance Framework 2022-23 – Issue 1.3 Board 10 May 2022

Strategic Objective 1 – To provide GREAT care in all services

There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and PICU and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements

Impact:
Low quality care environment specifically related to dormitory wards
Crowded staff environment and non-compliance with COVID-secure workplace environments
Non-compliance with statutory care environments
Non-compliance with statutory health and safety requirements

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
d. National capital funding restrictions for business as usual capital programme for Trusts and Integrated Care Systems
e. Gaps in relation to the revised Premises Assurance Model (PAM)

BAF Ref: 22-23 1b	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⟷	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through DATIX; COVID secure workplace risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; COVID secure workplace policy and procedure
Corrective – Short term investment agreed to support key risk areas including provision of equipment to ensure COVID secure workplace environments

Assurances on controls (internal)	Positive assurances on controls (external)
- COVID secure workplace assessments - Health and Safety Audits - Premises Assurance Management System (PAMS) reporting providing updates on key priority areas - Estates Strategy (under revision for 2022/23)	- Mental Health Capital Expenditure bidding process - External authorised reports for statutory health and safety requirements - 2020/21 Estates and Facilities Management internal audit (limited assurance)

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Estates Strategy delivery recommendations will need to be updated for ongoing COVID secure requirements	Review of Estates Strategy delivery recommendations to ensure compliance with ongoing COVID secure guidance [ACTION OWNER: COO]	Revised COVID compliant delivery recommendations	~~(31.03.22)~~ (31.05.22)	~~Unable to review until during 2021/22 financial year as strategy needs to be considered post-COVID or when and how 'living-with-COVID' is ascertained~~ ~~Estates Strategy is reviewed regularly at Trust Operational Oversight Leadership group (TOOL). Significant risks will be reviewed at year-end~~ The strategy is currently being reviewed/revised to reflect changes in line with progress on the Dormitory Eradication Programme	AMBER
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER: COO]	Delivery of approved business cases and surrounding associated schemes for dormitory eradication	(31.08.22) Hard deadline for national funding of March 2024	Allocation of £80m confirmed ~~Application for funding in place for new PICU and other hospital buildings, with a new plan in place once funding is approved, which would mean total~~ OBCs approved for two new build 54-bed acute units and refurbishment of two existing acute wards. Seeking approval of further OBC for Older Adult service relocation which will complete eradication of	AMBER

				dormitories. FBCs will be submitted for approval in May 2022	
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects taking into account gender considerations) [ACTION OWNER: COO]	Agreed programme of work with capital funding to support it	(31.08.22) PICU delivery date aligned to dorms new build and interim CCG contract dates	~~Application for funding in place for new PICU and other hospital buildings, with a new plan in place once funding is approved, which would mean total eradication of dormitories~~ OBCs approved for 14-bed male PICU and 8-bed Acute-Plus female facility. FBCs will be submitted for approval in May 2022	AMBER
Internal Audit recommendations highlighted the need for evidence of assurance on estate maintenance and wider governance for estate compliance with statutory legislation	Deliver Internal Audit report recommendations in full Premises Assurance Model (PAM) assessment to be completed [ACTION OWNER: COO] Review of current estates and facilities governance structures [ACTION OWNER: COO]	Completion of agreed recommendations and management actions Reporting to Finance and Performance Committee twice yearly and any exceptions in between Governance structure in place	~~31.03.22~~ 31.08.22	~~Plan for reporting of suite of assurance for estates delivered at ELT September 2021 outlining the timeline and process/Outline Business Cases (three in total) – These should be completed in November 2021~~ OBCs approved for two new build 54-bed acute units and refurbishment of two existing acute wards. Seeking approval of further OBC for Older Adult service relocation which will complete eradication of dormitories. OBCs approved for 14-bed male PICU and 8-bed Acute-Plus female facility. FBCs will be submitted for approval in May 2022 Internal governance structure in place and	AMBER

				meeting monthly Management audit undertaken by internal auditors Quarter 4 2020/21 Governance reporting will include audit recommendation response and delivery	
~~Insufficient staffing resources in the PICU and dormitory eradication project~~	~~Recruit temporary Strategic Lead on People for the PICU and dormitories project~~ ~~[ACTON OWNER: DPI]~~		~~31.03.22~~	~~New strategic lead for PICU recruited and commencing commenced 20.12.21~~	~~AMBER Changed to BLUE~~

Related operational high/extreme risks on the Corporate Risk Register: None

Board Assurance Framework 2022-23 – Issue 1.3 Board 10 May 2022

Strategic Objective 1 – To provide GREAT care in all services

There is a risk that the Trust fails to maintain continuity of access to information to support effective patient care

Impact: Inability of staff to access patient records from the right place at the right time

Root causes:

a. Transfer to new electronic patient record provider
b. Inefficient access to clinical information in current system
c. Interoperability of systems with partner organisations
d. Current significant number of forms and processes resulting in issues regarding the consistency of recording of information

BAF Ref: 22-23 1c	**Director Lead**: Gareth Harry (DBIT)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Direction ⟺	Low	Likelihood 2	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Local Implementation Groups (LIG) and overarching Clinical Design Authority (CDA) ensuring all forms and processes have been rigorously tested and signed off by representatives of the clinical services
Detective – Non-Executive Director (NED) Board member on OnEPR (one electronic patient record) Programme Delivery Board (PDB) providing project expertise and direct link to Board
Directive – OnEPR PDB governance oversight with respect to delivery of the new EPR with secured expert and experienced third-party provider; fully resourced project management team within the third-party provider and DHCFT; reporting on progress to Finance and Performance Committee (F&P) and fortnightly updates to ELT; rapid escalation of issues to ELT
Corrective – Phased approach to delivery (four phases over 18-month project delivery plan); 'Go/No Go' rationale agreed and measures for decision making, ahead of each delivery phase. Weekly 'Go/No Go' meeting in 10-week run up to 'Go Live' date for each phase of implementation

Assurances on controls (internal)	Positive assurances on controls (external)
- Weekly project update report and wider project progress report highlighting current position against delivery plan	

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Capacity within the IM&T Team to support programme delivery to the level required by the project plan	Identify and agree priorities and release of staff [ACTION OWNER: COO]	Compliance with the agreed resource plan for the project	31.05.22	Fully resourced plan and gateway review dates agreed with Channel 3 for the release of their resource as required ELT agreed to amalgamate phase 3 and 4 with a go live date of 24.01.22 – ~~This is delayed due to the current pandemic situation. Plan included fully resourced capacity plan.~~ ELT decided to postpone the planned go live of 24.01.22 due to omicron. New plan in place for delivery on 09.05.22. project currently on plan for delivery on that date	GREEN
Maintenance of staff well-being (in particular IM&T and Channel 3 staff) during final implementation of each delivery phase	Build in plans and expectations of working arrangements for IM&T and Channel 3 staff from phase 2 implementation onward [ACTION OWNER: DBIT]	Feedback from staff	31.05.22	Staff wellbeing considered on deciding to delay phase two and was an active influence on the judgement made to amalgamate phase 3 and 4 Adequate staffing resource and capacity built into programme plans for the remaining months	GREEN
Adherence to the project delivery plan due to unforeseen circumstances	Close monitoring of the project risk register and issues log/regular updates with potential to adjust phasing of 'go live' decisions for each phase [ACTION OWNER: COO]	Adherence to the project delivery plan, which includes a range of clear measurable criteria against key milestones	~~31.03.22~~ 31.05.22	ELT agreed to amalgamate phase 3 and 4 with a go live date of 24.01.22 – ~~This is delayed due to the current pandemic situation. Plan included fully resourced~~	AMBER

				~~capacity plan.~~ ELT decided to postpone the planned go live of 24.01.22 due to omicron. New plan in place for delivery on 09.05.22. project currently on plan for delivery on that date	

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 1 – To provide GREAT care in all services

There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage i.e. cyber-attack, equipment failure

Impact: This could lead to the disruption in the provision of services with risk to patient safety

Root causes:

a. Increasing reliance on a single electronic patient record
b. Increasing use of video software for the direct provision of care and operational purposes
c. Increased staff home working
d. Increasing electronic collaboration across health and social care partners
e. Increasing global instability and risk from state supported cyber attacks
f. Increase in locally developed system solutions to support DHCFT and partner operations and performance, i.e. COVID vaccination, health risk assessments, COVID flow testing, flu.

BAF Ref: 22-23 1d	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Direction ⟺	Moderate	Likelihood 2	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Trust utilises NHS provided solutions as widely as possible, i.e., Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure Health and Social Care Network (HSCN) specified by NHS Digital. Staff training on data security and protection. Regular all staff communications regarding safe ways of working and phishing emails. Contract with NHS Arden and Greater East Midlands Commissioning Support Unit provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust's compliance against them
Detective – Cyber essentials framework: NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities
Directive – Compliance with NHS Digital requirements. Monthly rigor review meeting with NHS Arden and Greater East Midlands Commissioning Support Unit to identify software solutions which require upgrading to ensure supported. Data Security and Protection Policies and Procedures. Business continuity plan and procedure
Corrective – Timely actions undertaken in response to vulnerabilities identified through controls/processes outlined above

Assurances on controls (internal)	Positive assurances on controls (external)
IM&T Strategy delivery update to F&P – September 2021	- Templar Cyber Organisational Readiness Report (CORS) - Annual external cyber review by Dynac (vulnerability scan) - Data Security and Protection annual review by Internal Audit, weighted toward cyber security - Compliance with Data Security and Protection Toolkit, including high levels of training compliance

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNER: COO]	Reporting to the Divisional Achievement Reviews (DARs)	~~31.03.22~~ 30.09.22	~~Due to start in Quarter 2 following development of division level plans~~ Programme of updating underway. Emergency Planning and Business Continuity Manager is reviewing each business continuity plan to ensure that they are appropriate and consistent	AMBER
~~Limited resource within organisation dedicated to cyber security~~	~~Consider development of a business case to increase cyber support [ACTION OWNER: COO]~~	~~Increased capacity to support cyber risk management~~	~~(31.03.22)~~	~~Head of cyber security and team in post at NHS Arden and Greater East Midlands Commissioning Support Unit. DHCFT is working with their team and maintaining communication through regular meetings Cyber resources are provided via the contract with NHS Arden and Greater East Midlands Commissioning Support Unit. This continues to meet the Trust's requirements – Action completed by 31.03.22~~	~~AMBER Changed to BLUE~~
Embedded programme of software and hardware upgrades	Prioritise work alongside organisational requirements and developments [ACTION OWNER: COO]	Information Technology Strategy (IT Strategy) 6-month update to Finance and Performance Committee	~~(31.03.22)~~ (31.05.22)	There is a continual review of hardware and software undertaken in conjunction with NHS Arden and Greater East Midlands Commissioning Support Unit monthly as part of our 'Rigor' programme. Actions are	GREEN

				agreed in the meeting to ensure that we continue to comply with the NHS mandate to operate on supported software and platforms	
Live testing of business continuity plans	Desktop incident response exercise on IT failure to be completed [ACTION OWNER: COO]	Exercise evaluation report to Finance and Performance Committee	~~28.02.22~~ 31.05.22	~~The Emergency Planning and Business Continuity Manager will be working with IM&T on testing of the business continuity plans~~ There is an outline plan to do a desk-based review of business continuity plans by 30.04.22. This is being co-ordinated by IM&T and Records and the Emergency Planning and Business Continuity Manager	~~AMBER~~ Changed to GREEN
Some gaps identified in Cyber Operational Readiness Support (CORS) review undertaken by Templar	Consideration of recommendations in relation to asset owners and policies. Trust to develop own actions in response [ACTION OWNER: COO]	Response to CORS recommendations report to Data Security and Protection Committee	~~31.03.22~~ 31.05.22	Semi deep dive done at November F&P Committee Cyber Organisational Readiness Support (CORS) recommendations all reviewed – All actions complete or underway and on target	GREEN

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 2 - To be a GREAT place to work

There is a risk that we do not sustain a healthy vibrant culture and conditions to make DHCFT a place where people want to work, thrive and to grow their careers

Impact: Risk to the delivery of high-quality clinical care
Inability to deliver transformational change
Exceeding of budgets allocated for temporary staff
Loss of income

Root causes:

a. National shortage of key occupations and registered professions
b. Future commissions of key posts insufficient for current and expected demand
c. Sufficient funding to deliver alternative workforce solutions
d. Retention of staff in some key areas
e. Overdependence on registered professions
f. Impact of COVID-19 pandemic
g. Increase in mental health demand and associated funding
h. Increase in use of technology
i. Consistent person-centred culture not fully embedded

BAF Ref: 22-23 2a	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: People and Culture Committee

Key Controls

Inherent risk rating			Current risk rating				Target risk rating			Risk appetite		
Extreme	Likelihood 4	Impact 5	High	Likelihood 4	Impact 5	Direction ↓	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

Preventative – Workforce plan covering wide range of recruitment channels including targeted campaigns, 'Work For Us' internet page, leadership development, new role and skill mix changes, leadership development programme, increased well-being support, system workforce hub
Detective – Performance report identifying specific hotspots and interventions to increase recruitment and retention, Freedom to Speak Up Guardian role, Peoples Services Leadership Team meeting to oversee delivery of the People Agenda. Health risk assessments. Health and wellbeing conversations and well-being action plans. Black, Asian, and Minority Ethnic (BME) risk assessments
Directive – Wellbeing Strategy, infrastructure and programmes to support staff health and wellbeing. Workforce plan to grow and develop the workforce. Assurance reports on delivery of People Strategy to People and Culture Committee. Leadership support sessions. Staff engagement forums
Corrective – Leadership and Management Strategy and development programmes to build inclusive and engaging leadership and management. Leadership Programme – Core Leaders. Occupational health contract monitoring meeting

Assurances on controls (internal)	Positive assurances on controls (external)
Workforce Performance Report to Executive Leadership Team monthly Bimonthly People Dashboard to People and Culture Committee, includes recruitment tracker and deep dives ELT rolling programme of deep dives of strategic building blocks	Outstanding results from 2020 staff survey, identifying significant improvements across all themes Safe staffing reports and Care Hours Per Patient Day (CHPPD) reporting (planned versus actual staff)

Employee relations assurance report to ELT Deep dive review of the risk to Audit and Risk Committee (January 2021)	Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and gender pay gap reporting 2020/21 Internal Audit: WRES and WDES data quality (significant assurance) Reduction in employee relations cases No employment tribunal cases

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Time taken to recruit to new and vacant posts Lack of a recruitment plan showing the vacancies and recruitment position Lack of correlation between finance, HR and operational systems and information Insufficient clarity on hotspot areas and what needs to be done to address these areas	Recruitment plans in place for workforce requirements related to capital projects and mental health investment plans (relating to PICU plans and dormitory eradication) Establish a Multi-Disciplinary Team Recruitment Task and Finish group to establish a clear position on vacancies, starting January and completing by end of March 2021 [ACTONS OWNER: DPI]	Vacancy rates, time to recruit data within performance report to Board. People dashboard to PCC and monthly people assurance report to ELT Diversity in appointments. Target of 20% of workforce as BME	~~31.03.22~~ 31.07.22	Recruitment processes working well. Plans in place for all new posts are being dynamically managed – Operational and 'business as usual' (BAU) A new group scrutiny meeting with People & Inclusion Services is being launched, with a clear set of actions to address on the recruitment part of the process, to review vacancies and establishment controls. Recruitment key performance indicators now in place The BME staffing rate continues to improve and is now at 16.5%	AMBER
Embedded flexible workforce arrangements in place	Implementing the learning from flexible working arrangement in response to the COVID-19 pandemic, i.e. home working Review of policies/processes and contracts of employment to embed flexible working [ACTONS OWNER: DPI]	Sickness absence rate reported in performance dashboards as outlined above Staff survey responses Pulse and people pulse check responses Percentage of people working on	~~(30.04.22)~~ (31.12.22)	DHCFT Promise for flexible working in place. Working from home and flexible working policies both updated. Guidance and advice for managers has been produced and focus groups on flexible working have been undertaken Pulse checks commenced and	GREEN

		flexible contracts with respect to hours and location (reporting metric to be developed)		will take place quarterly – Operational and BAU Flexible working group in operation (NHSE/I initiative), led by Nursing & Quality on a six-month programme Launch of hybrid principles from 01.04.22	
Fully embedded person-centred culture of leadership and management	Review of policies and processes to support a person-centred approach to leadership and management Review of leadership development offer Re-establish line manager development sessions Scrutiny of people data at divisional level [ACTONS OWNER: DPI]	Reduced number of formal staff relations issues/cases. Reported in monthly people assurance report to ELT Reporting to TOOL	Ongoing	'People First - Supporting colleagues fairly through workplace situations' in place and disciplinary and incident polices reviewed in line with approved proposal with 'Above Difference' to review cultural intelligence - Started with Board session on 15.09.21 External review of workforce policies completed ~~Commenced case oversight meeting to ensure timely and appropriate management~~ Cases now being escalated effectively to ensure timely and appropriate management	GREEN
Development of a funded Workforce Plan that delivers on new role development	Develop and implement 2021/22 of the Workforce Delivery Plan (WDP) [ACTON OWNER: DPI]	Vacancy rate of registered posts reported in performance dashboards as outlined above and recruitment report to IMT No of new roles in place, metric to be developed. Apprenticeship student nurse uptake reported to Workforce Delivery Plan Group	Ongoing	Delivery of plan being monitored though Workforce Planning Delivery Group, through to ELT and PCC. Initial WDP reported to Board May 2021 Medical Workforce Project Group review of all vacancies, recruitment and agency spend fortnightly	AMBER

