Derbyshire Healthcare NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY 7 MAY 2024 TO COMMENCE AT 9.30AM
CONFERENCE ROOMS A&B, RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY, DE22 3LZ

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks and apologies • Trust Vision and Values and 2024/25 Register of Interests • Annual Review of 2023/24 Declarations of Interest	Selina Ullah
PATIENT STORY			
2.	9.35	Patient Story *"Individual Placement and Support; my journey through Mental Health services to employment"*	Dave Mason
STANDING ITEMS			
3.	10.00	Minutes of the Board of Directors meeting held on 5 March 2024	Selina Ullah
4.		Matters arising – Action Matrix	
5.		Questions from members of the public	
6.	10.05	Chair's update	Selina Ullah
7.	10.15	Chief Executive's update	Mark Powell
STRATEGY, PERFORMANCE AND RISK			
8.	10.25	Integrated Performance report to include Finance, People Performance and Quality	Vikki Ashton Taylor/ Dave Mason/Rebecca Oakley/James Sabin
9.	10.45	Financial Plan Update	James Sabin
10.	10.50	Trust Strategy Progress Report	Vikki Ashton Taylor
11.00 BREAK			
11.	11.10	Making Room for Dignity Progress	Andy Harrison
GOVERNANCE AND COMPLIANCE			
12.	11.30	Corporate Governance Report, including: 12.1 Board Committee Terms of Reference 12.2 Audit and Risk Committee Year-End Report 12.3 Trust Sealings	Justine Fitzjohn
13.	11.35	Board Assurance Framework Update	Justine Fitzjohn
BOARD COMMITTEE ASSURANCE			
14.	11.50	Board Committee Assurance Summaries	Committee Chairs
REPORTS FOR NOTING ON ASSURANCE FROM BOARD COMMITTEES			
15.	12.15	Quality and Safeguarding Committee: 15.1 Guardian of Safe Working 15.2 Sexual Safety Charter	Lynn Andrews
16.	12.20	People and Culture Committee: 16.1 Annual Gender Pay-Gap Report 16.2 Annual Approval of Modern Slavery Statement	Ralph Knibbs
CLOSING BUSINESS			
17.	12.25	Identification of issues arising for inclusion or updating in the BAF	Selina Ullah
18.		Meeting effectiveness	

FOR INFORMATION
Summary of Council of Governors meeting held 5 March 2024
Glossary of NHS Acronyms
2024/25 Forward Plan

Questions applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretariat dhcft.boardsecretariat@nhs.net up to 48 hours prior to the meeting for a response by the Board. The Chair may, under the Foundation Trust's Constitution, request members of the public to withdraw for the Board to conduct remaining business in confidence as special reasons apply or because of information which could reveal the identities of an individual or commercial bodies.

The next meeting will be held at 9.30am on 2 July 2024 in Conference Rooms A and B, Centre for Research and Development, Kingsway. Arrangements will be notified on the Trust website seven days in advance of the meeting.

Users of the Trust's services and members of the public are welcome to observe 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 work compassionately and supportively with each other and those who use our services. We recognise a well-supported, engaged and empowered workforce is vital to good patient care.
Respect – we respect and value the diversity of our patients, colleagues and partners and for them to feel they belong within our respectful and inclusive environment.
Honesty – we are open and transparent in all we do.
Do your best – we recognise how hard colleagues work and together we want to work smarter, striving to support continuous improvement in all aspects of our work.

DECLARATION OF INTERESTS REGISTER 2024/25		
NAME	**INTEREST DISCLOSED**	**TYPE**
Lynn Andrews Non-Executive Director	• Trustee for Ashgate Hospice, Chesterfield	(e)
Vikki Ashton Taylor Deputy Chief Executive and Chief Delivery Officer	• Magistrate, covering mainly Derbyshire and Nottinghamshire Courts	(e)
Tony Edwards Deputy Trust Chair	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore, Derby	(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 • Elected Member, Leicester City Council • School of Business and Law Advisory Board Member, De Montfort University • Independent Chair, Derby and Derbyshire Drug and Alcohol Strategic Partnership • Justice of the Peace, Leicester, Leicestershire and Rutland Magistracy	(a) (a) (a) (a) (a) (a) (a) (a) (e) (e)
Ralph Knibbs Senior Independent Director	• Trustee of the charity called Star* Scheme	(d)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Mark Powell Chief Executive	• Treasurer, Derby Athletic Club	(d) (e)
James Sabin Director of Finance	• Spouse works at Sheffield Health & Social Care NHS Foundation Trust as Head of Therapeutic Environments	(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 • Trustee and Board member of NHS Providers representing Mental Health Providers	(a) (e) (e) (e) (e) (e) (e)
All other members of the Board of Directors have submitted a nil return, meaning they have no 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
Report to the Board of Directors – 7 May 2024