				The Workforce Plan is included in the overarching People & Inclusion Services budget planning	
People and Inclusion Directorate shaped to deliver against future needs of the organisation	Review of Peoples Services model and plans Identify resources required to shape culture locally Develop performance framework to support delivery of revised model [ACTONS OWNER: DPI]	Service line agreements KPIs	~~(31.03.22)~~ Ongoing	~~Negotiations almost complete with DCHS. New schedule of service agreed.~~ ~~New service level agreements and KPIs to be finalised.~~ ~~Performance management arrangements to be established~~ ~~Recruitment to two Assistant Director Posts in People & Inclusion complete and one underway. More formal service oversight meetings will be established in October 2021 with both Assistant Directors~~ ~~Oversight meetings were planned to start in December 2021 but have been deferred until 2022 due to the recent changes in the pandemic status~~ New schedule of service agreed New service level agreements and key performance indicators being finalised with some proposed changes on engagement Oversight meetings have recommenced Meetings between CEO and Human Resources leads in	~~RED~~ Changed to AMBER

				DCHS and DHCFT in place	
Consolidate health and wellbeing provision and infrastructure, ensuring learning from COVID-19 pandemic is incorporated	Align well-being offer to local Sustainability and Transformation Plan (STP) and national offers Updating well-being offer, in particular mental health interventions Roll out of health and wellbeing plans for all staff Review management of change policy to incorporate health and well-being discussions Similar review of appraisal policy and processes [ACTONS OWNER: DPI]	Maintain sickness absence rates to below 5% or below Reduction in sickness absence as a result of anxiety and stress Percentage uptake of health and wellbeing plans Published policies	~~(28.02.22)~~ (30.06.22)	Local, regional and national offer published via Trust intranet Increase uptake of health risk assessments Wellbeing offer has been reviewed. Health & Wellbeing Framework has been rolled out Review RESOLVE contract to increase capacity for referrals Consider a reflective practice offer Absence rates have not decreased as anticipated – Monitoring continues	AMBER
	~~Roll out of flu vaccination plan for autumn 2021~~ ~~[ACTON OWNERS: DPI/DON]~~	~~Increased uptake of staff flu vaccination by 30.11.21~~		~~Vaccination programme delivery is on track~~ ~~was completed for 2021~~	~~GREEN Changed to BLUE~~
Training compliance in key areas below target set by the Trust Long-term solution required for the training venues for mandatory training and induction	Recovery being implemented Mandatory training to be rostered Estates team to consider options for central room booking and for training [ACTION OWNERS: DPI/COO]	Percentage of compliance with mandatory training reported to ELT and bimonthly to Board as part of performance report Forward planning for training compliance	~~(31.03.22)~~ (30.06.22)	Recovery plan implemented, particularly in relation to ILS and Positive and Safe training. Forward plans to include rostering of training to be developed Significant impact of COVID-19 on release of staff – Extra resource given to support the Training and Development Team to improve attendance at training remains in place until	AMBER

				March 2022 Target is 85% and we are above this. A new training venue is required for Positive & Safe and Manual Handling training, this is being sourced	
Evidence of safer staffing levels of suitably qualified staff	Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements [ACTION OWNER: DPI]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	~~31.03.22~~ 31.05.22	New reporting process started to incorporate ward level reporting. Board approval has been given to recruit two registered and two non-registered staff per ward, which wards are now actioning. Monitoring of actions to ensure E-Roster has the correct safer staffing template for each ward continues	GREEN

Related operational high/extreme risks on the Corporate Risk Register:

Record ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
22727	People Services	Risk of not being able to recruit newly qualified mental health nurses	Over the last academic year, the Trust was asked to provide a total of 215 placements to meet the needs of the September 2020 cohort, to which we were only able to provide 99 placements. The university has been using placements outside of the Trust to meet the deficit and this will increase in line with the increase of student recruitment There is currently a system-wide approach being undertaken to look at placement expansion across Derbyshire NHS Trusts	07.10.21	31.05.22	HIGH

Strategic Objective 2 - To be a GREAT place to work

There is a risk of continued inequalities affecting health and well-being of staff

Impact:
Risk to the delivery of high-quality clinical care
Inability to attract, recruit and retain a motivated and diverse workforce
Risk to the health and wellbeing of our staff
Risk to patients and communities having access to the right services
Escalation in formal cases impacting on individuals and teams
Reduced confidence by our communities in our Trust

Root causes:

a. Commissioning of services does not meet the need of diverse communities
b. Change management and transformation programmes lead to deterioration in experience
c. Processes and policies have inbuilt bias
d. Processes for advocacy and raising issues not clear or dealt with well
e. Gaps in cultural competence of leaders and managers

BAF Ref: 22-23 2b	**Director Lead**: Jaki Lowe (DPI)	**Responsible Committee**: Trust Board

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⟺	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; annual review of people development plan commissioned through People and Inclusion Directorate; provision of information through induction processes for new staff; staff engagement sessions; Equality, Diversity and Inclusion (EDI) Delivery Group meeting; supported networks for diverse staff groups and allies; Health and Well-being Network; workforce planning design meeting; Culture and Leadership Delivery Group; Training and Education Delivery Group
Detective – EDI updates to ELT, monthly performance report to Board; recruitment reporting to TOOL; Reverse Commissioning Project Group; Reverse Commissioning Steering Group; Equality Forum; attendance management monitoring; take up of Reasonable Adjustment Passports; updating of Electronic Staff Record (ESR) regarding disability and long-term conditions
Directive – People Strategy; Inclusion Strategy; Joined Up Care Derbyshire (JUCD) People Strategy
Corrective – Leadership and management development strategy ensuring inclusion is at the heart of all development; exit interview feedback

Assurances on controls (internal)		Positive assurances on controls (external)			
Executive Leadership Team rolling programme of deep dives on strategic building blocks		2020 staff survey results Gender pay gap annual assessment and report Assessment and report annually for Equality Delivery System (EDS2) WRES and WDES annual report 2020/21 Internal Audit WRES/Disability Worker Exclusion Scheme (DWES) data quality (significant assurance)			
Key gaps in control	**Key actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion date (Action review date)**	**Progress against action**	**Action on track**
Develop an Equality, Diversity and Inclusion Strategy (EDI Strategy) Insufficient resources in place to deliver the plans	Refresh and expanding the strategy Roll out review of cultural intelligence Launch events for the Equality, Diversity and Inclusion Strategy Development of directorate equality dashboards Recruitment process for the head of EDI and Race Equality Lead [ACTIONS OWNER: DPI]	Improved position regarding staff motivation in staff survey and pulse checks Freedom to Speak Up Index to People and Culture Committee and Board Inclusion Recruitment report Positive Friends and Family Test Percentage of exit interviews completed Metrics within the employee relations report	(30.06.22)	Strategy has been developed, engagement and embeddedness ~~to be~~ reviewed. EDI delivery group will oversee delivery of the strategy Strategic approach taken to Trust Board November 2021 Delivery group now stood up to full operating expectations and will oversee delivery of the strategy	AMBER
Refresh and expand engagement plans. Include lessons learnt from response to COVID pandemic	Establish approach for refreshing and expanding the engagement plan and a group to oversee the refresh Refresh 12-month engagement plan Develop a cultural sensitivity approach to health and wellbeing discussions [ACTIONS OWNER: DPI]	Improved staff survey results Positive Friends and Family Test Positive pulse check	~~(30.04.22)~~ (31.05.22)	Engagement plan for next 12 months to be developed, in line with Trust COVID recovery roadmap Learning from COVID-19 has been completed and cultural sensitivity to health and wellbeing discussions were undertaken – Progress	GREEN

				reporting into TOOL	
Gaps in the cultural competence of leaders and managers resulting in staff reporting being disadvantaged due to their protected characteristics	Roll out of cultural competence training to equip leaders and managers to be able to lead and support staff and provide the best experience for service users Participation in the national pilot on disciplinary processes Training on acceptable behaviours in teams where there are issues [ACTIONS OWNER: DPI]	Live WRES monitoring at corporate and directorate level BME case numbers Setting of targets at divisional level Development of divisional WRES Action plans	30.06.22	Health risk assessment has been revisited and is now a dynamic process. Roll out of master classes for cultural intelligence start September 2021. Cultural workshops undertaken in areas of need (on disparity ratio of BME staff at Band 7 and above)	AMBER
Unequal experience of people with protected characteristics through recruitment process	Review of assurance framework that inclusion and recruitment guardians will use Increase the number and availability of Recruitment Inclusion Guardians (RIGs) Establish an escalation process where a RIG is not in place System Recruitment Pilot to change the recruitment process Review of all data from the Freedom to Speak Up Guardian, disciplinary cases and grievances to identify areas to address [ACTIONS OWNER: DPI]	Improved BME recruitment process outcomes Improved disparity ratios Review the role of the RIG from a panel member to an assurance process	~~28.02.22~~ 31.12.22	Increased the number of inclusion guardians to 50+ System wide pilot on reviewing recruitment process ~~has commenced and will conclude in February 2022~~ was paused during the latest part of the pandemic. It will relaunch in June Senior appointments disparity at the most senior level have improved	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 3 - To make BEST use of our money

There is a risk that the Trust fails to deliver its revenue and capital financial plans

Impact: Trust becomes financially unsustainable

Root causes:

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes
b) Non approval of business case for national funding
c) Insufficient capital envelope for JUCD system that inhibits Trust capital spend requirements for required self-funded projects
d) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements during and beyond the pandemic
e) Non-delivery of expected financial benefits from transformational activities
f) Non-delivery of required levels of efficiency improvement
g) Lack of sufficient cash and working capital
h) Loss due to material fraud or criminal activity
i) Unexpected income loss or non-receipt of expected transformation income (e.g. long-term plan (LTP) and Mental Health Investment Standard (MHIS) without removal of associated costs
j) Costs to deliver services exceed the Trust financial resources available
k) Lack of cultural shift/behaviours to return to financial cost control regime
l) Inability to reduce temporary staffing expenditure
m) Ongoing or re-emergence of COVID-related costs with insufficient covid funding

BAF Ref: 22_23 3a	**Director Lead**: Claire Wright (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
High	Likelihood 3	Impact 5	Extreme	Likelihood 4	Impact 5	Direction ↑	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

Preventative – Integrated Care System (ICS) sign off and support for dormitory eradication work. Devoted and adequate team for Programme delivery. High quality business cases. Regular meetings with NHSIE on programme progress. Meaningful stakeholder engagement (internal and external). Robust cash flow forecasting and delivery. Multi-disciplinary development of financial plans for new programmes of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counter fraud training and annual counter fraud work programme: Enhanced cash management and forecasting aligned to large capital and transformational programmes

Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); scrutiny of financial delivery, bank reconciliations; continuous improvement including cost improvement planning (CIP) and efficiency / QI delivery; contract performance, local counter fraud scrutiny

Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol and Plan Do Study Act.

Risk and gain share agreements, Local Operating Procedure for Acute Capital Programme
Corrective – Risk mitigation activity and oversight at ICS system/other partnership level. Proactive reporting and forecasting of capital and wider transformation programme progress enabling remedial activity to take effect. General corrective management action; Use of contingency reserve (if available); Disaster recovery plan implementation; Performance reviews and associated support / in-reach

Assurances on controls (internal)	Positive assurances on controls (external)
- Dormitory eradication and PICU Programme monitoring and reporting. Urgent decision- making taking place and relevant meetings in place - Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific including 'Use of Resources' reporting updates - Assurance levels gained at Finance and Performance Committee - Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations - Independent assurance via internal auditors, external auditors and counter fraud specialist that the figures reported are valid and systems and processes for financial governance are adequate - Local Operating Procedure in operation for Acute Capital Programme - Board and F&P oversight of Acute Capital Programme delivery - Outline Business Cases (OBCs) approved and early draw down funding agreed for enabling and early works ahead of Full Business cases (FBCs) approvals	- NHSE/I feedback throughout progress of dormitory eradication Programme and business cases in programme - Systems Finance and Estates Committee/System Project Management Office/system DoF meetings etc. - Internal Audits – Financial integrity and key financial systems audits - External Audits – Strong record of high-quality statutory reporting with unqualified opinion - National Fraud Initiative – No areas of concern - Local Counter fraud work – Referrals show good counter fraud awareness and reporting in Trust and no material losses have been incurred. Use of risk-based activity in new counter fraud standards Information Toolkit rating – Evidencing strong cyber risk management (ref fraud/criminal financial risk)

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Trust cash and capital risks related to national funded acute capital programme: - Inflation cost risk - Risk-share - Cashflow timings and variability - Guaranteed Maximum	Risk share arrangements with PSCP Optimism bias and contingency discussions with NHSE/I on cash and capital	Cash and capital reporting and forecasting evidences plan delivery or indicates areas of required management action	March 2024 and beyond (review quarterly)	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations Hyper-inflation risk is currently very high due to world events and economy	RED

Price exceeds national funding envelope (due to hyperinflation and other factors)					
System capital programme funding shortfall for self-funded Trust capital programme: System Capital Departmental Expenditure Limit (CDEL) inadequacy for system capital requirements	System capital planning includes dorms/PICU self-funded elements. Discussions with NHSE/I – Attempt to access non CDEL funding for PICU. VAT abatement discussions with HMRC	Capital reporting remains on track and within plan	March 2024 and beyond (review quarterly)	System capital plan being finalised. Longer term planning commenced HMRC view awaited. NHSE/I PICU capital information awaited	AMBER
Additional revenue not approved by System for Older Adults Service Relocation OBC	Close partnership working with CCG and System partners to agree OBC as System document	System approvals in April 2022	May 2022	CCG and DCHS partners contributing to OBC development	AMBER
FBCs do not achieve national approval	Programme approach and engagement with all stakeholders. Close involvement with NHSE/I	Approval in system and by national investment committee	May 2022 submission	FBCs to go through governance train May concluding in national submissions in May and national approval expected August 2022	GREEN
Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight	Enhanced bank and agency costs reported as part of wider financial and workforce reporting	March 2023 (Quarterly)	Reports to ELT and F&P outlining current areas of pressure and required actions in March and April	RED
Non-delivery of required recurrent cost reduction and improved efficiency and Quality Improvement	Compilation and delivery of planned Trust efficiencies and quality improvements to deliver 2022/23 plan including recurrent long term cost reductions to return to breakeven	Efficiency and QI reporting to Execs and F&P	March 2023 (Quarterly)	Partial delivery plan at time of draft plan submission (17 March). Full plan required for final Plan submission (28 April)	RED
Covid costs continue and exceed funding available	Return to pre-pandemic operating models and release of additional costs	Covid cost reporting as part of wider financial reporting	March 2023 (Quarterly)	Pandemic uptick in first quarter of 2022/23. Awaiting updated IPC guidance	RED

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 3 - To make BEST use of our money

There is a risk that learning from the response to the COVID-19 outbreak, and transformation plans developed prior, does not lead to sustainable embedded transformation

Impact: Improvements in the quality of care, working lives and service efficiencies are lost

Root causes:

a) Impact of the COVID-19 pandemic and adherence to directives including COVID secure environments
b) Increased use of clinical consultations and interventions using virtual technology in response to COVID-19
c) Increased use of videoconferencing for clinical and corporate meetings in response to COVID-19
d) Closer relationships between community teams and inpatient services developed as a result of working within COVID-19 guidance
e) Less miles travelled miles on trust business due to greater use of virtual technology and videoconferencing
f) Flexible working arrangements for colleagues increased in response to COVID-19
g) Understanding of factors which have led to the reduction in sickness and absence of colleagues
h) Historical reliance on staff based in trust estate
i) Limited team autonomy to make local improvements at pace
j) Improvements to acute pathway length of stay during the pandemic are lost

BAF Ref: 22-23 3b	**Director Lead**: Gareth Harry (DBIT)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⟺	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Adherence to national and local guidance in relation to responding to the COVID-19 pandemic; Trust review group exploring how office and working spaces can reformed going forward
Detective – Transformation Team; EQUAL Forum; regular reporting to Finance and Performance Committee on pipeline to include future transformation; home working and COVID secure policies and procedures
Directive – Estates Strategy includes rationalisation of corporate estate. Home working promise agreed and circulated to all staff; Quality Improvement (QI) Strategy; clinical strategies
Corrective - Fortnightly System Restoration Cell focused on joint plans; restoration plans in line with Phase 3 national planning; evidence of local improvements at team level, i.e., risk stratification of caseloads, discharge processes. 'QI Life' software and use of will capture and report benefits. Ongoing covid guidance from the Trust Executive Team

Assurances on controls (internal)	Positive assurances on controls (external)
Reporting and deep dives to F&P Feedback from EQUAL Forum	- Patient surveys for patients with learning disabilities and Serious Mental Illness (SMI) conducted by Healthwatch

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Implementation of the Estates Strategy in relation to community and corporate estate	Conduct estates optimisation work for community and corporate services [ACTION OWNER: COO]	Freeing up corporate estate to be utilised for clinical space	~~31.03.22~~ 30.06.22	Work ongoing in line with Trust Roadmap ~~(Phase 1) Consideration of short-term estates changes to support service recovery (at Phase 2 onwards) and medium/longer term issues post COVID-19~~ ~~Full implementation of the Estates Strategy will be ongoing throughout 2021/22 as we still don't fully understand what any long-term COVID-19 mitigations might remain/be needed~~ The Estates Strategy is currently being reviewed/revised to reflect changes in line with progress on the Dormitory Eradication Programme	GREEN
Embedding of current ways of working in a post COVID environment	Maintain directives on virtual meetings and non-patient facing activities to support new ways of working [ACTION OWNER: DBIT]	Less miles travelled on trust business compared to a pre COVID baselines More hours working from home compared to a pre COVID baselines	~~(31.03.22)~~ (30.06.22)	The organisation is continuing to operate under COVID-secure guidelines. Further work being undertaken at team, divisional and organisational level during phase 1 of the roadmap (Quarter 1) to look at medium-term operational models Ahead of phase 2 of the roadmap a shift in approach to face-to-face operational meetings based on risk	AMBER

				assessments rather than Trust-wide directives will take place. The ambition to retain use of Teams for non-developmental meetings at a team and individual level remains Phase 3 of the roadmap implemented from 01.10.21. New ways of working embedded into divisional plans as agreed at TOOL. Potential for ongoing COVID-19 restrictions in late quarter 3 and quarter 4. The Trust roadmap is under fortnightly review by ELT Roadmap progress delayed by Omicrom wave. Revised roadmap issued 07.02.22	
~~Consistency of application with respect to use of videoconferencing software for patient consultations vs face to face in person consultations~~	~~Agreed protocol for when face to face in person appointments are necessary for patient safety with the understanding all other contacts would be via video or phone [ACTION OWNERS: DON/MD]~~	~~Percentage use of video/phone contacts with patients in line with the agreed protocol~~		~~Further work undertaken at team, divisional and organisational level during first phase of the roadmap to look at medium-term operational models and ongoing use of video contacts – Complete~~	~~BLUE~~
Learning from COVID-19 pandemic outbreak Pulse checks/staff survey - check	Review learning from colleagues [ACTION OWNER: COO]	Positive staff feedback on learning from COVID-19	~~31.03.22~~ 31.05.22	Live staff engagement sessions continued throughout pandemic. Learning the Lessons surveys/focus groups undertaken, reported to Board Pulse checks completed in 2021. Staff survey ~~2020~~ 2022 results shared ~~and learning taken, including regarding the impact of COVID-19~~	GREEN

Implemented clinical strategies and Quality Improvement (QI) strategies and sign off all actions	Refresh Quality Improvement strategy and implementation plan Build in prioritised actions from clinical improvement strategies into divisional business plans [ACTIONS OWNER: DBIT]	Increase in no of people trained and supported to undertake Quarter 1 actions at a local team level Delivery against the divisional business plans	~~(31.03.22)~~ (30.06.22)	Roadmap outlines resumption of strategic work later in 2021/22 Planning sessions with divisions/teams postponed due to focus on pandemic response. The Transformation Team are regularly meeting with divisional colleagues around 2021/22 and 2022/23 plans QI Strategy was agreed by the Quality & Safeguarding Committee in November 2021. Transformation Team working has recommenced following redeployment QI Implementation Plan agreed by Quality and Safeguarding Committee and Finance and Performance Committee in December 2021. Staff now starting training in QI methodologies	~~RED~~ Changed to AMBER
Improvements to acute pathway length of stay during pandemic are reversed	Fortnightly out of area monitoring meetings continuing, led by Medical Director Crisis team expansion and crisis alternatives to admissions in place and continuing to be developed. Social worker input on wards being sustained Transformational change postponed by pandemic restarted [ACTIONS OWNER: DBIT]	Bed occupancy being managed at less than 85%	~~(31.03.22)~~ (30.06.22)	The COO has instigated a new approach to the management of acute flow focusing on delivery of 85% bed occupancy rather than length of stay. New mechanisms are being implemented for patient reviews and discharge coordination Out of area acute placements are at very low levels since June 2021. Fortnightly monitoring meetings stood	AMBER

				down Acute length of stay was included in MADE in October 2021 and plans are in development based on results of the event, focussing on how we maintain 85% bed occupancy. Recommendations are feeding into a QI approach at a ward level using data to address process differences and variation Omicrom Wave response and national expectations on medically fit for discharge patients resulted in refreshed approach to flow and ongoing work to embed new processes learnt through the MADE events. Initial positive impact on occupancy and out of area placements, which continues to improve further. To be reviewed quarterly	

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 3 - To make BEST use of our money

Principal risk: Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change on senior managers from across the system may impact negatively on the cohesiveness of the Derbyshire health and care system

Impact: Financial position of the Derbyshire Health and Care system worsens; working relationships across the system deteriorates; loss of confidence from regulators in the Derbyshire system

Root causes:

a) New senior management relationships across organisations, with potential new appointments in system leadership roles with the creation of the new ICS as an NHS body and the creation of provider collaboratives
b) Creation of mental health, learning disability and autism provider collaborative may destabilise some of the established relationships in place across Derbyshire
c) Creation of system level governance structures may impact on provider Foundation Trust governance arrangements and decision-making processes
d) CCG staff impacted by change, may lead to increased staff turnover in teams supporting the delivery of the Mental Health Long-Term Plan and subsequent loss of organisational memory
e) The Trust taking on additional lead-provider responsibilities at an ICS or regional level could impact on the quality, performance and financial risks faced by the organisation

BAF Ref: 20_21 3c	**Director Lead**: Gareth Harry (DBIT)	**Responsible Committee**: Trust Board

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⟺	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Governance structures in place at a system and Delivery Board level. Ongoing close communication with NHSE/I, mental health and learning disability teams at a regional and national level. Assumed NHSE/I-led appointment process to new ICS Board positions
Detective – Early meetings to be put in place with all new appointees at an executive level. Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives. Due diligence processes undertaken prior to accepting any lead provider responsibilities
Directive – Mental Health, Learning Disability and Autism System Delivery Board to engage widely across membership on the development of any provider collaborative with agreed plans and processes. Gateway process run by NHSE prior to agreement to establish the Trust as lead-provider in any regional collaborative
Corrective – Weekly meetings of wider system transformation team to continue, providing support and advice to colleagues across the system. Regular meetings with system partners to plan and respond to risks and issues related to lead provider responsibilities

Board Assurance Framework 2022-23 – Issue 1.3 Board 10 May 2022

Assurances on controls (internal)	Positive assurances on controls (external)
- Regular reporting of position to Board by CEO - Regular ELT updates and discussions - NED Board members on JUCD committees and Board - Board agreement required prior to undertaking of lead-provider responsibilities	- Monthly Mental Health and Learning Disability assurance meetings with NHSE/I teams with DHCFT represented by DBIT - Appointments/ assurance of new ICS board through NHSE/I processes - Gateway process run by NHSE prior to agreement to establish a Trust as lead-provider in regional collaboratives

Key gaps in control	Key actions to close gaps in control	Impact on risk to be measured by	Expected completion date (Action review date)	Progress against action	Action on track
Maintenance of relationships with CCG colleagues during period of change and potential instability	Weekly meetings of wider MHLD system transformation team. Support and guidance provided from DHCFT Early meetings at DHCFT Board level with all new appointees into the ICS Board [ACTION OWNER: DBIT]	Staff turnover from wider transformational team, including CCG staff Positive working relationships formed with all new appointees in the Derbyshire system	~~(30.04.22)~~ (31.05.22)	Weekly meetings continuing A permanent ICS Chair was appointed in July 2021. The CEO advert was published on 01.09.21. Integrated Care Board CEO appointed in October 2021; incumbent CCG CEO successful. Other executive posts being recruited to from December 2021 Recruitment process ~~initiated with first stage of interviews in w/c 14.02.22 recruitment process~~ ongoing within ICS Board	AMBER
~~Ensuring DHCFT board members are represented in positions of responsibility in JUCD governance structures~~	~~DHCFT Non-Executive Directors representing the organisation on a range of JUCD system governance committees and groups [ACTION OWNER: CEO]~~	~~DHCFT Board oversight of JUCD system and levels of confidence in system working and decision-making (measured in Board development sessions)~~		~~Non-Executive Directors including the Chair are now represented on JUCD governance Boards/committees~~	~~BLUE~~
Plan required for the development of the Mental Health, Learning Disability and Autism System Delivery Board (MHLD SDB) to become a	Plan to be developed in partnership with all other organisations in the collaborative [ACTION OWNER: CEO]	Development and agreement of Mental Health, Learning Disability and Autism (MHLD&A) Provider Collaborative before December 2021	(31.05.22)	All Boards in the Derbyshire system have agreed their support for the direction of travel for a single provider collaborative across the	GREEN

provider collaborative				system and sitting below that it is explicit that there will be a MHLD&A provider Alliance. Work is starting imminently on what that form would look like ~~Two~~ Three cross system development sessions held (and three more planned) on the creation of an Alliance. Expect agreement to be in place amongst partners before end of May 2022	
Increased decision-making at a system and/or provider collaborative level may impact on Trust-level governance structures becoming obsolete without regular review and change	Review of trust governance arrangements to be conducted in response to creation of ICS as an NHS Body with Non-Executive and Executive Director representation on the Board and the creation of a provider collaborative for Mental Health, Learning Disability and Autism [ACTION OWNER: CEO/Trust Secretary]	Board level confidence in new and emerging governance structures and ability to gain assurance on DHCFT risks and issues via system level governance regime	~~(28.02.22)~~ (30.06.22)	NHSE/I published ICS guidance documents and resources on 19.08.21 to support systems' transition into statutory Integrated Care Boards (ICBs) by 01.04.22. This document summarises these resources and provides detailed commentary on the ICB functions and governance guidance, model constitution and ICS people guidance A new series has been launched to help colleagues understand the new ICS. The CEO updated the Council of Governors on the MHLD SDB. The series of engagement events with key system leaders continues	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

PART TWO – SYSTEM BASED RISK IMPACTING ON AND MITIGATED BY MULTIPLE SYSTEM ORGANISATIONS

Multiple System Strategic Risk

There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS in-patient LD bedded care

Impact: May lead to avoidable harm and delays in accessing appropriate services, affecting patients, their family members and staff

Root causes:

o) The community Intensive Support Team and Learning Disability models have non-standardised operating models and require more capacity
p) Currently the delivery and commissioning partnership in Derbyshire have not met national standards
q) The collective vision for Learning Disability services across Derbyshire and the formal outcome to achieve repatriation to Derbyshire has not been effective with some people remaining in outsourced areas of England for extended and significant periods of time
r) Inpatient bedded facilities do not meet safer staffing levels due to substantial vacancies
s) Derbyshire bedded facilities do not meet current standards, e.g., en-suite accommodation, safety and environmental standards and the seclusion room does not meet the required standards as outlined in the Mental Health Act Code of Practice. (The CQC did note the lack of appropriate provisions in the seclusion room available in 2016 but this was not noted as a requirement notice)
t) The current LD bedded care facilities do not meet the national specifications for the Royal College of Psychiatrists Learning Disability recommended standards
u) Gaps in controls – Derbyshire bedded care facilities for LD services have not had a full CQC inspection since 2016 as a core service. There may have been a drift in scrutiny connected to inspection

BAF Ref: 22-23 MS1	**Director Lead**: Ade Odunlade (COO)	**Responsible Committee**: Quality and Safeguarding Committee within DHCFT Quality and Performance Committee within the Derbyshire ICS Mental health, LD and Autism Board in terms of system operational delivery

Key Controls

Inherent Risk Rating			Current Risk Rating				Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Direction ⇔	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Health and safety audits; risk assessments; investment in estates development; workforce plan covering recruitment and retention. Mental Health Act Code of Practice
Detective – CQC inspection reports; quality visit programme/virtual clinical service contact visits; incident, complaints and risk investigations; safety check log; Head of Nursing and Matron compliance visits
Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; policies and procedures available via Trust intranet
Corrective – Board committee structures and processes ensuring escalation of safety and quality issues; NICE Quality standards, Royal College of

Psychiatrist standards for LD, CQC action plans; learning from incidents, complaints and risks; actions following clinical and compliance audits; workforce issues escalation procedures; reporting to commissioners on compliance with safety and quality standards					
Assurances on controls (internal)		**Positive assurances on controls (external)**			
Regional and national escalation process internal preparation		Advisory support provided by DHCFT to the system on bedded care standards for Learning Disability in-patient services Involvement of Local Government Association to deliver a peer review Involvement of external consultants – Two reports			
Key gaps in control	**Key actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion date (Action review date)**	**Summary of progress on action**	**Action on track**
The community Intensive Support Team and Learning Disability models require review	Review all models of support offered by the Intensive Support Team [ACTION OWNERS: COO/DON/MD]	Outcome of review – Improved models of support	~~31.03.22~~ 31.05.22	COO to submit review report to Quality and Safeguarding Committee ~~in March 2022~~	GREEN
Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live their lives in the least restrictive manner as close to home as possible	Develop an improvement plan for all Derbyshire in-patient LD&A services, to include the model, delivery, regulation and standards [ACTION OWNER: COO]	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission and market stimulation and development Make significant impacts on the number of stranded patients who have delayed discharges in units across the country resulting in the NHSE escalations	~~(28.02.22)~~ (31.05.22)	Initial review of progress to follow the review of models of support currently offered Monthly reviews of progress, development and implementation to be undertaken	RED
Current substantial staff vacancies are negatively impacting on safer staffing levels in a non-DHCFT Derbyshire	Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	~~(28.02.22)~~ (31.05.22)	Reviews of safer staffing and stabilisation in non-DHCFT Derbyshire bedded LD facility	AMBER

bedded care facility	Staff temporarily redeployed from DHCFT to DCHS to ensure immediate safety and develop service stabilisation [ACTIONS OWNERS: COO/DON/DPI]			Reviews of DHCFT safer staffing, due to destabilisation of DHCFT services on releasing staff to an alternative facility	
Clinical care standards in a non-DHCFT Derbyshire bedded care facility including care plans, levels of incidents, restrictive practices including the use of long-term segregation are not compliant with clinical care standards	Develop an improvement plan for all Derbyshire in-patient LD&A services [ACTION OWNERS: COO/DON)	Full compliance with required care standards External review of Long-Term Segregation and review to end restrictive practices	~~(28.02.22)~~ (31.05.22)		RED
Lack of adherence to national guidance and policy on in-patient care in a non-DHCFT Derbyshire bedded care facility	Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER: COO/DON]	Delivery of approved business cases for development of single en-suite facilities, seclusion suite at specification standards and other improving the therapeutic and healing environment requirements Implementation of programme of work	~~(31.03.22)~~ (31.05.22)	Initial review and development of business plan to be undertaken, progress to reviewed ~~by 31.03.22~~ Work to provide facilities that meet national standards to be completed – Expected completion date to be confirmed	AMBER

Related operational high/extreme risks on the Corporate Risk Register:

22677	Non-Trust	Bed availability across the Learning Disability and Autism (LD/A) secure regional pathway	There is pressure on female medium secure unit (MSU) beds in the region and at a national level. This is impacting on the ability to admit patients, particularly to female LD/A beds 'Impact', the collaborative provider is aware of the risk 25.04.22: There remains to be pressure on the MSU female pathway and secure pathways for male and female LD&A provision 11 secure wards at St Andrews remain paused for admission. The risk remains unchanged in April 2022 and continues to impact Derbyshire women awaiting access to these beds	12.08.21	31.05.22	**EXTREME**

Risk Rating

Board Assurance Framework 2022-23 – Issue 1.3 Board 10 May 2022

The full Risk Matrix, including descriptors, is shown in the Trust's Risk Management Strategy

RISK ASSESSMENT MATRIX					
The Risk Score is a multiplication of Consequence Rating X Likelihood Rating					
The Risk Grade is the colour determined from the Risk Assessment Matrix					
	CONSEQUENCE				
LIKELIHOOD	INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
RARE 1	1	2	3	4	5
UNLIKEY 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

Actions on Track for Delivery Against Gaps in Controls and Assurances	Colour Rating
Action completed	Blue
Action on track to completion within proposed timeframe	Green
Action implemented in part with potential risks to meeting proposed timeframe	Amber
Action not completed to original or formally agreed revised timeframe. Revised plan of action required	Red

Action Owners

CEO	Chief Executive Officer
DOF	Deputy Chief Executive and Executive Director of Finance
MD	Medical Director
DBIT	Director of Business Improvement and Transformation
COO	Chief Operating Officer
DON	Director of Nursing and Patient Experience
DPI	Director of People and Inclusion

Definitions

Preventative	A control that limits the possibility of an undesirable outcome
Detective	A control that identifies errors after the event
Directive	A control designed to cause or encourage a desirable event to occur
Corrective	A control to limit the scope for loss and reduce the extent of undesirable outcomes

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 10 May 2022

Corporate Governance Report

Purpose of Report

To seek approval of a number of Governance documents, note the assurance on Board Committee year end reporting and receive the Trust sealings report.

Executive Summary

Included are several governance documents requiring Board approval. These are:

- NHS Improvement Year-End Self-Certification
- Modern Slavery Statement
- Terms of Reference (ToRs) for Board Committees
- The Trust Sealings register (for information).

Assurance is provided from the Audit and Risk Committee on the year-end governance reporting from Board Committees. All ToRs are consistent to enable the Committees to act under emergency ToRs agreed in April 2020 in response to the COVID-19 pandemic. Additional revisions were as follows:

COVID-19 Business Continuity Terms of Reference for Board and Committees

With the exception of the Audit and Risk Committee all the Board Committee ToRs were revised in April 2020 to provide consistent flexibility for them to act under emergency ToR agreed in response to the COVID-19 pandemic with the quorum reduced to one Executive Director and two Non-Executive Directors (for Non–Executive Director only Committees - quorum has been two Non-Executives). These emergency ToR have remained in place throughout 2021/22.

All the Board Committees approved their Terms of Reference during their 2021/22 year-end effectiveness review and are attached to this report as Appendix 3. A minor change was made to the People and Culture Committee ToR to include the Assistant Director of Organisational Development as a core attendee.

The Mental Health Act Committee ToR have been revised to include Trust Secretary as a formal member of the Committee. The Director of Nursing and Patient Experience has been removed as a member and will attend meetings as required.

Section 6.6 in the ToR for the Quality and Safeguarding Committee relating to the terms of reference and membership of its reporting sub-committees have been updated to replace the Trust Management Team (TMT) with Trust Operational Oversight Leadership (TOOL). 6.7 has also been updated to replace Trust Management Team with TOOL.

Since the ToR were approved by the Board Committees in March it has become necessary to include an additional paragraph in the ToR for the Finance and Performance Committee and Quality and Safeguarding Committee to reflect the Trust's ambition as Lead Provider of the East Midlands Perinatal Mental Health Provider Collaborative.