Annual Review of Declarations of Interest

Purpose of Report

This report provides the Trust Board with the year-end 2023/24 Register of Directors' interests. This register will be published in the Annual Report for 2023/24. 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. Directorship and other significant interests held by NHS Board members should be declared on appointment and kept up to date.
- 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.
- For this reason each Director should make a continual declaration of any interests they have to the Board Secretary as they arise.
- To ensure openness and transparency during Trust business, the Register is included at the next meeting in the papers that are considered by the Board of Directors at each meeting.

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	X
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long term sustainability.	X

Risks and 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 an interest, each Board member has 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 2023/24.

Report presented by: **Selina Ullah**
Trust Chair

Report prepared by: **Jo Bradbury**
Corporate Governance Officer

DECLARATION OF INTERESTS REGISTER 2023/24		
NAME	**INTEREST DISCLOSED**	**TYPE**
Lynn Andrews Non-Executive Director	• Trustee for Ashgate Hospice in Chesterfield	(e)
Vikki Ashton Taylor Director of Strategy, Partnerships and Transformation	• Magistrate covering mainly Derbyshire and Nottinghamshire Courts	(e)
Tumi Banda *(until May 2023)* Interim Director of Nursing and Patient Experience	• Jabali Men's Network	(d)
Tony Edwards Deputy Trust Chair	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore – Derby • Director of Craftcore Derby	(e) (e)
Carolyn Green *(until Sep 2023)* Director of Nursing and Patient Experience	• Midlands and East Regional Director, National Mental Health Nurse Directors Forum	(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 • Elected Member, Leicester City Council • Justice of the Peace, Leicester, Leicestershire and Rutland Magistracy	(a) (a) (a) (a) (a) (a) (a) (e)
Ralph Knibbs Senior Independent Director	• Vice Chair, RFU Diversity & Inclusion Implementation Group, England Rugby Football Union (voluntary position) - ended June 2023. • Head of HR, UK Athletics (employed position). • Founding member and Steering Group Member, The Rugby Black List (voluntary position). • Trustee of Star* Scheme Charity (voluntary position) - from December 2023.	(e) (e) (e) (e)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Jaki Lowe *(until Nov 2023)* Director of People and Inclusion	• General Medical Council Associate	(e)
Ade Odunlade *(until Nov 2023)* Chief Operating Officer	• Society of African Nurses and Midwives • Research Lead on Observations for Ox e-Health • Chair, NHS Providers Chief Operating Officers Network • Governor of Eden Park High School, Beckenham, Kent • Member of the Advisory Board of XRT Therapeutics (digital organisation helping people to overcome phobia and anxiety) • Advisory Board Member – Healthcare Strategy Forum • Deputy Chair CAD Charity Foundation – Education funding for Girls from poor background in Africa	(d) (e) (e) (e) (e) (e) (e)
Mark Powell Chief Executive	• Treasurer, Derby Athletic Club	(d) (e)
Becki Priest *(until May 2023)* Interim Director of Quality and Allied Health Professionals	• Has a consultancy called IPS support assisting health and care organisations to implement employment support or to review their practice. Regularly undertakes contracted work with IPS Grow which is part of social finance.	(b)
James Sabin *(from Feb 2024)* Director of Finance	• Spouse works at Sheffield Health & Social Care NHS Foundation Trust as Head of Therapeutic Environments	(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 • Trustee and Board member of NHS Providers representing Mental Health Providers	(a) (e) (e) (e) (e) (e) (e)
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(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 MEETING OF THE BOARD OF DIRECTORS

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

Tuesday, 5 March 2024

MEETING HELD IN PUBLIC

Commenced: 9.30am Closed: 12:39pm

PRESENT	Selina Ullah	Trust Chair
	Tony Edwards	Deputy Trust Chair
	Lynn Andrews	Non-Executive Director
	Deborah Good	Non-Executive Director
	Ashiedu Joel	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Mark Powell	Chief Executive
	Vikki Ashton Taylor	Director of Strategy, Partnerships and Transformation
	Dr Arun Chidambaram	Medical Director
	Justine Fitzjohn	Trust Secretary
	Rebecca Oakley	Acting Director of People and Inclusion
	James Sabin	Director of Finance
	David Tucker	Interim Director of Operations
IN ATTENDANCE	Vicki Baxendale	Deputy Director of Regulated Practice
	Kyri Gregoriou	Deputy Director of Nursing and Quality Governance
	Anna Shaw	Deputy Director of Communications and Engagement
DHCFT/2024/020	Ian Watkiss	Consultant Psychologist and AC Trainee (Team Story)
DHCFT/2024/020	Charmian Round	Clinical Psychologist and Clinical Lead (Team Story)
DHCFT/2024/030	Joe Thompson	Assistant Director of Clinical Professional Practice
DHCFT/2024/033	Tam Howard	Freedom to Speak Up Guardian
	Jo Bradbury	Corporate Governance Officer
APOLOGIES	Ralph Knibbs	Senior Independent Director
	Lee Doyle	Interim Director of Operations
	Dave Mason	Interim Director of Nursing and Patient Experience
OBSERVERS	Nosheen Asim	Medical Staffing Co-ordinator/Officer
	Fiona Birkbeck	Public Governor, High Peak and Derbyshire Dales
	Sandra Austin	Volunteer, Carers Forum

DHCFT/ 2024/019	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah welcomed Board colleagues and observers to today's meeting. Apologies were as stated. There were no declarations of interest on agenda items. The Board noted the current Declarations of Interest Register.
DHCFT/ 2024/020	**TEAM STORY "AUTISM SPECTRUM DISORDER (ASD) ASSESSMENT SERVICES"**

Kyri Gregoriou, Deputy Director of Nursing and Quality Governance, introduced Ian Watkiss, Consultant Psychologist, who shared the Quality Improvement journey the team has taken over the last 12 months.

Ian gave a brief overview of the team's starting point and explained the service was created around nine years ago for those suspected of having autism and in recent years, the team has experienced a 350% increase in referrals since 2022, when previously contracted to provide 26 assessments per month.

Due to a long process for people to progress from initial referral, through to a complex and detailed assessment, the waiting list was almost four years long, which impacted negatively on staff morale, turnover and sickness absence.

The Board noted that during an away day in March 2023, the team had focussed on resolutions and identified improvements to three elements of the pathway:

Input – the service could only be effective if referrals were prioritised, to ensure a clinical need for diagnosis, clinicians needed to work closer with administration/clinical staff to ensure the team's processes and timelines were streamlined and that staff felt listened to in their ideas about ways forward for the service.

Process – involvement of service users at the pre-assessment stage, to identify quicker assessments methods. People were discharged quicker if they didn't return pre-assessment packs, Did Not Attend (DNA) or did not reply to the team in a timely manner, confirming the importance of the pre-assessment process (whilst considering the impact of ASD on people's interactions). Other clinicians within the Trust with an interest in ASD assessments to receive additional training, providing an opportunity for assessments to take place across different services.

Output – reduce the length of written reports, whilst maintaining a high-quality service with good patient experience.

It was noted that due to the pathway changes between January and August 2023, the waiting list reduced due to an average increase to 32 assessments per month. Staff also reported positive experiences, they felt listened to and trusted, had improved job satisfaction and suggested more recommendations.

Finally, Ian advised the Trust had applied for registration with the National Autistic Society and the next steps included plans to incorporate an attention deficit hyperactivity disorder (ADHD) service.

Vikki Ashton Taylor, Director of Strategy, Partnerships and Transformation, praised the resulting transformation, benefitting service users and staff and asked what learning could be taken from this. Ian responded that it was crucial to get the engagement of the team and to work at a pace they were comfortable with. Charmian Round, Clinical Psychologist and Clinical Lead, agreed that the team's views on which parts of the service can and can't be compromised were key.

Deborah Good, Non-Executive Director, congratulated the team and was interested to understand ongoing plans to manage the waiting list and if the ability to deliver exceptional care would impact the volume. Ian advised that the service is currently working to full capacity and the only option would be to increase this capacity or reduce those added to the waiting list.