"To receive assurance in relation to the fulfilment of the aspects of the Trust's roles

and responsibilities as Lead Provider of the East Midlands Perinatal Mental Health Provider Collaborative during the development and subsequent implementation of the provider collaborative, including the effective operation of Northamptonshire Healthcare Commissioning Hub support."

Members of the two committees have given their agreement to this revision by email as there was not another scheduled committee meeting before the draft ToR were submitted to Audit and Risk Committee on 28 April before submitting to the Board for approval on 10 May.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	X
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

The Trust has complied with national guidance and statutory duties. Each Committee or Committee Chair has been assured through their review that the Committees are working effectively and meeting the requirements of the Terms of Reference (ToR) as required per the Corporate Governance Framework.

Consultation

The Modern Slavery Statement has been considered by the People and Culture Committee. The year-end governance reports and ToRs have been through the individual Board Committees and monitored through the Audit and Risk Committee.

Governance or Legal Issues

The NHS Improvement Year-End Self-Certification is in compliance with the Trust's licence and the Modern Slavery Statement is mandated. The year-end governance reports are in line with governance best practice. The NHS Audit Committee Handbook advises that an Audit Committee, in line with best practice in other sectors, should prepare a report to the Board that sets out how the Committee has met its ToR. One of the general roles of the Board under the scheme of delegation is to agree the ToRs for Committees of the Board.

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation))

including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

In relation to Modern Slavery Statement the Trust commits to the design and implementation of services, policies and measures that meet the diverse needs of services, the population and workforce, ensuring that none are placed at a disadvantage over others.

There is no direct impact on those with protected characteristics arising from other aspects this report. However, governance of the Trust includes broad consideration of equality and diversity issues for example as a key part of Board Committee business, and as an important element of governor training and development to ensure that decision making encompasses equality impact considerations. Each Board Committee has a specific objective around equality.

Recommendations

The Board of Directors is requested to:

1. Approve the NHS Improvement Year-end Self-Certification (Appendix 1)
2. Approve the Modern Slavery Statement for 2021/22 (Appendix 2)
3. Approve the suite of Terms of Reference for Board Committees (Appendix 3)
4. Note the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their Terms of Reference during 2021/22.
5. Note the Trust seal report (Appendix 4).

Report presented by: **Justine Fitzjohn, Trust Secretary**

Report prepared by: **Justine Fitzjohn, Trust Secretary**
Sue Turner, Board Secretary

1. NHS Improvement Year-end Self-Certification

NHS Foundation Trusts are required to annually self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

Providers need to self-certify after the financial year end that, in relation to their NHS provider licence conditions:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution; Condition G6(3)
- The provider has complied with required governance arrangements; Condition FT4(8
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service Condition CoS7(3)
- Publication of condition G6(3) self-certification; condition G6(4)

The proposed declaration is included as Appendix 1 for Board approval. The declaration highlights key evidence and narrative to support the declarations.

Recommendation:

The Board of Directors is asked to approve the NHS Improvement Year-end Self-Certification. The declarations will then be posted on the Trust's web-site

2. Modern Slavery Statement

The Trust has to publish an annual statement setting out the steps they take to prevent modern slavery in their business and their supply chains. This is a requirement under Section 54 (Transparency in Supply Chains) of the Modern Slavery Act 2015. The statement must be updated every year and published on the Trust website within six months of the financial year-end.

The Trust's statement has recently been considered and signed off by the People and Culture Committee. The Committee was assured that the Trust has met the criteria for the 2020/21 financial year. The proposed statement for 2021/22 is attached at Appendix 2.

Recommendation:

The Board of Directors is requested to approve the Modern Slavery Statement for 2021/22, noting that once approved the statement will be uploaded to the Trust's website.

3. Year-end governance reporting from Board Committees and approval of Terms of Reference (ToRs)

At its meeting on 28 April 2022, the Audit and Risk Committee received the full year end summaries for the following Committees as well as their Terms of Reference (ToR):

- Remuneration and Appointments Committee
- Finance and Performance Committee
- Audit and Risk Committee
- Quality and Safeguarding Committee
- People and Culture Committee
- Mental Health Act Committee

In April 2020 the Trust adapted a number of its governance structures in response to the NHSEI guidance letter 'reducing the burden and releasing capacity to manage the pandemic'. In relation to the Board and its Committees, emergency ToR were adopted which gave flexibility on quorum and membership and re-focused agendas as well as the mandate to hold meetings virtually.

The Board Committees reviewed their activity during the past year against the background of this lighter governance approach and sought verbal confirmation from their members that they had fulfilled the key duties under their ToR and were operating effectively in providing assurance to the Trust Board or escalating risks.

The Audit and Risk Committee received assurance from the summary reports that the Committees have effectively carried out their role and responsibilities during 2021/22. The suite of ToRs are included as Appendix 3.

Recommendation:

The Board of Directors is requested to approve the suite of ToRs for the Board Committees and note the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their ToR during 2021/22.

4. Register of Trust Sealings

The six-monthly update on the authorised use of the Trust Seal since the last report to the Board on 2 November 2021 is attached for information at Appendix 4.

Recommendation:

The Board of Directors is requested to note the contents of the report.

Appendix 1

Condition G6

Condition G6(2) requires NHS foundation trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring

Providers must annually review whether these processes and systems are effective must publish their G6 self-certification within one month following the deadline for sign-off (as set out in Condition G6(4)).

Proposed declaration:

The Board declares that the Licensee continues to meet the criteria for holding a licence (Condition G6)

This declaration is supported by evidence as outlined in the Trust's Annual Governance Statement, Board Assurance Framework and through the work of the Board Assurance Committees in ensuring management of risks and ongoing compliance. This has been supported through a number of internal audit reports carried out in year which provided significant assurance of our governance processes and positive the CQC 'Good' rating from the 2020 Well Led inspection.

2. Continuation of Services Condition 7

Commissioner requested services (CRS) are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and which will be subject to regulation by NHSI. Providers can be designated as providing CRS because:

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable.

Primary evidence is contained in the Going Concern assessment which has been considered by the Audit and Risk Committee. This assessment is based solely on the anticipated future provision of our services in the public sector in line with current guidance. This decision will be reviewed each year in order to ensure that accounts are prepared on an appropriate basis given prevailing circumstances at the time. The Trust's financial management arrangements, overseen by Finance and Performance Committee. This is described in full along with mitigating actions in the 2021/22 Board Assurance Framework.

Proposed Declaration:

The Board declares that the licensee has a reasonable expectation that the licensee will have the required resources available to it after taking account

distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

3. Condition FT4 Declaration

NHS foundation trusts must self-certify under Condition FT4 (8) whether the governance systems achieve the objectives set out in the licence condition.

The Trust has flexed its governance structures to maintain a well-led organisation with robust governance in the context of wholly unprecedented challenges presented by COVID-19. There has been regular updates to the Board on the on-going management of corporate governance within the Trust, the principles of which were approved by the Board in April 2020 and in light of NHSEI's 'Reducing burden and releasing capacity to manage the COVID-19 pandemic' letters. The Trust has effective Board and committee structures, reporting lines and performance and risk management systems. See attached Corporate Governance Statement for further information against each item.

Proposed declaration:

The Board confirms that it complies with all elements of the Corporate Governance Statement (condition FT4)

4. Certification on Training of governors

Providers must review whether their governors have received enough training and guidance to carry out their roles.

Despite the COVID-19 pandemic governor training has been carried out throughout the year; sessions were held digitally. All new governors attend a bespoke induction and all governors were encouraged to attend the training and development sessions, areas for development included finance (led by a Trust Director); the Integrated Performance Report and engagement. Governors were also encouraged to attend virtual GovernWell sessions organised by NHS Providers, and the NHS Providers conference which gave governors the opportunity to network with governors from other Trusts and to share good practice.

Proposed declaration:

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Corporate Governance Statement – 2021/22

1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	
Response	**Confirmed**
Risks and Mitigating actions The Trust has been required to flex its governance structures but has following national guidance and best practise. The robustness of these processes are set out in the Annual Report and Annual Governance Statement. The Trust received a 'Good' rating in the CQC Well Led inspection in 2020. Board Committees continue to review effectiveness with year-end reviews undertaken by each Committee during February/March 2022 for onwards scrutiny and oversight by the Audit and Risk Committee and then Trust Board.	
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	
Response	**Confirmed**
Risks and Mitigating actions The Trust has continued to embed good practice developed through self-assessment the NHSI and CQC well-led framework. The Trust had several areas of positive feedback on corporate governance elements of well-led following the CQC comprehensive inspection report received. The Trust has followed NHSEI's guidance as set out in the 'Reducing burden and releasing capacity to manage the COVID-19 pandemic' letters.	
3. The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	
Response	**Confirmed**
Risks and Mitigating actions The Trust corporate governance framework has been implemented successfully in terms of Board and Board Committee responsibilities, delegation and escalation. There is a process for review of all Board Committees to reflect on their effectiveness.	
4. The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:	

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;

(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) To ensure compliance with all applicable legal requirements.

Response	**Confirmed**

Risks and Mitigating actions

The Board, via its Committees where relevant, oversees the Trust duties as listed. Items are escalated to the Trust Board from Committees to ensure key risks are addressed.

5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and

resolving quality issues including escalating them to the Board where appropriate.	
Response	**Confirmed**
Risks and Mitigating actions Quality Leadership is overseen by the Trust Board and assurance on quality of care is provided through the Quality and Safeguarding Committee. Issues and risks are escalated to the Board as required. While working under Level 4 emergency procedures some compliance has been impacted by the pandemic response but essential quality and safety has been managed through the Incident Management Team, Executive Directors and the Quality and Safeguarding Committee. Quality is led on the Trust Board jointly by the Medical Director and Director of Nursing and Patient Experience. We have continued to review and improve our integrated performance report to Trust Board to ensure robust oversight of operational performance, workforce, financial and quality issues.	
6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	
Response	**Confirmed**
Risks and Mitigating actions The Remuneration and Appointments Committee consider the composition of the Board to ensure that this is appropriate in terms of skill mix and qualifications. The Fit and Proper Persons Test Policy has been fully implemented and is embedded. Wider workforce issues are considered by the People and Culture Committee with risks and issues escalated to the Board as required and routinely through assurance summaries.	

Derbyshire Healthcare
NHS Foundation Trust

Appendix 2

MODERN SLAVERY STATEMENT – 2021/22

INTRODUCTION

This Statement is made pursuant to section 54 of the Modern Slavery Act 2015 and sets out the steps that Derbyshire Healthcare NHS Foundation Trust (the Trust) has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. The Trust has a zero tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to put effective systems and controls in place to safeguard against any form of modern slavery taking place within our business or our supply chain.

AIM OF THIS STATEMENT

The aim of this statement is to demonstrate that the Trust follows good practice and all reasonable steps are taken to prevent slavery and human trafficking.

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking, with the Procurement Department taking the lead responsibility for compliance in the supply chain.

ABOUT THE ORGANISATION

The Trust is a provider of mental health, learning disability and children's services across the city of Derby and wider county of Derbyshire. We provide a variety of inpatient and community based services throughout the county. We also provide specialist services across the county including substance misuse and eating disorders services.

Successful partnership working is essential to the delivery of many of our services. The Trust works in close collaboration with our commissioners and fellow providers of local healthcare services, together with local authority colleagues at Derby City Council and Derbyshire County Council, and voluntary and community sector organisations. Derbyshire Healthcare is an active partner in Joined Up Care Derbyshire, an Integrated Care System of health and care organisations working collectively to address challenges and improve the level of joined up working within the local health and care economy.

The Trust provides services to a diverse population, including areas of wealth alongside significant deprivation. The Trust's catchment area includes both city and rural populations, with over 70 different languages being spoken.

We became a Foundation Trust in 2011 and we employ over 2,400 staff based in over 60 locations across the whole of Derbyshire. Across the county and the city, we serve a combined population of approximately one million people.

OUR POLICIES ON SLAVERY AND HUMAN TRAFFICKING

The Trust is aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. The Trust is committed to ensuring that there is no modern slavery or human

trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

Currently all awarded suppliers sign up to our terms and conditions of contract which contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains; and that they conduct their businesses in a manner that is consistent with the Trust's anti-slavery policy.

The Trust policies, procedures, governance and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. We also conform to the NHS employment check standards within our workforce recruitment and selection practices. This strategic approach incorporates analysis of the Trust's supply chains and its partners to assess risk exposure and management on modern slavery.

We operate a number of internal policies to ensure that we are conducting business in an ethical and transparent manner. These include the following:

Recruitment and Selection policy and procedure: We operate a robust recruitment policy including conducting eligibility to work in UK checks for all directly employed staff. Other checks include checks of identity, evidence of qualifications, health clearance, employment history and in areas of safeguarding risk a Disclosure Barring Service criminal records check. External agencies are sourced through the NHS Improvement nationally approved frameworks and are audited to provide assurance that pre-employment clearance has been obtained for agency staff to safeguard against human trafficking or individuals being forced to work against their will.

Equal Opportunities: We have a range of controls to protect staff from poor treatment and/or exploitation which comply with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment, and access to training and development opportunities.

Safeguarding Policies: We adhere to the principles inherent within both our Safeguarding Children and Adults policies and procedures. These provide clear guidance so that our employees are aware as to how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.

Freedom to Speak Up Policy: We operate a Speak Up policy so that all employees know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals.

Standards of Business Conduct (within Standing Orders): This policy explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

WORKING WITH SUPPLIERS

The Procurement Team ensures that due diligence is undertaken for all new and ongoing suppliers of goods and services to the organisation and their associated Supply Chains by sourcing through the following compliant routes:

1. Competitive OJEU (Official Journal of the European Union) procurements tendered in compliance with EU guidance which require suppliers to confirm they comply with the Modern Slavery Act. To support their response bidders are also required to state:

a. *the organisation's structure, its business and its supply chains;*
b. *its policies in relation to slavery and human trafficking;*
c. *its due diligence processes in relation to slavery and human trafficking in its business and supply chains;*
d. *the parts of its business and supply chains where there* is *a risk of slavery and human trafficking taking place, and the* steps *it* has *taken to* assess *and manage that risk;*
e. *its effectiveness in ensuring that slavery and human trafficking* is *not taking place in its business or supply chains, measured against such performance indicators as it considers appropriate;*
f. *the training and capacity building about slavery and human trafficking available to its staff.*

2. Procurement through compliant national government frameworks. The Trust purchases large amounts of products from third party distributors such as NHS Supply Chain and utilises framework agreements from national framework providers such as Crown Commercial Services (CCS) which include specific questions around the Modern Slavery in their procurement documentation and any breaches of labour laws which result in disqualification of unsuitable organisations.

3. All contracts and associated purchase orders are raised on the NHS Standard Terms and Conditions which suppliers are mandated to comply with. These conditions state:

10.1.28 it shall: (i) comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and (ii) notify the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains;

10.1.29 it shall at all times conduct its business in a manner that is consistent with any anti-slavery Policy of the Authority and shall provide to the Authority any reports or other information that the Authority may request as evidence of the Supplier's compliance with this Clause 10.1.29 and/or as may be requested or otherwise required by the Authority in accordance with its anti-slavery Policy.

4. The Procurement Team upholds the Chartered Institute of Procurement and Supply (CIPS) Code of Professional Conduct.

TRAINING

Advice and training about Modern Slavery and human trafficking is available to staff through our mandatory Safeguarding Children and Adults training programmes, our Safeguarding policies and procedures, and our Safeguarding Leads. It is also discussed at our compulsory staff induction training.

Awareness is also raised through information sharing on the Trust intranet and our public website.

Advice and training about Modern Slavery and human trafficking is available to staff through our Safeguarding Children and Adults training programme. The Trust is committed to and follow the Derbyshire and Derby Safeguarding Adults Policy and Procedures and the Derby and Derbyshire Safeguarding Children Partnership Procedures.

OUR PERFORMANCE INDICATORS

We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if:

- No reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

BOARD OF DIRECTORS' APPROVAL

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to Section 54(1) of the Modern Slavery Act 2015 and constitutes our organisation's modern slavery and human trafficking statement for the current financial year.

Signed on behalf of the Board of Directors:

Selina Ullah
Trust Chair

Ifti Majid
Chief Executive

Derbyshire Healthcare
NHS Foundation Trust

Appendix 3

Remuneration and Appointments Committee Terms of Reference

Purpose

The Committee is responsible for identifying and appointing candidates to fill Director positions on the Board of Directors including the Chief Executive, voting and non-voting Executive Directors. The Committee is also responsible for establishing and keeping under review a remuneration policy in respect of Executive Directors and to advise upon and oversee contractual arrangements for Executive Directors.

1. **Authority**

1.1 The Remuneration and Appointments Committee (the Committee) is constituted as a standing Committee of the Trust's Board of Directors (the Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

1.2 The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board to obtain external legal or other independent professional advice. The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5 As a Committee of the Board, the Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit.

1.6 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.7 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Committee will ensure consideration has been given to equality impact related risks.

1.8 To actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion

1.9 As a designated policy ratification group, (see 'Policy on Policy Documents) the Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The membership of the Committee shall consist of:

- Trust Chair
- All Non-Executive Directors.

2.2 The Trust Chair will chair the Committee.

2.3 When appointing or removing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 as amended by the Health and Social care Act 2012 (the Act) (that is all the non-executive directors). When appointing or removing the other Executive Directors the Committee shall be the committee described in Schedule 7, 17(4) of the Act (that is the Trust Chair, the Chief Executive and the Non-Executive Directors).

3. Attendance

3.1 Meetings of the Committee may be attended by:

- Chief Executive
- Director of People and Inclusion
- Trust Secretary
- Board Secretary
- Any other person who has been invited to attend the meeting by the Committee so as to assist in deliberations.