Selina thanked Ian and Charmian and observed that co-designing the service has paid dividends and underpins the Trust's value of People First, she also suggested that a silver or gold service is acceptable rather than platinum and the learning needs to be harnessed.

RESOLVED: The Board of Directors was greatly inspired by the outstanding progress of the team.

DHCFT/ 2024/021	**MINUTES OF THE PREVIOUS BOARD OF DIRECTORS MEETING** The draft minutes of the previous meeting held on 16 January 2024 were accepted as a correct record of the meeting.
DHCFT/ 2024/022	**ACTION MATRIX AND MATTERS ARISING** There was one action due for completion in May 2024. There were no matters arising.
DHCFT/ 2024/023	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been received.
DHCFT/ 2024/024	**CHAIR'S UPDATE** Selina provided the Board with her reflections on activity since the previous Board meeting on 16 January 2024 and gave an overview of visits and meetings attended, in relation to the Trust and Staff, the Council of Governors, Board of Directors, System Collaboration and Regulators, NHS Providers and NHS Confederation. Selina was keen to express thanks to Trust colleagues for their ongoing commitment, dedication and passion for patient care and safety. Highlights included meeting with newly elected Governors and discussions on the forthcoming appraisal process for the Chair and Non-Executive Directors. It was noted that Selina had attended the Quality and Safeguarding Committee in February and was impressed at the rigour in seeking assurance on quality and safety and also the continuing, system-wide discussions about the financial challenge being faced by the NHS, the reality of having to make some difficult choices and also the opportunities. **RESOLVED: The Board of Directors noted the content of the report**
DHCFT/ 2024/025	**CHIEF EXECUTIVE'S REPORT** Mark Powell's Chief Executive's report covered current local issues and national policy developments. The report also reflected a wider view of the Trust's operating environment and is intended to inform and support strategic discussion, whilst serving to horizon scan for risks and opportunities that may affect the organisation. On behalf of the Trust, Mark was pleased to welcome newly appointed Director of Finance, James Sabin, to his first Board Meeting and also expressed thanks to Rachel Leyland and Jo Wilson, Interim Directors of Finance for their fantastic support over the last few months. Mark highlighted that the range of local support services for people with immediate mental health needs has been expanded, providing enhancement to a number of Acute offers, including crisis support and a mental health helpline. Investment and development in these ventures is ongoing, as part of Joined Up Care Derbyshire. Mark also advised that planning for 2024/25 was underway with system partners whilst awaiting the delayed national planning guidance from NHSE. Following the recent industrial action, Lynn Andrews, Non-Executive Director, asked about disruption for staff when appointments need to be rescheduled. Arun Chidambaram, Medical Director, responded that the Trust has been able to mitigate against this when dates are notified in advance. However, often there is insufficient notice and the Trust's approach is to ensure anyone previously affected is not inconvenienced again and there is

	no evidence to show any harm has occurred due to delayed or cancelled appointments. This is to be covered in more detail at the next Quality and Safeguarding Committee meeting. Arun confirmed that the Trust is analysing data to identify any harm, however this is especially difficult to quantify, particularly for Community Mental Health teams. He added that the impact on the physical health of people with severe mental illness is a big area of focus within the new clinical model. **RESOLVED: The Board of Directors noted the report.**
DHCFT/ 2024/026	**<u>INTEGRATED PERFORMANCE REPORT (IPR)</u>** The IPR provided an update on key finance, performance and workforce measures at the end of January 2024. Executive Directors drew attention to the following areas and responded to questions: **Operational Performance** David Tucker, Interim Director of Operations, highlighted the most improved areas which included continued reduction in CAMHS waiting times, exceeded targets with the dementia diagnosis rate and increased access within the community perinatal service. He pointed out the most challenging areas which were waiting times in the following services, Autism Assessment, Community Paediatrics, Talking Therapies and Memory Assessment. In addition, there was the ongoing issue of inappropriate out of area placements and inpatient bed occupancy levels. Deborah was concerned at the 3,285 out of area bed days, in particular the impact this has from a patient and carer perspective. David confirmed that it is not always possible to secure a place close to home and patients can be placed anywhere across England, he added that the relevant service remains in regular contact and aims to repatriate to Derbyshire or discharge as soon as possible. Mark advised that the Trust was in the process of commissioning a number of inpatient beds close to Derbyshire, this would support the continuity of care principles until the opening of the new facilities. Ashiedu Joel, Non-Executive Director, was interested to understand the factors that define inappropriate placements, to which David referenced national guidance and gave examples, such as if the patient is also a member or staff or if a patient asks to be placed out of area. Mark recognised this was a very pressing issue and advised NHSE had been asked for support with the transformation work. However, he drew attention to the improved waiting list performances. **People Performance** The Board noted the key areas of the report, which included improving trends in Appraisal compliance, principles around hybrid/blended working and good training compliance. Rebecca Oakley, Acting Director of People and Inclusion commented that anxiety, stress or depression related illness remains the highest reason for sickness absence. Due to the nature of sickness absence, Lynn was keen to understand what the Trust can offer to support staff in accessing services. Rebecca confirmed that there is a plan in place for long-term absence and support for managers, also the inhouse clinical psychologist continues particular focus on early intervention. She added that employees had access to a 24/7 helpline,