4. Quorum

4.1 A quorum shall be three members.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board meeting as an urgent item.

5. Frequency of Meetings

Meetings shall be held quarterly or as required.

6. Duties and Responsibilities

Monitor's Code of Governance (July 2014) - these terms of reference are based in part, on best practice as set out in that code and have been drafted referring to the provision in the code. The code states as two of its principles that;

"There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration."

"There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence."

To be responsible for identifying and appointing candidates to fill all the executive director positions on the Board and for determining their remuneration and other conditions of service.

The Committee will ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

These terms of reference are intended to ensure that the Trust's procedure for the appointment of the Cchief Executive and other directors (excluding Non-Executive Directors) to the Board reflect these principles.

6.1 Appointments role

6.1.1 To be responsible for identifying and appointing candidates to fill all the executive director positions on the Board including the Chief Executive, voting and non-voting Directors. Non-Executive Directors are appointed through the Nominations and Remuneration Committee of the Council of Governors.

6.1.2 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, and nomination committee of the Council of Governors, as applicable, with regard to any changes.

6.1.3 Give full consideration to and make plans for succession planning for the Chief Executive and other executive board director roles taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the Board in the future.

6.1.4 To advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments.

6.1.5 Ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

6.1.6 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

6.1.7 Consider any matter relating to the continuation in office of any Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract. The Committee will oversee ongoing compliance with the Fit and Proper Person requirements of Directors.

6.2 Remuneration Role

6.2.1 Establish and keep under review a remuneration policy in respect of Executive Directors.

6.2.2 Consult the Chief Executive about proposals relating to the remuneration of the other Executive Directors.

6.2.3 In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors (voting and non-voting) on locally-determined pay in accordance with all relevant Foundation Trust policies, including:

- salary, including any performance-related pay or bonus
- provisions for other benefits, including pensions and cars
- allowances.

6.2.4 In adhering to all relevant laws, regulations and Trust policies:

- establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust

- use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors (both voting and non-voting) on locally-determined pay, while ensuring that increases are not made where Trust or individual performance do not justify them

6.2.5 Monitor and assess the output of the evaluation of the performance of individual executive directors and consider this output when reviewing changes to remuneration levels.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded. These will be held confidentially by the Trust Secretary on behalf of the Trust Chair.

7.3 The Committee shall ensure that Board emoluments are accurately reported in the required format in the Trust's annual report.

7.4 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its terms of reference and give details of any significant issues and how they have been addressed.

7.5 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.6 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Remuneration & Appointments Committee	16 March 2022
Approved by Audit & Risk Committee	28 April 2022
Approved by Board of Directors	

Audit & Risk Committee Terms of Reference

Purpose

This is the principal Committee for seeking independent assurance on the general effectiveness of the Trust's internal control and risk management systems and for reviewing the structures and processes for identifying and managing key risks. It is responsible for reviewing the adequacy of all risk and control related statements prior to approval by the Board and for seeking assurances on these controls. In discharging its responsibilities the Committee takes independent advice from the Internal Auditor or seeks any other legal or professional advice as required to discharge its responsibilities.

1. Authority

1.1 The Audit and Risk Committee (the Committee) is constituted as a Committee of the Trust's Board of Directors. Its constitution and Terms of Reference are set out below, and are subject to amendment at future Board of Directors meetings. The Committee shall not have executive powers in addition to those delegated in these Terms of Reference.

1.2 As a Committee of the Board, the Audit and Risk Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit. This includes identification, review and scrutiny of all relevant risks on the Board Assurance Framework.

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Audit and Risk Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion

1.7 As a designated policy ratification group, (see 'Policy on Policy' document) the Audit and Risk Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The Committee shall be composed of at least three independent non-executive directors, at least one of whom should have recent and relevant financial experience.

2.2 One of the members shall be appointed Chair of the Committee by the Board of Directors.

2.3 The Trust Chair shall not be a member of the Committee (but may attend by invitation as appropriate).

2.4 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

3. Attendance

3.1 Only members of the Committee have the right to attend meetings, but the Deputy Chief Executive & Director of Finance and Trust Secretary shall generally be invited to attend routine meetings of the Committee. Other Executive Directors and/or staff and executives shall be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility and will be expected to attend as requested.

3.2 The Chief Executive, as accountable officer, may be invited to attend meetings and should discuss at least annually with the Committee the process for assurance that supports the governance statement. He/she should attend when the Committee considers the Annual Governance Statement and the annual report and accounts.

3.3 The External Auditor or his representative should normally attend meetings.

3.4 The Head of Internal Audit should also attend routine meetings.

3.5 A representative of the local Service will attend at least two meetings of the Committee per year.

3.6 A governor representative may be invited to attend meetings of the Committee as an observer when the Committee considers the Annual Governance Statement and the annual report and accounts.

3.7 The Trust Secretary shall be the secretary to the Committee and will provide appropriate support and advice to the Chair and the Committee members.

3.8 At least once per year the Committee should meet privately with the external and Internal Auditors.

Access

3.9 The Head of Internal Audit, representatives of External Audit and Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

4. Quorum

4.1 A quorum shall be two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency of meetings

5.1 Meetings shall be held at least four times per year, the total number of meetings being determined by the assurance required by the Committee to discharge its responsibilities. The Board of Directors, Chief Executive, External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

6. Duties and Responsibilities

6.1 The Committee's duties and responsibilities can be categorised as follows:

Integrated governance, risk management and internal control

6.2 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities, clinical and non-clinical, that supports the achievement of the Trust's objectives.

6.3 To consider the Board Assurance Framework and high level risks, including Deep Dives of risks as appropriate.

6.4 In particular to review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances

- the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- arrangements for the effective management of clinical and corporate risk to underpin the delivery of the Trust's strategic objectives

- arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Protect Standards

- The Committee shall maintain an oversight of the Trust's general material control and risk management systems, including processes and responsibilities, the production and issue of any risk and control-related disclosure statements. The key record to guide the Committee's work will be the Board Assurance Framework (BAF).

6.5 As part of its integrated approach, the Committee will ensure appropriate information flows, to the Committee from executive management and from and between other Board Committees, in relation to the Trust's overall internal control and risk management position.

6.6 To monitor corporate governance (e.g. compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

6.7 To develop and use an effective assurance framework to guide the Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these Terms of Reference.

Internal audit

6.8 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

6.9 To oversee on an ongoing basis the effective operation of internal audit in respect of:

- Adequate resourcing
- Co-ordination with external audit
- Meeting the Public Sector Internal Audit standards 2019
- Providing adequate independent assurances
- Having appropriate standing within the Trust
- Reviewing and approving the internal audit plan ensuring that this meets the internal audit needs of the organisation.

6.10 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.11 To consider the provision of the internal audit service, the cost of the audit.

6.12 To monitor the effectiveness of internal audit and to conduct an annual review of the internal audit function.

External audit

6.13 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an External Auditor and related fees as applicable. To the extent that the recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

6.14 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.

6.15 To assess the External Auditor's work and fees each year and based on this assessment, to make the recommendation above to the Council of Governors with respect to the re-appointment or removal of the Auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

6.16 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

6.17 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

6.18 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

6.19 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

Annual accounts review

6.20 To approve the Annual Report and Accounts including the Quality Report and Annual Governance Statement on behalf of the Trust Board. In doing so the Committee will determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes
- Changes in, and compliance with the accounting policies, practices and estimation techniques
- Areas where judgment has been exercised
- Explanation of estimates or provisions having material effect
- Explanations for significant variances
- The schedule of losses and special payments
- Significant adjustments in the preparation of the financial statements and any unadjusted statements
- Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved
- Changes in and compliance with guidance relating to the preparation of the Quality Report

- Compliance with the Annual Reporting Manual requirements for the content of the annual report as published by NHS Improvement.

6.21 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

Raising Concerns (Whistleblowing)

6.22 To review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

Standing orders, standing financial instructions and standards of business conduct

6.23 To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

6.24 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

6.25 To review the scheme of delegation.

Other

6.26 To review performance indicators relevant to the remit of the Committee.

6.27 To examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee.

6.28 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

6.29 To review the work of all other Trust committees in connection with the Committee's assurance function.

6.30 The Committee may also request specific reports from individual functions within the Trust (for example, clinical audit).

6.31 The Committee may refer specific issues to the Board, Finance and Performance Committee and other Committees and make recommendations as appropriate.

6.32 The Committee will receive assurance reports on Data Security and Protection arrangements, particularly in respect to compliance with the Data Security and Protection Toolkit and legislative compliance including the Data Protection Act and General Data Protection Regulations.

6.33 Audit and Risk Committee has a specific responsibility for overseeing the management of conflicts of interest and evaluating the Trust's response to implementing the Trust's Conflict of Interest Policy. The Committee is specifically cited in the national guidance in respect of consideration of any breaches.

6.34 Responsibility for the oversight of data quality assurance.

6.35 The Committee is committed to ensuring that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise, the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Committee shall present details to a meeting of the Board of Directors in addition to the assurance summary.

7.3 The Committee will report annually to the Board of Directors and the Council of Governors in respect of its work in support of the Annual Governance Statement, specifically commenting on:

- The assurance framework and its fitness for purpose
- The effectiveness of risk management within the Trust
- The integration of and adherence to governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts
- Any pertinent matters in respect of which the Committee has been engaged.

7.4 The Committee's annual report should also describe how the Committee has fulfilled its Terms of Reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

7.5 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

8. Administrative Support

8.1 The Committee shall be supported by the Trust Secretary whose duties in this regard include, but are not limited to:

- Agreement of the agenda with the Chair of the Committee and attendees
- Preparation, collation and circulation of connected papers in good time
- Ensuring that those required to attend are invited to the meeting in good time
- Ensuring that the minutes are taken and keeping a record of matters arising and issues to be carried forward
- Manage the forward plan of the Committee's work
- Arranging meetings for the Chair with directors and advisers as necessary
- Advising the Committee as appropriate on pertinent issues/areas of interest/policy developments
- Enabling training and development of Committee members as appropriate
- Reviewing every decision to suspend the standing orders.

9. Review of Terms of Reference

The Terms of Reference of the Committee shall be reviewed at least annually.

Approved by Audit & Risk Committee	24 March 2022
Approved by Trust Board	

Derbyshire Healthcare
NHS Foundation Trust

Finance and Performance Committee Terms of Reference

Purpose

The prime purpose of the Committee is to gain assurance on all aspects of financial and operational performance, on behalf of the Board. The Committee also oversees and approves business developments as well as considering progress with commercial and contractual matters. The Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

1. Authority

1.1 The Committee oversees and approves business developments as well as considering progress with commercial and contractual matters.

The Committee may refer specific issues to the Board, Audit and Risk Committee and other Committees and make recommendations as appropriate. Matters formally delegated to the Finance and Performance Committee by the Board of Directors are:

- Continuous Improvement including CIP (Cost Improvement Programme) plan reporting
- Contractual compliance performance reporting
- Treasury Management – to approve policy, procedures, controls and monitoring of policy implementation
- Working Capital Facility – to approve (if applicable)
- Estate strategy delivery oversight including assurance on performance of the estates and facilities management function, on maintenance programmes and on statutory and regulatory compliance – twice yearly updates
- Indicative 5 year capital plan – approval
- Reference Costs: process - sign-off
- Emergency Preparedness, Resilience and Response (EPPR)
- Health and Safety Compliance Report

1.2 Aside from those specific matters listed, the Committee otherwise gains assurance on matters through reports and exceptions provided to it.

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Finance & Performance Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Finance & Performance Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

1.8 As a Committee of the Board, the Finance & Performance Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit.

1.9 To receive assurance in relation to the fulfilment of the aspects of the Trust's roles and responsibilities as Lead Provider of the East Midlands Perinatal Mental Health Provider Collaborative during the development and subsequent implementation of the provider collaborative, including the effective operation of Northamptonshire Healthcare Commissioning Hub support.

2. Membership

2.1 The membership of the Committee shall comprise:

Chair of Committee – Non Executive Director
Two other Non-Executive Directors
Director of Finance
Chief Operating Officer
Director of Business Improvement and Transformation

2.2 If the Chair is not present, one of the Non-Executive Directors will chair the meeting. Other staff may be required to attend, at the invitation of the Committee.

2.3 Members of the Committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings.

2.4 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies attending no more than one third of meetings on an exception basis.

3. Attendance

3.1 Other staff may be required to attend at the invitation of the Committee.

3.2 The Chief Executive Officer reserves the right to attend any meeting.

4. Quorum

4.1 A quorum shall normally be four members, including at least two Executive Directors and two Non-Executive Directors; noting that as a minimum the executive attendance must include both the Director of Finance and the Chief Operating Officer or their deputies acting as their direct representative. Where the use of emergency terms of reference have been put in place for the delegation and purpose of carrying out the functions of the Trust during the COVID-19 pandemic the quorum can be reduced to one Executive Director and two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

5.1 Meetings should be held bi-monthly with additional meetings if required.

6. Duties and Responsibilities

6.1 To monitor the development and delivery of financial and operational aspects of the Trust strategy through:

- Detailed oversight of current and future financial performance including financial risks
- Detailed oversight of current and future operational performance

6.2 To monitor delivery of the continuous improvement programme including CIP.

6.3 To oversee progress on contractual negotiations.

6.4 To receive reports on business and commercial matters.

6.5 To consider outline business cases and proposals and to approve or make recommendations to Board accordingly.

6.6 To receive reports or referrals from committees and other meetings, relevant to the work of this Committee.

6.7 The agenda for the Committee will be informed by a forward plan of regular items but will also receive reports on relevant issues requiring additional scrutiny and assurance pertaining to actual and anticipated performance and/or when required by Trust Board or Audit and Risk Committee.

6.8 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.9 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.10 To ensuring that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agenda and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Finance and Performance Committee	15 March 2022
Approved by Audit & Risk Committee	28 April 2022
Approved by Board of Directors	

Quality and Safeguarding Committee Terms of Reference

Purpose

The prime purpose of the Committee is to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to promote safety and excellence in patient care, Identify, prioritise and manage risk arising from clinical care, ensure the effective and efficient use of resources through evidence-based clinical practice; and protect the health and safety of Trust employees. The Quality and Safeguarding Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

The Committee is also responsible for setting the Safeguarding Quality Strategy, to provide quality governance and gain assurance on all aspects of the safeguarding agenda. The Committee's purpose is to provide assurance to the Trust Board that the organisation is effectively discharging and fulfilling its statutory responsibility for safeguarding to ensure better outcomes for children and vulnerable adults.

1. Authority

1.1 The Board of Directors has approved the establishment of a Quality and Safeguarding Committee as a Committee of the Board in accordance with standing orders.

1.2 As a Committee of the Board, the Quality and Safeguarding Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Quality Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Quality Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

1.8 A safeguarding operational subgroup is to meet quarterly and will report to the Committee to prepare assurances and highlight exceptions.

1.9 Minutes of meetings held by the Safeguarding Operational Group will be provided to the Quality and Safeguarding Committee.

1.10 To receive assurance reports and scrutinise, as required, other activity reports from the Safeguarding Operational Group, noting any exceptions and escalating concerns as necessary.

1.11 To receive assurance in relation to the fulfilment of the aspects of the Trust's roles and responsibilities as Lead Provider of the East Midlands Perinatal Mental Health Provider Collaborative during the development and subsequent implementation of the provider collaborative, including the effective operation of Northamptonshire Healthcare Commissioning Hub support.

2. Membership

2.1 The membership of the Committee shall comprise:

- Non-Executive Director – Chair of the Committee
- Non-Executive Director (2)
- Director of Nursing and Patient Experience or a nominated deputy
- Medical Director or a nominated deputy
- Chief Operating Officer or a nominated deputy

3. Attendance

3.1 Attendees for specific agenda items at the request of the Committee:

- Deputy Director of Nursing and Quality Governance
- Lead professional for Patient Safety
- Chief Pharmacist
- Research and Clinical Audit Manager
- Risk and Assurance Manager
- Assistant Director of Clinical Professional Practice
- Health and Safety Manager
- Safeguarding Children Lead
- Safeguarding Adults Lead
- Chairs or Deputy Chairs of COATs (Clinical Operational Assurance Team) will be required to attend specific agenda items at the request of the Committee.

3.2 The following may also attend:

- Chief Executive Officer
- Trust Chair

- Director of People and Organisational Effectiveness
- Director of Business Improvement and Transformation
- Trust Secretary

Any other attendees will be invited upon request.

3.3 If the Committee Chair is not present, the meeting shall be chaired by another Non-Executive Director.

3.4 Members of the Committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings.

3.5 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies to attend no more than one third of meetings on an exception basis.

3.6 The Committee's Executive Lead must be in attendance or the Medical Director will act as the Committee's executive lead.

3.7 Nominated deputies for Executive members will contribute to attendance figures but will not contribute to quorum.

3.8 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

4. Quorum

4.1 A quorum shall normally be three members, including at least one Executive Director and two Non-Executive Directors This is in line with the use of emergency terms of reference that have been put in place for the delegation and purpose of carrying out the functions of the Trust during the COVID-19 pandemic. The quorum can be reduced to one Executive Director but this must be either the Director of Nursing or Medical Director and two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

5. Frequency

5.1 Meetings shall be held monthly.

6. Duties and Responsibilities

In respect of general governance arrangements:

6.1 To ensure that all statutory elements of operational risk and quality governance are adhered to within the Trust including the requirements of our regulators, NHS Improvement and the Care Quality Commission (regulations).

6.2 To provide a clear link with the Trust's Strategy and Quality framework when agreeing quality governance priorities and monitor scrutinise these areas to provide assurance and inform the Board on the strategic direction for Quality and monitor the performance of the clinical services.