Ashiedu asked how the Trust measures the ongoing impact of COVID-19 on morale and wellbeing, to which Rebecca advised there was no official requirement to report on this. However, Derbyshire Community Health Services NHS Foundation Trust (DCHS) has a dedicated resource, offering awareness for managers and their redeployment process identifies and tracks those diagnosed with long COVID.

It was noted turnover had dipped during COVID-19 and spiked afterwards. The position has remained at 12% for the last year, which was a similar picture nationally for mental health trusts. Rebecca explained that the Trust had developed an internal system to increase exit interview response and the ambition was to achieve 80% compliance.

Finance

James Sabin, Director of Finance, reported that the year-to-date position is a deficit of £2.3m against a planned surplus of £1.0m, an adverse variance of £2.9m. He advised the plan includes an efficiency requirement of £8.8m phased equally across the financial year with development of recurrent plans to minimise the adverse impact into 2024/25, as currently 75% is being delivered non recurrently.

In relation to the withdrawal of the Public Dividend Capital (PDC) funding of £2.5m, Geoff Lewins, Non-Executive Director, asked if there was any resolution around the patient with a complex eating disorder. James responded that it was hoped to manage this out and to focus on cost efficiencies around agency consultants and nursing staff.

Tony Edwards, Deputy Trust Chair recognised the challenge to find additional recurrent savings, however, he wanted to highlight the significant savings that have been achieved to date.

It was noted that continued scrutiny is in place across all areas, with pressure to build next year's plan.

The Board agreed that the team story reflected the positive ability to influence efficiencies through organisational culture.

Mark cautioned that difficult decisions were likely needed over the next two to three months in order to remain financially sustainable and he emphasised the responsibility of the Board to ensure mental health remains prominent in the system, along with physical health.

Quality

Kyri Gregoriou, Deputy Director of Nursing and Quality Governance, reported on the challenges of acquiring suitable placements for those clinically ready for discharge and the Trust continues to work in collaboration with Joined Up Care Derbyshire to identify solutions.

The Board noted there has been a rise in incidents recorded as "self-harm" and physical assault of staff by patients. Learning points to reduce incidents of this type are in review.

It was also noted that simulation-based training is to start in March 2024, which will include interventions to maintain low levels of prone restraint.

Selina challenged the high agency costs in light of the reduced number of care hours per patient per day (CHPPD), to which Kyri explained the need to ensure effective observations to manage risks, such as self-harm.

The Board noted that a reduction in formal complaints received has been influenced by the electronic patient survey, which supports early resolution.

RESOLVED: The Board of Directors:

	1. Accepted limited assurance on current performance across the areas presented, due to the remaining challenges. **2. Formally agreed that the 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.**
DHCFT/ 2024/027	**STRATEGY UPDATE – QUARTER 3, 2023/24** Vikki provided the Board with an update on progress in delivering the priority actions identified in the Trust Strategy, highlighting those priorities that have been delivered to date, priorities that are partially completed, and priorities that are in progress but with significantly more work to enable delivery by the agreed delivery date. The Board noted development of a new Trust Strategy, to be launched in September 2024, which will set out the Trust's response to national policy and the contribution to the system level Joint Forward Plan, namely addressing health inequalities and collaboration. Tony observed the inclusion of the financial situation, which provided effective alignment with the five-year strategy. Vikki advised the new strategy is ambitious but realistic and Trust-wide engagement will shape the culture, vision and values, and drive strategic priorities. **RESOLVED: The Board of Directors noted the 2023/24 Q3 progress in delivering the priority actions as set out in the updated 2022–2025 Trust strategy and the progress to develop a new Trust Strategy.**
DHCFT/ 2024/028	**CONTINUOUS QUALITY IMPROVEMENT (QI): A STOCKTAKE** The Board was updated on the delivery of the current 2021-2024 Quality Improvement Strategy, work which has taken place to date, ongoing evaluation of impact including examples, and next steps informing the next strategy later in 2024. Tony and Lynn praised the report which evidenced the foundations for a more sustainable position and acknowledged the input from Vikki and Jo Wilson, Acting Interim Director of Finance, in driving change towards strengthening leadership. The Board noted that leaders have been trained in QI and this would encourage greater focus in the coming months. **RESOLVED: The Board of Directors noted the progress of activities to date in delivery of the 2021-2024 Quality Improvement Strategy, and the development of a new strategy in 2024.**
DHCFT/ 2024/029	**STAFF SURVEY** Rebecca presented a summary of the National NHS Staff Survey 2023 results for Derbyshire Healthcare, which was conducted between September and November 2023. The results are compared against 51 organisations in the same benchmarking group - Mental Health & Learning Disability and Mental Health, Learning Disability & Community trusts. It was noted that the results are divided into the People Promise themes, scored on a 0-10 scale. The Board recognised the improved response rate and the discussed the resulting themes to be prioritised, which were: • raising and addressing concerns • culture of inclusion and respect for all

	• career development. **RESOLVED: The Board of Directors noted the summary of the National 2023 Staff Survey results.**
DHCFT/ 2024/030	**<u>OUTCOME OF PATIENT STORIES</u>** Joe Thompson, Assistant Director of Clinical Professional Practice, provided an overview of the eight stories that have been brought to the Trust's Public Board between November 2022 and March 2024. Joe reported that the stories had been shared by patients, Experts by Experience and a carer, representing several different Trust services. The Non-Executive Directors challenged how resulting actions had made an impact and discussed how the expectations of story tellers is managed. Mark commented that the Board can look at relevant detail with openness and transparency, however, it is not always possible to implement some of the recommended improvements. Tony questioned the level of follow up that is undertaken and how the story tellers' experience is measured. Joe confirmed that the stories can be difficult to summarise and that every effort is made to set realistic expectations. He added that where it is not possible to implement acceptable outcomes, individuals are signposted appropriately. It was agreed that future reporting will reflect more explicit follow-up actions, including outcomes and feedback from storytellers on the whole experience. **RESOLVED: The Board of Directors:** **1. Noted the report.** **2. Made recommendations for improvement of the process.**
DHCFT/ 2024/031	**<u>POSITION STATEMENT – CQC – EFFECTIVE</u>** Kyri presented the report which provided a Quality Position statement in respect of the Trust's compliance against the Care Quality Commission's (CQC) Effectiveness domain and provided an overarching assessment, recognising areas of strength and improvement whilst outlining areas where further improvements are needed in order to achieve better outcomes for people who use the Trust's services. Geoff queried whether the target for Supervision compliance was realistic due to the low trajectory. Kyri recognised the complexity to influence culture via the process and the trajectory may have been delayed due to process changes and policy reviews. Mark suggested Supervision compliance might benefit by adopting the Trust's approach for non-compliance of mandatory training and stated that it is fundamental for Board Committees to receive assurance on clear, forward trajectories. It was agreed that the aspirations to achieve were evident, however, based on metrics and measures, there was an inconsistent application, and the self-assessment for the new Care Quality Commission (CQC) framework provides the required assurance to comply. Lynn proposed that she work with Dave Mason, Interim Director of Nursing and Patient Experience, to revise the format of reporting assurance on CQC core standards and ensure trajectories are included in the performance reporting. **ACTION.** **RESOLVED: The Board of Directors determined limited assurance against the Effectiveness domain, on the basis that that there is a generally sound system of control designed to meet the requirement of the domain however, there are some weaknesses which put the achievement of specific outcomes at risk.**