6.3 To provide direction to the quality governance activities of the Trust's services and divisions. This will include setting strategy, delegating activities and monitoring clinical performance against this strategy or quality priorities.

6.4 To scrutinise, gain assurance and approve the Trust's Quality Position Statements and Quality Governance Annual Reports before submission to the Board.

6.5 To have final sign off of the Trust Quality Account prior to Audit and Risk Committee approval.

6.6 To approve the terms of reference and membership of its reporting sub-committees, the primary reporting committee will be the Executive chaired quality sub-group known as TOOL (Trust Operational Oversight Leadership). This is an operational delivery group but it will also scrutinise the clinical performance of the key sub-groups known as the Integrated Clinical Operational Assurance Teams at service level; and to oversee the work of those sub-committees and their clinical reference sub-groups, receiving reports from them, reviewing their work plans and clinical escalation issues. This will include oversight and escalation from the Divisional achievement reviews.

6.7 To scrutinise the work of the TOOL and receive assurance from the Chair of the group on quality performance issues and mitigating actions to ensure safe and effective services.

6.8 To agree to refer specific issues to the Board and other Board Committees where required and make recommendations as appropriate.

6.9 To receive and approve the annual Clinical Audit Programme consistent with the audit needs of the Trust and consistent with the Quality priorities.

6.10 To have oversight and gain assurance on the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 1998.

6.11 To make recommendations to the Audit and Risk Committee concerning the annual Internal Audit plan, to the extent that it applies to matters within these terms of reference; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register.

6.12 To have overview, responsibility and gain assurance for all regulations and standards as described by the Care Quality Commission as part of our responsibilities under the Care Quality Commission (Registration) Regulations 2009 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

6.13 To promote within the Trust a culture of open and honest reporting of any situation, including Duty of Candour, that may threaten the quality of patient care in accordance with the Trust's policy on Raising Concerns and monitoring the implementation of that policy. This will include an approach that enables an open patient safety culture and gain assurance on its implementation.

6.14 To ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

6.15 To oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust.

6.16 To ensure that risks to patients are minimised through the application of a comprehensive risk management system including clinical risk registers, monitoring and learning from deaths and associated monitoring.

6.17 To oversee the process and gain assurance within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, mortality, complaints and litigation and those examples of good practice are disseminated within the Trust and beyond if appropriate.

6.18 To ensure a clear link with the Mental Health Act Committee on aspects of quality governance that are cross cutting clinical standards across mental health act or mental capacity act legislation that impacts upon clinical standards.

6.19 To maintain a forward plan of regular agenda items as identified by the scheme of delegation.

6.20 To ensure a clear link and be assured with the Commissioners Quality Assurance Group, and that escalated clinical concerns, gaps in commissioning and patient safety concerns are discussed and monitored through the joint commissioner and provider risk and issues log.

6.21 To gain assurance and monitor the work of the Trust-wide groups which report to the Quality and Safeguarding Committee, currently the Serious Incident Requiring Investigation (SIRI) group, the Physical Health Care Committee, Health and Safety Committee, Drugs and Therapeutics Committee, Patient Experience Group and any short term named task and finish groups established to design or develop Trust Clinical Strategy.

6.22 To co-operate with and assist the work of other Trust-wide groups which report or scrutinise the work of the Quality and Safeguarding Committee, e.g. governors' Governance Committee or the Council of Governors.

6.23 To receive assurance on how the Trust has developed and planned for all clinical service re-design with sign off of any associated clinical safety plans to mitigate any significant or material changes in service, which have been designed and developed by the Clinical Operational Assurance Teams.

6.24 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.25 To oversee the development of an annual review of performance of the Committee against key areas of delegated authority and provide a check that all areas of governance and responsibility have been monitored.

6.26 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.27 To set the Safeguarding Quality Strategy, to provide quality governance and gain assurance to all aspects of the safeguarding agenda and lead the assurance process on behalf of the Trust for the following areas:

6.27.1 **Children's Act** has a statutory duty of care towards children (Children Acts 1989 and 2004) at risk of harm who are resident in Derby city and Derbyshire in our care. The committee will ensure as an organisation we have safeguards in place not only protects and promotes the welfare of vulnerable children, but that we have a significant impact on children in our care's health and well-being.

6.27.2 **The Care Act (2014)** Safeguarding adults at risk of abuse or neglect (Section 42 and named other relevant NHS legislation and NHS Safeguarding Adults policy and procedures.

6.27.3 **Counter Terrorism legislation** The Counter Terrorism and Security Bill, which is currently before Parliament (December 2014) at the time of writing, seeks to place duty on specified authorities (identified in full in Schedule 3 to the bill, and set out in this draft guidance) to have due regard to the need to prevent people from being drawn into terrorism through Prevent.

6.27.4 **A formal link to the area Safeguarding Children and Adults Boards** and provide systems leadership to our wider geographical and community safeguarding responsibilities and be the conduit for linking the community Safeguarding Board strategies with the Trust strategy.

6.27.5 **Promote a proactive and preventative approach** to safeguarding through our Flourishing Families agenda.

6.27.6 Ultimately to provide assurance to the Trust Board that the organisation is effectively discharging and fulfilling its statutory responsibility for safeguarding to ensure better outcomes for children and vulnerable adults.

6.27.7 Ensure the Trust workforce is appropriately trained in safeguarding children and adults to their appropriate level depending on their role and responsibility.

6.27.8 To determine strategic and operational development that will enable the Trust to integrate best practice in safeguarding across the Trust. The Committee has a responsibility to improve and develop Safeguarding practices consistent with national and local legislation, guidance and standards in safeguarding children and vulnerable people.

6.27.9 To ensure that the Trust embeds Think Family principles within all aspects of care and service developments to enable 'Flourishing Families'.

6.27.10 To provide rigorous and transparent assessment of performance and effectiveness and quality of practice for Safeguarding of Children and Family and Vulnerable Adults Services within the Trust.

6.27.11 To advise the Trust Board of national and local standards and Derby and Derbyshire Safeguarding Board arrangements.

6.27.12 The Committee will oversee Serious Case Reviews, Independent Learning Reviews, Domestic Homicide Reviews and all safeguarding major incidents and will advise service level directors and operational managers of recommendations, lessons learnt and compliance requirements.

6.27.13 The Committee will oversee and assure itself that all Safeguarding Boards for Children and Adults are appropriately represented and feedback from Boards to the Trust Board is in place

6.27.14 The Committee will oversee and assure itself on the Prevent and Channel: Supporting Individuals Vulnerable to Recruitment by Violent Extremists agenda. Establish or use existing mechanisms for understanding the risk of radicalisation. Communicate and promote the importance of the duty; as outlined in any counter terrorism legislation (2015) and ensure staff implement the duty effectively.

6.27.15 The Committee will oversee and assure itself on the Multi-Agency Public Protection Arrangements (MAPPA) with relevant agencies including the police. These processes ensure that the requirements for offenders in the community needs are met and duties to public safety are met fully.

6.27.16 The Committee will oversee and assure itself on the MARAC agenda, the Multi-Agency Risk Assessment Conference, that the trust is discharging its duty. The MARAC aims to share information to increase the safety, health and well-being of victims/survivors - adults and their children; improve agency accountability; and improve support for staff involved in high-risk domestic abuse cases

6.27.17 Have authority in the setting the quality standards, defining and monitoring of clinical practice in safeguarding children and vulnerable adult people through delegated duties to the Safeguarding Operational Group.

6.28 Safeguarding Adults Key Responsibilities

6.28.1 Schedule 2 of the Care Act (2014). That Geographical links to the Safeguarding Adults Boards must have a clear, agreed understanding of the roles, responsibilities, authority and accountability of its member agencies, therefore the Trust should annually:

- Review suitable governance arrangements an effective infrastructure and adequate resources
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships
- Provide links to other boards and partnerships
- Provide a person-centred, outcome focused safeguarding policy and procedures
- Ensure that there is awareness training for all health and social care staff and Police who work directly with people with care and support needs
- Ensure that there is a specialist training for all practitioners who have direct responsibilities for safeguarding work
- Develop and publish a Trust strategy specifying each service areas responsibilities
- Link with the wider community to inform its work and learn of the work of the Board
- Sign off the Safeguarding Adult Annual reports, detailing what the Trust and its members have achieved, including how they have contributed to the Board's objectives and what has been learned from and acted upon from the findings of Safeguarding Adults Reviews and Case Reviews and other Domestic Homicide reviews and associated audits
- Arrangements for the quality assurance of the effectiveness of safeguarding work.

6.29 Safeguarding Children Key Responsibilities

- Scrutinise the Safeguarding Children Annual report, oversight of the Section 11 audit work and assurance that the Trust discharges its duty responsibly in line with national requirements
- Review suitable governance arrangements an effective infrastructure, adequate resources
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships
- Provide a child centred, outcome focused safeguarding policy and procedures
- Ensure that there is training for all health and social care staff and Police who work directly with people with care and support needs
- Develop and publish a Trust strategy specifying each service areas' responsibilities
- Sign off the Children and Looked After Children Annual Reports, detailing what the Trust and its members have achieved, including how they have contributed to the board's objectives and what has been learned from and acted upon from the findings of Safeguarding Serious Case Reviews

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Quality and Safeguarding Committee	12 April 2022
Approved by Audit & Risk Committee	28 April 2022
Approved by Board of Directors	

People & Culture Committee Terms of Reference

Purpose

The Committee supports the organisation to achieve a well-led, values driven and inclusive positive culture. The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trust's current and future needs including workforce engagement and development.

1. Authority

1.1 The People and Culture Committee is constituted as a standing committee of the Foundation Trust's Board of Directors. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Board of Directors meetings. The People and Culture Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and to secure the attendance of both internal and external officers with relevant experiences and expertise it if considers this necessary.

1.3 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

1.4 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The People & Culture Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the People & Culture Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template.

All policy documents are allocated a policy ratification group as they are published on Connect.

1.8 As a Committee of the Board, the People & Culture Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit, this includes the delivery and implementation of the Trust's 3 year People Strategy.

2. Membership

2.1 The membership of the Committee will comprise:

- Non-Executive Directors x 3 (one will be appointed as the Chair)
- Director of People and Inclusion
- Medical Director
- Chief Operating Officer

The Deputy Medical and Operations Directors are to attend meetings as nominated deputies if the Medical Director or Chief Operating Officer are unable to attend.

In attendance as core attendees:

- Assistant Director of Organisational Development
- Deputy Director of Communications and Involvement will attend only when items to be discussed are relevant

2.2 A quorum shall be three (not less than two non-executive directors and one executive director).

2.3 Members are expected to attend a minimum of four meetings per year.

2.4 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies to attend no more than one third of meetings on an exception basis.

3. Attendance

3.1 Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust, and other individuals may attend all or any part of its meetings as and when is necessary.

3.2 The Chief Executive Officer reserves the right to attend any meeting

3.3 The Trust Chair will appoint the Chair of the Committee

3.4 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

3.5 The Board Secretary will be in attendance and provide administrative support.

3.6 A register of attendance will be maintained and reviewed by the Committee annually.

4. Quorum

4.1 A quorum shall normally be three (not less than two non-executive directors and one executive director) and is in line with the use of emergency terms of reference that

have been put in place for the delegation and purpose of carrying out the functions of the Trust during the COVID-19 pandemic the quorum can be reduced to one Executive Director and two Non-Executive Directors.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

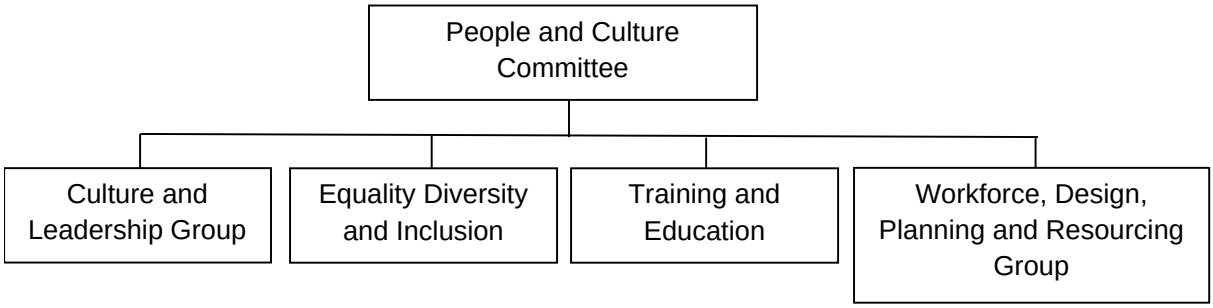
5.1 The Committee will meet on bi-monthly basis with additional meetings being called when necessary.

6. Duties and Responsibilities

6.1 The Committee will support the organisation to achieve a well led, values driven positive culture. The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trusts current and future needs.

6.2 The Committee will monitor the implementation of the People Strategy and report progress to the Board by exception

6.3 A number of supporting groups / forums will be accountable to the People and Culture Committee whilst not exhaustive; it is anticipated that the following groups will have a direct or indirect relationship and will be agreed within the Committee:



6.4 The Committee will oversee and monitor workforce performance.

6.5 The Committee review and monitor the Workforce metrics and Board Assurance Framework and ensure the Board is kept informed of any significant workforce risks.

6.6 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.7 The Committee is to be assured that mechanisms are in place to review and monitor the effectiveness and capability of the workforce across the whole Trust and that appropriate actions are taken to address issues of poor performance and bring about continuous quality improvement.

6.8 The Committee is to be assured that the Trust identifies lessons for improvement and implements these in all relevant areas.

6.9 The Committee is to be assured that National standards, guidance and best practice are systematically reviewed and embedded within the Trust.

6.10 The Committee is to be assured that the views of staff and appropriate others are systematically and effectively engaged in organisational development activities.

6.11 The Committee is committed to ensuring that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honest.

6.12 The Committee will oversee the leadership, training and education framework and monitor progress.

6.13 The Committee will monitor the implementation of agreed action plans in relation to organisational interventions and measure the effectiveness of change.

6.14 The Committee will review its effectiveness by self-assessment on an annual basis and at the end of each meeting. The annual review will be presented to the Audit and Risk Committee.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by People and Culture Committee	22 March 2021
Approved by Audit and Risk Committee	28 April 2021
Approved by Trust Board	

Mental Health Act Committee Terms of Reference

Purpose

The Committee monitors and obtains assurance on behalf of the Hospital Managers and the Trust as the detaining authority that the safeguards of the Mental Health Act are appropriately applied. It also monitors related statute and guidance and reviews the reports following Mental Health Act inspections by the Care Quality Commission.

1. Authority

1.1 The Board of Directors has approved the establishment of a Mental Health Act Committee as a Committee of the Board. The purpose of the Committee is to obtain assurance, on behalf of the "Hospital Managers" and the Trust as the detaining authority, that the safeguards and provisions of the Mental Health Act are appropriately applied; to take account of the provisions of related statute and guidance, such as Mental Capacity Act, Deprivation of Liberty Safeguards (DOLS) and Human Rights Act.

1.2 The Committee will exercise its responsibilities by fulfilling a scrutiny and monitoring role from receipt of regular activity data and inspection reports from an Operational Group; by obtaining assurance that best practice is deployed across the Trust.

1.3 As a Committee of the Board, the Mental Health Act Committee has an important role to provide assurance on the progress and risks arising relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit. It will consider any exceptions or risks escalating these to the Trust Board or referring to the Executive Leadership Team as necessary.

1.4 The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.5 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions

1.6 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Mental Health Act Committee will ensure consideration has been given to equality impact related risks.

1.7 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.8 As a designated policy ratification group, (see 'Policy on Policy Documents) the Mental Health Act Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. These include policies in relation to the Mental Health Act and Code of Practice requirements, and the duties of Associate Hospital Managers, including the protocols for the hearing of appeals and reviews. It also includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

1.9 An operational subgroup will meet approximately one month before the full Committee to prepare assurances and highlight exceptions.

2. Membership

2.1 The membership of the Committee shall comprise:-

- Non-Executive Director – Chair of the Committee
- Non-Executive Director (2)
- Medical Director or a nominated Deputy
- Trust Secretary

2.2 Members of the Committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings

2.3 If the Committee Chair is not present, the meeting shall be chaired by another Non-Executive Director.

3. Attendance

3.1 Additional attendees shall comprise:-

- Mental Health Act Manager
- Representative of Associate Hospital Managers
- Director of Nursing and Patient Experience when required
- Other senior management/professional leads may be invited at the discretion of the Committee Chair.

3.2 The Chief Executive Officer reserves the right to attend any meeting.

4. Quorum

4.1 Quorum is normally a minimum of three members including at least two Non-Executive Directors. The use of emergency powers by the Chair and CEO have been put in place for the delegation and purpose of carrying out the functions of the Trust during the COVID-19 pandemic.

4.2 Meetings may be held by conference call or by electronic means, by exception, so long as those present can hear each other and contribute simultaneously to the meeting.

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

5.1 Meetings will be held quarterly.

6. Duties and Responsibilities

6.1 To receive compliance and assurance reports from the Operational Group regarding the number of patients subject to detention under each section of the Mental Health Act for the previous quarter as part of a rolling twelve month review to identify any variation or trends (including diversity data) and provide interpretation of data including an outline of actions arising as appropriate.

6.2 To consider matters of recommended good practice, and in particular the requirements of the Code of Practice (Revised): Mental Health Act (1983) and its Code of Practice as amended and approve policy changes to receive assurance on the steps taken to implement and embed recommended good practice relating to the requirements of the Mental Health Act, Mental Capacity Act and related legislation.

6.3 To receive assurance reports and scrutinise, as required, other activity reports from the Operational Group e.g. the use of seclusion, noting any exceptions and escalating concerns as necessary.

6.4 To receive assurance reports relating to the Care Quality Commission Inspection Reports and the implementation of the management response as defined by the Operational Group, providing scrutiny and challenge and noting exceptions and risks escalated by the operational group. With regard to Section 136, to oversee and receive assurance on the use of this section through the multi-agency Section 136 sub-committee.

6.5 To oversee the implications of related legislation, principally the Mental Capacity Act, (including Deprivation of Liberty), Human Rights Act guidance and other related legislation as appropriate, receiving assurance on impact, risk and effective implementation throughout the Trust.

6.6 To oversee that training needs are satisfactorily met to ensure compliance with legislative and best practice requirements, through assurance reporting and in general help promote awareness of the requirements of the Mental Health Act, Mental Capacity Act and associated legislation.

6.7 When receiving information on Mental Health Act activity and reports, the Committee will pay due regard to the Trust's Equality and Diversity Agenda.

6.8 To ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

6.9 To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.10 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.11 To maintain a forward plan of regular agenda items to encompass the role and remit of the Committee as outlined in the Terms of Reference.

6.12 To oversee the development of an annual review of performance of the Committee against key areas as outlined within the Terms of Reference and confirm that all areas of governance and responsibility have been monitored.

6.13 Receive feedback from Associate Hospital Mangers and review any performance issues arising from mental health tribunals.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Mental Health Act Committee	11 March 2022
Approved by Audit and Risk Committee	28 April 2022
Approved by Trust Board	

Appendix 4 - Register of Trust Sealings

Purpose of Report

This report provides the Trust Board with a six month update of the authorised use of the Trust Seal since the last report to the Board on 2 November 2021.

Executive Summary

In July 2019 Section 8.18 of the Standing Financial Instructions and Standing Orders of the Board of Directors was amended and the contract value for when the Trust seal is required was increased from £100,000 to £500,000. Therefore, every contract which exceeds £500,000 shall be executed under the Common seal of the Trust and be signed by the Trust Secretary and an Executive Director (voting or non-voting) duly authorised by the Chief Executive and not from the originating department (as set out in the Board's Standing Financial Instructions point 8.18).

These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates and Agile Working Strategy. In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

A report on use of the seal was last made to the Board on 2 November 2021. Since the last report, the Trust Seal was once as follows (the contract value for this transactions was valued at over £500,000):

- DHCFT79: P22 Framework agreement, design and refurbishment of two adult acute inpatient facilities, Radbourne Unit, Derby.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care	X
2) We will ensure that the Trust is a **great place to work** by attracting colleagues to work with us who we develop, retain and support by excellent management and leadership	
3) We will make the **best use of our money** by making financially wise decisions and will always strive for best value to make money go further	X

Assurances

Use of the Trust Seal has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Consultation

N/A

Governance or Legal Issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Financial Instructions and Standing Orders of the Board of Directors.

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

There is no direct impact on those with protected characteristics arising from this report.

Recommendations

The Board of Directors is requested to note the authorised use of the Trust Seal since November 2021 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Report presented by: **Justine Fitzjohn**
Trust Secretary

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

Derbyshire Healthcare NHS Foundation Trust

Board Committee Assurance Summary Reports to Trust Board – 10 May 2022

The following summaries cover the meetings that have been held since the last public Board meeting held on 1 March 2022:

- Mental Health Act Committer 11 March
- Finance and Performance Committee 15 March
- People and Culture Committee 22 March
- Audit and Risk Committee 24 March
- Quality and Safeguarding Committee 8 March and 12 April

Mental Health Act Committee - key items discussed 11 March 2022
Mental Health Act (MHA) Report The report covered the number of detained patients on a rolling 12-month period and showed a stable position. The data contained in the report was comprehensively reviewed and provided significant assurance that the safeguards of the MHA have been appropriately applied within the Trust.
Liberty Protection Safeguards Although the code of practice is yet to be issued Liberty Protection Safeguards (LPS) are expected to be introduced in June. The progress update provided assurance that preparation for the introduction of LPS within the Trust is on track.
Update on Mental Health Legislation The government has launched a consultation on the Mental Health Units (Use of Force) Act which aims to prevent the inappropriate use of force and ensure transparency and accountability about the use of force in mental health units. Requirements were due to commence in May 2022 but have been delayed due to COVID.
Training Compliance The report showed a satisfactory level of compliance particularly with Safeguarding. Mental Capacity Act training currently has an 83% compliance level.
Update from Associate Hospital Managers Associate Hospital Managers are undertaking a number of hearings. There have been no issues with either contested or uncontested hearings.
Escalations to Board or other Committee(s) None.

Key risks identified None	
Consideration of any items affecting the BAF Gaps in control relating to MCA training compliance will be logged under BAF risk 1a for monitoring.	
Next Meeting – 10 June 2022	
Committee Chair: Ashiedu Joel, Non-Executive Director	**Executive Lead: Dr John Sykes Medical Director**

Finance and Performance (F&P) Committee - key items discussed 15 March 2022
2022/23 System and Operational Planning – draft submission sign-off Contents of draft organisational plan submission for 2022/23 considered in detail: including operational budget setting principles for pay and non-pay and treatment of vacancies and vacancy factors and full year effect of investments. Unmitigated and mitigated positions outlined (organisation and system). Key risks highlighted including levels of efficiency required in planning assumptions and agency ceiling. Additional refinement work to do between draft and final submission in April 2022. Both capital and revenue assumptions scrutinised. Impact on Trust Strategy refresh.
Financial governance and plan delivery including CIP and future financial planning update Financial situation outlined as at end of February 2022. Forecasting breakeven. COVID costs redistributed to source areas. Key pressure areas discussed including agency costs in particular. Agency deep dive analysis to come to future Committee. Key reasons for run rate changes in income, pay and non-pay. Summary of capital position discussed. Agreed to keep Board Assurance Framework (BAF) risk level unchanged.
Operational Performance Performance as of January 2022. Discussion of response to Council of Governors from last meeting and manual audits of bring forward cancellations. Autism Spectrum Disorder (ASD) assessments and levels of activity. Commitment in Mental Health Learning Disability and Autism Delivery Board (MHLDA) plan for redesign of Neurodevelopmental pathway for all ages. Clinical risk assessment and support for people on waiting list. Delivery plan for 22/23 across providers being developed. Success in reducing out of area placements and achieving 85% occupancy levels. Positive results on acute flow promising for the future. COVID current levels increasing and future expected NHS and mental health specific services presentations. Ukrainian crisis potential impact on NHS. Limited assurance.
TCP proposal and transition Harmonisation of Learning Disability and Autism (LDA) services update. Senior leaders working across DCHS and DHcFT to respond to pathway challenges. Ash Green action plan delivery. Governance discussions. Data visibility and insight work. Derbyshire LDA escalation and recovery plan. Challenging but seeing some successes.
Assurance on Estates strategy – dorms eradication and Psychiatric Intensive Care Unit (PICU) Comprehensive update including: Older Adult case development. Planning permissions achieved for national schemes and tree-clearing. Enabling works progress and early funding agreed. Full Business Case development in last six weeks of timeline, VAT abatement HMRC response awaited. Programme activities and key risks outlined. GMP being worked on (inflation risk). Radbourne Unit's load-bearing walls cited as a key risk issue impacting on go live dates and cost

impact. Consultation responses positive. Organisational change management and cultural development programme in development. Financial governance and assurance process for high value contracts requiring Board sign-off. Risk profile evolving with hyper-inflation, volatility and risk sharing including value engineering and value assessments. Really good progress acknowledged. Limited Assurance.

OnEPR Assurance update

Phases 3 and 4 have 9 May go live date. Programme update discussed and key issues and risks outlined. Triangulation with discussions in other committees expressing positive benefits of OnEPR system and link to Derbyshire single healthcare record programme. Discussion beyond go-live dates and optimising and evaluating the delivery of benefits, standardisation agenda and delivery of e prescribing.

Board Assurance Framework risks

Final review of 2021/22 BAF risks for this committee. 2022/23 BAF under development. Finance risk remains rated extreme. Look ahead to new year BAF risks.

Emergency Preparedness Resilience and Response (EPRR) follow up on actions

Detail provided for summary and timeline for the delivery of action plan. Progress slower than planned on policy changes. Governance process in train. Dates for delivery presented and resource for delivery of timelines. The fundamental level of EPRR in the Trust remains strong with robust action plan.

Year-end review the Committee's effectiveness and Terms of Reference review

Committee considered its activity and effectiveness across 2021/22 and confirmed that it had fulfilled its terms of reference and is operating effectively in providing assurance to Trust Board or escalating issues if necessary. Cited examples such as good agenda coverage, good linkages and triangulation with other committees, good challenges well-responded, good scrutiny and challenge, well-balanced discussion across shorter and longer-term thinking.

No amendments were required to the terms of reference

Escalations to Board or other committees

None – but flag of dormitory eradication and PICU capital programme inflation cost risks, will already be covered in April update to Board

Next scheduled meeting – 24 May 2022

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

Extraordinary Finance and Performance Committee meeting held 25 April 2022 primarily to approve the DHCFT Financial Plan submission for 2022/23 - key items discussed

2022/23 System and Operational Planning – final submission sign-off

Contents of Trust final organisational plan submission for 2022/23 considered in detail understanding the movements in numbers from draft to final plan. Operational budgets, income, pay and non-pay, including full year effect of prior year investments. Value of required efficiency at 3% requires further work to define full delivery plan (work underway). Discussion of various risks included in and excluded from the planning position, as instructed by Regional NHSEI colleagues, in particular the treatment of covid costs beyond May 2022 and excess inflation assumptions. Capital assumptions, cash and risks also outlined. Noted the increased regulatory scrutiny expected on temporary staffing costs. Overall proposed system plan position noted (as provided by Integrated Care System (ICS) Director of Finance.

DHCFT plan submission as set out was approved

Delegation of approval of any subsequent minor change given to CEO and Director of Finance (DoF) for alignment to any changes in system position, but alternative wider agreement required if change was to be more material.

Agency and bank deep dive

Full year 2021/22 temporary staffing report scrutinised. The actions agreed by Executive Leadership Team (ELT) were discussed including recruitment actions outlined by the Chief Operating Officer (COO). Temporary staffing is a significant area of increased focus and ongoing scrutiny. Key risk factors include covid and non-covid sickness absence levels, other covid-related staffing requirements, keeping safer staffing levels, recruitment activity, as well as more cultural factors of change post-pandemic. Speed required for change in run rates via a range of general activities across the Trust, as well as focus on hotspot areas. Noting the multifactorial causes of temporary staffing usage. Context of a deficit financial plan for the first time whilst turning around to sustainability beyond the 2022/23 deficit financial plan and deliver the refreshed Trust strategy.

Quality Improvement (QI) Strategy update

Update on QI including LifeQI platform and digital PMO across JUCD. Need to bridge the Trust's financial efficiency gap and identify full efficiency requirements in the financial plan. Update included key areas in train and the progress with QI training rollout, noting the delays created by Omicron. Discussed the training requirements and longer term benefits of staff release for training competing with day to day challenges of care delivery.

Mental Health Helpline evaluation report

Updates included the increase in volume of activity, the timing of majority of calls, the demography of callers and the primary reasons for calling. Success of partnership with P3. Paper outlines where intervention has succeeded in avoiding the need to attend emergency departments and or ambulance conveyance. There are a small number of very frequent callers with case-by-case system intervention using triangulation across services. Helpline having very beneficial impact.

Learning Disability and Autism - Harmonisation Update

Harmonisation work across Derbyshire Community Health Services and Derbyshire Healthcare. Senior leaders working together. DHcFT as lead for LDA services in JUCD. Discussions included employment, electronic records, CQC accountability and responsibility, clinical and workforce strategies with developments to transform bedded offer in Derbyshire. Cross-partner data visibility is another area of work. Performance noted in the delivery of required trajectory for Transforming Care Partnership TCP cohort in the scope of regularity escalation. Work in train to collate a wider overview of the financial position across all parts of system.

Multi-Agency Discharge Event (MADE) update

Summary of outputs and insights from MADE work supported by RW Health which focussed on pathways, improvement in levels of occupancy and length of stay, medically fit for discharge issues and other patient flow factors (internal and wider system) and suggestions for areas of focussed work to consolidate success and bring further improvements.

People and Culture Committee - key items discussed 22 March 2022

Summary of BAF Risks

The Committee considered the BAF Risk 2a it is responsible for "*There is a risk that we do not sustain a healthy vibrant culture and conditions to make Derbyshire Healthcare Foundation Trust (DHCFT) a place where people want to work, thrive and to grow their careers*" in the context of subsequent committee discussions and work programme.

People and Inclusion Assurance Dashboard

Challenges have been seen in corporate services as most corporate teams have been redeployed to other roles servicing the pandemic. Although appraisals were stood down during the pandemic teams have continued to be supported. Positive results from the staff survey identified people felt well led and supported.

Current priorities involve employee relations by increasing positive team cultures. Other priorities include improving the experience of BME staff. The work of the Freedom to Speak Up Guardian (FTSUG) and the positive working relationship the FTSUG with People Services was positively acknowledged.

Annual Modern Slavery Statement for 2021/22

To Committee assessed whether the Trust has met the criteria for the preceding financial year. The Board will be asked to approve the Annual Modern Slavery Statement and this will be uploaded to the Trust's website, replacing the previous version.

No changes were required. It was noted that from a safeguarding point of view there are certain vulnerable patient groups who might have been subject to slavery and exploitation. These patients receive specialist treatment from front line staff.

Equality, Diversity and Inclusion (EDI) activities. Workforce Disability Equality Standard (WDES) Action Plan and the annual Workforce Race Equality Standards (WRES) Action Plan.

The Committee discussed how EDI activities take place in line with the Trust's Inclusion Strategy, WRES and WDES action plans and in collaboration with the various networks.

Significant assurance was received from this comprehensive programme that aims to give a real understanding of how discrimination works, focusing on eliminating systemic discrimination and bringing lived experience into decision making.

Leadership Strategy

An overview of the proposed strategic intent to the Trust's leadership approach for 2022/23 set out the model of the approach to developing leaders over the next 12 months. The report prompted helpful discussion and good stimulus of ideas for co-production and empowerment, accountability and performance management in the approach to developing leaders.

Training compliance

The Committee received an update on training compliance and actions that are being undertaken to support staff to achieve and maintain training compliance.

There have been several understandable periods of paused training activity over the last two years during the pandemic to ensure that services were able to maintain safer staffing levels. It was understood that following the recommencement of training from mid-February for all mandatory programmes, additional capacity has been provided to work on training accountability to make programmes appropriate and not over complicated.

Although limited assurance was obtained from training compliance outcomes, significant assurance was received with work that is in place to improve and develop training programmes,

increase compliance and plans to ensure all training takes a consistent approach to competence requirements by role.

People and Culture Committee Year-end Effectiveness review and Terms of Reference review

Having reviewed the business carried out during 2021/22 the Committee was satisfied it had performed effectively throughout the year. Meetings had been well chaired under clear and structured agendas that were supported with well-informed reports. Time will be dedicated at a future meeting to establish how the system will impact the work of this Committee and the part it will play.

The TORs were agreed subject to the addition of Assistant Director of Organisational Development as a core attendee.

The Public Sector Equality Duty (PSED) Report (April 2021-March 2022)

The report helps to ensure that the Trust complies with obligations under the Public Sector Equality Duty (PSED: section 149 of the Equality Act 2010) and national mandates.

The Committee acknowledged that the Trust has an extensive range of the mature networks that are extremely active and approved the report for publishing on the Trust website by 31 March.

Escalations to Board or other committees

None

Board Assurance Framework – key risks identified

None

Next Meeting – 17 May 2022

Committee Chair: Margaret Gildea	**Executive Lead: Jaki Lowe, Director of People and Inclusion**

Audit and Risk Committee - key items discussed 24 March 2022

Annual Report and Accounts planning timetable

An overview of the year-end timetable planning for the production of the Annual Report and Accounts (Including Annual Governance Statement) and Quality Account provided evidence that preparatory reports for the purpose of the audit have been submitted by those charged with governance.

The proposed date of 14 June was agreed for the 2021/22 Annual Report and Accounts approval and sign off meeting prior to the submission deadline of 22 June.

Freedom to Speak Up (FTSU) Policy Framework

The FTSU Guardian is meeting the five day target of responding to cases. Ongoing themes are associated with staff health and wellbeing. Staff who spoke up were asked to complete an evaluation of their experience. Many reported that they will be happy to speak up again. The FTSU process is delivered to new starters at their induction. The FTSUG has also presented tailored training sessions to the Junior Doctor network and has developed an e-learning module.

The Committee received and supported the ongoing development of an FTSU strategy, which will serve to further improve and support continuous improvement in embedding the Speaking Up culture within the Trust.

Significant assurance was received with the adequacy of the Trust's arrangements by which Trust staff may, in confidence, speak up about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

Waiver of Standing Financial Instructions

Significant assurance was received from Waiver Log and the process followed to approve and record waivers.

2020/21 Year-End Report of the Audit and Risk Committee and Review of Terms of Reference

The Committee considered the year-end report on its activity and effectiveness for 2021/22, comparing its work to its Terms of Reference. The report demonstrated the breadth of the matters covered and evidenced that the Committee had worked effectively in the last 12 months. The terms of reference were reviewed and agreed with no changes considered necessary. The report was approved for onward review by the Trust Board in May.

Internal Audit progress

Internal audit progress work completed since the last meeting included the agreed terms of reference for the review of the Data Security and Protection Toolkit. Internal Auditors are in the process of finishing the 2021/22 planned work on e-rostering and risk management. The Internal 2022/23 Internal Audit Plan was reviewed and agreed. The Internal Audit Charter setting out the scope of internal audit was noted.

Counter Fraud activity update

The Committee was satisfied with the progress made with counter fraud activity and supported the counter fraud plan for the financial year 2022/23.