DHCFT/ 2024/032	**BOARD ASSURANCE FRAMEWORK (BAF) UPDATE** Justine Fitzjohn, Trust Secretary, presented the fourth issue of the BAF and explained that there has been overall improvement in the status of the risks and five areas of improvement in the status of actions, with one improved overall risk rating. It was noted that there were two risks that were in a worse position, (2B) as progress has not been made with the talent management process and (3A) due to the removal of £2.5m of income due to a guidance change related to the new builds. **RESOLVED: The Board of Directors:** **1. Reviewed and approved the fourth issue of the BAF for 2023/24 and the assurance provided 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. Reviewed all risks within the report and agreed they should be carried forward to the 2024/25 BAF.** **3. Agreed to continue to receive updates in line with the forward plan for the Trust Board.**
DHCFT/ 2024/033	**FREEDOM TO SPEAK UP GUARDIAN REPORT** Tam Howard, Freedom to Speak Up Guardian, presented the half yearly report which gave the Board data on the number of Freedom to Speak Up (FTSU) cases within the Trust, along with an analysis of trends and actions being taken to improve speaking up culture. Tony and Selina queried how the bullying and harassment theme linked back to the staff survey results and were keen to offer support to address. Tam stressed the importance of ensuring timely resolution with a focus on "you said, we did" and pointed out that the Trust sits lower than the national average of 22% for these cases. Rebecca was pleased to see reasonable adjustments as a theme and was interested to learn how the Trust benchmarked nationally in relation to clinical safety. Tam confirmed there was a gap which may be due to a reluctance to raise clinical concerns with herself. Ashiedu and Selina were surprised to hear that National Guardian's Office doesn't request a breakdown on ethnicity reporting and agreed a triangulation of this information across the organisation was needed. It was agreed that effective FTSU mechanisms were in place, however, it was important to link in with the staff survey and to involve the Board to ensure effective resolutions are in place. **RESOLVED: The Board of Directors:** **1. Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda.** **2. Received assurance on the Trust FTSU agenda and supported proposals made by the FTSUG to promote a culture of open and honest communication to support staff to speak up.**
DHCFT/ 2024/034	**BOARD COMMITTEE ASSURANCE SUMMARIES** The Board Assurance summaries from recent meetings of the Trust Board Committees were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. The following points were brought to the attention of the Board by Committee Chairs: **Finance and Performance Committee**: Tony Edwards, Committee Chair, highlighted that work has now started for Ward 32 and the Bluebell ward with focus moving to recruitment and service transformation. The Board noted the transition since 'go-live' for East Midlands

	Perinatal Mental Health Provider Collaborative has gone well and that operational and financial planning is underway. **People and Culture Committee:** In the absence of Ralph Knibbs, Committee Chair, Ashiedu highlighted progress shown around mandatory training compliance, staff turnover, vacancies and recruitment, attendance and absence, bank usage and Freedom to Speak Up. It was noted that strengthened governance around team cultures has been established and there has been an increased Staff Survey response rate. **Quality and Safeguarding Committee:** Lynn Andrews, Committee Chair, pointed out the new format of the Board Assurance Summaries and that overall, there had been a downward trajectory in terms of Complaints and the Patient Experience team is now focusing on improving the quality of response and early resolution. The Board was pleased to note the successful mitigations of clinical and operational risks within the Children's 0-19 Years service. **Audit and Risk Committee:** the update was taken as read. **RESOLVED: The Board of Directors noted the Board Assurance Summaries.**
DHCFT/ 2024/035	**ASSURANCE FROM THE QUALITY AND SAFEGUARDING COMMITTEE** **Learning from Deaths Mortality Report:** Lynn confirmed that on 13 February 2024, the Committee had received significant assurance from the report, which covered the period 1 September 2023 to 31 December 2023. **RESOLVED: The Board of Directors accepted the 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/ 2024/036	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** No issues were identified for inclusion in the BAF.
DHCFT/ 2024/037	**MEETING EFFECTIVENESS** It was agreed that the meeting had covered interesting discussions and provided the opportunity to see the fantastic work being carried out at the Trust. Observers at the meeting were asked for their thoughts. Fiona Birkbeck, Public Governor, was impressed at the focus on people with expertise on top, which provided a good balance. Sandra Austin, Volunteer, Carers Forum, was encouraged by plans to address out of area beds and the progress with the autism assessment service.
The next meeting to be held in public session will be held in person at 9.30am on 7 May 2024 in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