External Audit Strategy Memorandum

External Auditors, Mazars presented the External Audit Strategy Memorandum that summarised their audit approach, significant audit risks and areas of key judgements.

Mazars confirmed they were confident that delivery dates for the 2021/2 Annual Report and Accounts are achievable due to the support received from the Trust.

Key risks identified

None

Next Meeting – 28 April 2022

Committee Chair: Geoff Lewins	**Executive Lead: Justine Fitzjohn, Trust Secretary**

Quality and Safeguarding Committee - key items discussed 8 March 2022

Summary of Board Assurance Framework (BAF) Risks

The Committee reviewed BAF risk 1a *"There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"* it has oversight of in the context of discussions and the current work programmes.

The Committee also considered the new risk that has been added to the BAF for which the Committee is responsible that impacts on and is mitigated by multiple organisations. The risk that *'There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS inpatient LD bedded care".* The current risks associated with not being able to deliver a safe service to LDA patients in Derbyshire will be included in the BAF as a system risk and will be updated after the Trust has met with other system partners and agreed the next steps in the programme.

Safeguarding Children Assurance Report

The Committee reviewed Safeguarding Children activity and considered progress made against the strategy and assurance levels against statutory and legislative requirements. Although there are no significant concerns associated with keeping up with demand, sustained levels of domestic violence are applying pressure to clinical and support. Significant assurance was received with Safeguarding Children activity, systems and controls within the Trust.

Children in Care Markers of Good Practice

The Markers of Good Practice (MOGP) is the support/challenge performance management tool used to seek assurance for the Clinical Commissioning Group (CCG) Quality Schedule. The report evidenced the mechanics behind Children in Care.

Significant assurance was taken from the work concerned with looked after children and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people.

Safeguarding Adults Assurance Report

This report updated the Committee on Adult Safeguarding performance, including, training, Mental Capacity Act performance, Person in Position of Trust (PiPoT) and Multi-Agency Safeguarding Hub (MASH) performance.

Discussion concluded that tight governance, detection and response is in place within the Safeguarding Adults unit. The report provided significant assurance that statutory duties are being met, the quality priority of Improving sexual safety is moving forward with regional links being made and work in progress. Significant assurance was also obtained from the progress of actions and completion of significant incidents.

Harmonisation of Learning Disability and Autism Services

The Committee considered a position statement on the harmonisation of Learning Disabilities and Autism (LDA) services in Derbyshire, working across DCHFT and Derbyshire Community Health Services (DCHS).

In supporting DCHS, DHCFT staff have maintained stability and care to patients. Senior leads across both organisations are working together to define and establish the optimal approach to developing and operating a consistent model of care for LDA services across the whole of Derbyshire.

CQC Action Plan Status

The Committee considered and discussed outstanding CQC actions and was satisfied with the level of evidence that confirmed the completion of actions. It was agreed that an action update will be received at each meeting until all actions have been completed.

Patient Experience Quarterly Report

This report provided an update on themes and changes made to services as a result of feedback on incidents and complaints made to the Patient and Carer Experience Committee. The Committee was satisfied that clinical practice is being monitored against these themes and taken through the Clinical Operational Assurance Teams (COATs) by Heads of Nursing who actively scrutinise and intervene. Significant assurance was received on the content of the report.

2021/22 Clinical Audit Annual Report

The Committee considered the effectiveness of the 2021/22 Clinical Audit Programme. Delivery of the Clinical Audit programme was impacted by COVID-19 due to staff being redeployed. It is clear that Clinical Audit provides increasing opportunity for quality improvement (QI) and is an integral part of the QI platform. Areas to improve effectiveness of Clinical Audit and use of Quality Improvement methodologies have been identified and will be implemented.

The Committee was satisfied that the report demonstrated the effectiveness of this year's programme. The report showed improvements in practice where agreed improvement actions have been implemented and a repeat audit or re-audit carried out. Significant assurance was received overall.

Verbal update on Quality Improvement training programme

The Quality Improvement (QI) training programme has been delayed by the Covid pandemic. A training programme of six sessions for the first cohort to be completed by April is now underway. Thirteen Trust colleagues within this cohort will become associated trainees. The wider programme management will be managed through transformation projects across the four organisations within the programme. The live QI system is up and running and will expand further when the training programme is fully rolled out. The aim is that by March 2023 over 1000 staff will be trained in QI.

The Committee was satisfied with the progress made in implementing the QI training programme and agreed that assurance on operational delivery will be driven through Trust Operational Oversight Leadership (TOOL) and Divisional Performance Reviews.

Getting it Right First Time Adult Mental Health Crisis and Acute Care Deep Dive

The Committee considered the Trust's response to key points arising from the Getting It Right First Time (GIRFT) virtual deep dive that Dr Ian Davidson (Clinical Lead for GIRFT Mental Health) undertook with Derbyshire Healthcare NHS Foundation Trust on 15 July 2021.

The Trust's response was to incorporate the key points into existing operational and transformational plans already underway across the Trust, such as the OnEPR programme and/or within system wide plans, reported through delivery groups to the Mental Health Learning Disability and Autism and Children's System Delivery Board.

Significant assurance was obtained from the Trust's response to the programme plan. It was agreed that significant assurance can only obtained when all the actions contained in the GIRFT action plan have been delivered.

Board Assurance Framework – key risks identified

The BAF is to be updated to include risks associated with not being able to deliver a safe service to LDA patients in Derbyshire will be included in the BAF as a system risk.

Escalations to Board or other committees

None

Next Meeting – 12 April 2022

Committee Chair: Dr Sheila Newport	**Executive Lead: Carolyn Green, Director of Nursing and Patient Experience**

Quality and Safeguarding Committee - key items discussed 12 April 2022

Summary of BAF Risks

BAF risks were considered within the Committee's current work programme. Updates were discussed and agreed for Risk 1a "*There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board"*.

The Committee also considered the new risk that has been added to the BAF for which the Committee is responsible that impacts on and is mitigated by multiple organisations. The risk that *'There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS inpatient LD bedded care"* and agreed that these gaps in control will be updated in the BAF after discussions have been held with System partners.

Health Protection Unit update

Significant assurance was received from the achievements, preventative clinical practice through vaccination and working practices of the Health Protection Unit (HPU).

Quality Performance Dashboard

The high level quality metrics showed a stable position despite increased admissions and services being under pressure.

CQC action plan delivery

As at March 2022 there were twelve outstanding actions with six overdue. These six actions relate to mandatory training and wider actions which require additional evidence. Monthly reviews are conducted with the Governance and Compliance Co-ordinator. Evidence for complying with CQC actions has been reviewed by the Deputy Director of Nursing and Quality Governance and the action leads. The Committee was satisfied with the approach being taken to establish compliance with the outstanding recommendations.

Draft Quality Account 2021/22

The draft Quality Account for 2021/22 containing feedback from Executive Directors and Non-Executive Directors was reviewed. The Quality Account details the Trust's approach to quality over 2021/22, the challenges faced by the COVID-19 pandemic, and how the Trust has continued to drive through quality improvements, delivering high quality and innovative care during the most difficult year the NHS has ever faced. The final draft will be received for sign off at the May meeting.

Annual Serious Incidents (SIs) report

Limited assurance was received from the SI report due to sickness absence within the SI team which has caused a backlog. Extra capacity is being provided to the team and plans are in place to assist with the flow of incidents through the system.

Learning from Deaths Mortality Report

Due to sickness absence levels within the mortality team there is a backlog of non Datix reportable deaths that require reviewing against the red flags outlined in the Royal College of Psychiatrists Care Review Tool. Despite this, there were no concerns with the findings of the report. All deaths reported through the Incident Reporting and Investigation Policy and Procedure (Datix) continue to be reviewed. Additional capacity has been brought in to supplement the team.

The Mortality Report was accepted as assurance of the Trust's approach and would be received by the Board of Directors and then published on the Trust's website as per national guidance.

Year-end effectiveness report and review of terms of reference The Committee considered the year-end report on its activity and effectiveness and confirmed that it had fulfilled its terms of reference during 2021/22. The report demonstrated the extensive matters covered and evidenced that the Committee had worked effectively. The terms of reference were reviewed and agreed with no changes considered necessary.	
Improving patient safety - CQC key lines of enquiry This was a comprehensive review of the Trust's approach to improving safety against the National NHS Patient Safety Strategy and CQC key lines of enquiry (KLOE). Significant assurance was received from the Trust's safety culture and patient safety systems but due to high risk areas that will be included in the BAF i.e. deterioration after migration of clinical records and low compliance with SMI register, limited assurance was received overall from the report.	
Escalations to Board or other committees None	
Board Assurance Framework – key risks identified Mitigating action to reduce inpatient deaths is to be included in the BAF risk 1a.	
Next Meeting – 12 May 2022	
Committee Chair: Dr Sheila Newport	**Executive Lead: Carolyn Green, Director of Nursing and Patient Experience**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 10 May 2022

Report from the Council of Governors meetings

The Council of Governors has met twice since the last report in January 2022: on 1 March 2022; and an extraordinary meeting on 13 April 2022. Following national guidance on keeping people safe during COVID-19 and the need for social distance, the meetings were conducted digitally via Microsoft Teams.

Council of Governors held on 1 March 2022

Chief Executive update

The Deputy Chief Executive provided governors with an update on the current situation regarding the COVID-19 pandemic, and the Integrated Care System.

Update on next Round of Non-Executive Director (NED) appointments

The Trust Secretary provided governors with an update on the recruitment process for the NED appointments.

Non-Executive Director Deep Dive Report

Margaret Gildea, Senior Independent Director and Chair of the People and Culture Committee presented the Deep Dive to governors. Margaret gave an overview of her role within the Trust.

Escalation of items to the Council of Governors

Four items of escalation were received from the Governance Committee meetings held on 8 December 2021 and 8 February 2022 respectively:

Question one: Governors seek assurance that the issues raised concerning the Trust in Roy's story shared with the Trust Public Board on 2 November 2021; and with the Governance Committee on 8 December 2021 have been addressed; and if not addressed what plans are in place to address the issues.

Question two: Governors seek assurance that patients are given appropriate communication if an appointment is cancelled. Concerns have been raised by members and the public that some cancellations are only communicated to patients at the last minute and can have an emotional impact on the patient. Concern has also been raised that parents of young people are not being included in communications to enable them to support their child.

Question three: Governors seek assurance on what additional support staff have access to during the pandemic and also if they have long COVID? Is additional support being provided by Occupational Health and wellbeing support staff?

Question four: Governors discussed the issues that staff networks are experiencing and sought assurance that the issues are being addressed including: getting appropriate support, training, time to fulfil the Chair and Vice-Chair roles, supervision, communication with the Trust.

The responses were tabled at the meeting.

Verbal Summary Integrated Performance Report

The Integrated Performance Report (IPR) was presented to the Council of Governors to provide an overview of the performance of the Trust. The NEDs 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

The Chair of the Governance Committee presented a report of the meeting held on 8 February 2022.

Election update

The Membership and Involvement Manager provided the Council of Governors with an update on the recent public and staff governor elections and gave assurance that the election process is undertaken in line with the model election rules as laid out in the Trust's Constitution.

Review of The Governor Membership Engagement Action Plan

The Membership and Involvement Manager provided an update on the governors Membership Engagement Action Plan. Governors are elected to represent their local communities and the Action Plan has been developed to increase engagement with members and to promote the governor role.

Any Other Business

The Deputy Trust Chair and Membership and Involvement Manager conveyed their appreciation to all governors whose terms of office end on 20 March 2022.

Extraordinary Council of Governors meeting held on 13 April 2022

Appointment of a Non-Executive Director

- Governors approved the appointment of Ralph Knibbs as Non-Executive Director of the Trust Board at an annual fee of £12,638 for a three year term commencing when the necessary recruitment checks have been completed and factoring in an appropriate handover
- Noted that all appointments to the Trust Board are subject to satisfactory completion of the Fit and Proper Persons Tests
- Noted plans for the remaining vacancy

Governors' Nominations and Remuneration Committee membership

- Approved Annette Gilliland as a new public governor member of the Governors' Nominations and Remuneration Committee.

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
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
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services Standards
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
B	
BAF	Board Assurance Framework
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BAME	Black, Asian & Minority Ethnic group
BoD	Board of Directors
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCT	Community Care Team
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CHPPD	Care Hours Per Patient Day
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CPA	Care Programme Approach
CPD	Continuing Professional Development

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRB	Criminal Records Bureau
CRG	Clinical Reference Group
CRHT	Crisis resolution and home treatment
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAT	Drug Action Team
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DIT	Dynamic Interpersonal Therapy
DNA	Did Not Attend
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DBIT	Director of Business Improvement and Transformation
DOF	Director of Finance
DON	Director of Nursing
DPI	Director of People and Inclusion
DNA	Did not attend
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
EIP	Early Intervention In Psychosis
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising & Reprocessing Therapy
EMR	Electronic Medical Record

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
EPR	Electronic Patient Record
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FFT	Friends and Family Test
FOI	Freedom of Information
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F&P	Finance and Performance
5YFV	Five Year Forward View
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HoNOS	Health of the Nation Outcome Scores
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
ICM	Insertable Cardiac Monitor
ICS	Integrated Care System (formerly ACS)
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IMT	Incident Management Team
IM&T	Information Management and Technology
OOA	Outside of Area
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
IPT	Interpersonal Psychotherapy
J	
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LOS	Length of Stay
LPS	Liberty Protection Safeguards
M	
MADE	Multi-agency Discharge Event
MARS	Mutually Agreed Resignation Scheme
MAU	Medical Assessment Unit
MAS	Memory Assessment Service
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.
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MD	Medical Director
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
MHLT	Mental Health Liaison Team
MHRT	Mental Health Review Tribunal
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSU	Medium secure unit
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NIHR	National Institute for Health Research
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OT	Occupational therapy
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
PCN	Primary Care Networks
PDSA	Plan, Do, Study, Act
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLIC	Patient Level Information Costs
PMLD	Profound and Multiple Disability
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measure
PSF	Provider Sustainability Fund
PSIRF	Patient Safety Incident Review Framework
Q	
QAG	Quality Assurance Group
QC	Quality Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Term / Abbreviation	**Terms in Full**
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
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SMI	Severe Mental Illness
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SystmOne	Electronic patient record system
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
TOOL	Trust Operational Oversight Leadership (replaced IMT)
U	
UDBH	University Hospitals of Derby and Burton
UEC	Urgent and emergency care
V	
VARM)	Vulnerable Adult Risk Management
VO	Vertical Observatory
W	
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

(updated 11 January 2022)

2022-23 Board Annual Forward Plan

Exec Lead	Meeting date	10 May 22	5 Jul 22	6 Sep 22	1 Nov 22	17 Jan 23	7 Mar 23
	Paper deadline	**25 Apr**	**27 Jun**	**29 Aug**	**24 Oct**	**9 Jan**	**27 Feb**
Trust Sec	Declaration of Interests	X	X	X	X	X	X
DON	Patient/Staff Story	X	X	X	X	X	X
CHAIR	Minutes/Matters arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of effectiveness of meeting	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	X
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update - Green Plan sign off (November each year)	X	X	X	X Green Plan	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
COO/DOF	NHSI Financial Annual Plan Month 7-12 2022/23				X		
DPI	Staff Survey Results	X					
DPI	Annual Gender Pay Gap Report for approval						X
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for Board delegated authority for People and Culture Committee meeting on 20 September to approve the October submissions			X			
DPI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC in Sep				X		
DPI	Workforce plan for 2021/22		X				
DPI	2022/23 Flu Campaign			X			
Trust Sec	NHS Improvement Year-End Self-Certification	X					
Trust Sec	Year-end governance reporting from Board Committees and approval of ToRs	X					
Trust Sec	Corporate Governance Report	X					
Trust Sec	Review SOs, SFIs, SoD plus review/ratify SFI Policy (as Policy Review section below)						Amendment SFI
Trust Sec	Trust Sealings (six monthly - for information)	X			X		
Trust Sec	Annual Review of Register of Interests	X					
Trust Sec	Board Assurance Framework Update	X	X		X		X
Trust Sec	Freedom to Speak Up Guardian Report (six monthly)			X			X
Trust Sec	Fit and Proper Person Declaration		X				
Trust Sec	Annual Approval of Modern Slavery Statement	X					
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
OPERATIONAL PERFORMANCE							
DON/DOF/ DPI/COO	Integrated performance and activity report to include Finance, People, performance and Quality Dashboard	X	X	X	X	X	X
DPI	Equality Diversity and Inclusion (EDI) update				X		
DON/COO/ DPI	Workforce Standards Formal Submission/Safer Staffing (prior to publishing on website)	X					

Exec Lead	Meeting date	10 May 22	5 Jul 22	6 Sep 22	1 Nov 22	17 Jan 23	7 Mar 23
QUALITY GOVERNANCE							
EXEC	Quality Position Statement Report - focus on CQC domains (Well Led CQC & NHSI) as per schedule - Caring led by DON due April 2022	Caring DON	Well Led Trust Sec				
MD	Learning from Deaths Mortality report (quarterly publication) (Jul/Nov/Jan/Mar)	AR	X		X	X	X
MD	Guardian of Safe Working Report		X		X	AR	X
DON	Infection Prevention and Control Annual Report and BAF				AR		
MD	Re-validation of Doctors Compliance Statement			X			
DON	Receipt of Annual Reports: - Annual Looked After Children - Safeguarding Children and Adults at Risk				AR AR		
DON	Outcome of Patient Stories - every two years - next due March 2024						
POLICY REVIEW							
DOF/ Trust Sec	Standing Finance Instructions Policy and Procedures Review SOs, SFIs, SoD plus review/ratify SFI Policy (next SFI review July 2022)		X				
Trust Sec	Fit and Proper Person Policy due 31/03/2023						X
Trust Sec	Engagement between the Board of Directors and the CoG due pror to expiry 31/10/2022			X			