ACTION MATRIX - BOARD OF DIRECTORS (PUBLIC) - MAY 2024							
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
05-Sep-2023	DHCFT/2023/101	Action Matrix - BAF Update	Trust Secretary	Triangulation of BAF and scheduling of Board Committee meetings to be assessed.	31-Mar-2024	A similar issue around scheduling of Finance and Performance reporting has been raised. Discussions are taking place outside of the Board meeting.	Red
16-Jan-2024	DHCFT/2024/009	Integrated Performance Report (IPR)	Interim Director of Operations	Future reports to include an update on readmissions.	07-May-2024	Update will be included in next version of the IPR.	Yellow
05-Mar-2024	DHCFT/ 2024/025	Chief Executive's Report	Medical Director	Update for Quality and Safeguarding Committee in relation to the impact on staff/patients with rebooking cancelled appointments.	18-Apr-2024	Included on QSC agenda for Apr-2024 meeting.	Green
05-Mar-2024	DHCFT/ 2024/031	Position Statement - CQC Domains	Interim Director of Nursing and Patient Experience	To revise the CQC core standards reports and include forward trajectories for respective performance to meet CQC compliance.	02-Jul-2024	In review and new format to be presented at Jul-2024 Board meeting.	Amber

Key:	**Action Overdue**	RED		**1**	**25%**
	Action Ongoing/Update Required	AMBER		**1**	**25%**
	Resolved	GREEN		**1**	**25%**
	Agenda item for future meeting	YELLOW		**1**	**25%**
				4	**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 5 March 2024. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. I start my report with my visits to a number of our services starting with the Catering Service on 20 March. I had a very open and frank conversation with Paul Beckworth, Catering Services Manager, who highlighted the challenges of the service as well as the new developments and opportunities arising from the new Making Room for Dignity transformation programme. Paul also highlighted the move to a greener agenda and reducing carbon emissions using environmentally friendly goods and transportation.

   I also visited Cherry Tree Bungalows and was able to sit in on a service handover meeting. I was pleased to see the excitement of the team at the prospect of some long-awaited capital works which would enhance service delivery greatly.

   On 26 March, I visited the AHP (Allied Health Professionals) Hub and the Physiotherapy team. Sri Kota and members of his team explained how they had managed to address a huge surge in referrals following the pandemic using Quality Improvement (QI) and maintaining a focus on staff wellbeing. It was truly a high performing team given the team consists of 7.5 whole time equivalent (WTE) posts and covers both Derby and Derbyshire. I also visited the Chaplaincy Service and would like to thank Andrew Hope for his service to the Trust. Andrew is leaving the Trust to set up his own private counselling practice. Mark Powell and I visited the People Services team, the e-Roster (Electronic Roster) team, Estates and Facilities team and Patient Experience team. Each team had their own unique way of presenting their team and the work they do. We had a fun quiz with the People Services team and the e-Roster team gave us a number of service-specific goodies and ideas for how the Trust could save money. The Estates and Facilities team impressed us with their presentations, self-reflection and improvement journey as well as showcasing an appetite for further developments and improvements. Once again, the Patient Experience team demonstrated the importance of patient voices and the need to respond quickly and compassionately to issues raised by our patients, service users and carers. A big thank you to all of the services for their openness, commitment and enthusiasm to do their best for our patients.

2. On 23 March, I met with Staff-side representatives Lee Fretwell, Lead Steward, and Staff-side Chair for the RCN Union, Paul Hardy, Lead Convenor for UNISON Union, and Brian Austins, UNITE Union Representative. We spoke about efficiencies, operational structures and our recent Care Quality Commission (CQC) inspections and the programme of actions we have embarked on for consistent and sustainable change and improvement.

3. On 1 May, the Medical Senate invited myself and the Non-Executive Directors (NEDs) to attend. The purpose of the Medical Senate is to co-ordinate the medical professionals' ambitions for clinical leadership, service development, research and strategic direction.

4. I continue to join the live engagement events being hosted via Microsoft 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 also join these calls.

Council of Governors

5. 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 met with our Governors, including some of our newly appointed Governors, on a virtual coffee session on 2 April. It was an informal meeting and a way to better get to know each other and understand some of the issues that are of interest and of concern.
6. The Council's Governance Committee met on 16 April, chaired by David Charnock, and discussed mainly governance matters including the draft governor and membership section of the Annual Report 2023/24, the Quality Account, the draft Governor statement, and the Governor declarations of interest annual update. The Committee also discussed the development of the new Trust Strategy.
7. On 11 March, I held a session with Governors to gain their feedback on NEDs to complete the 360-degree appraisal process for each of the NEDs. 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 and their insight. The Governors were pleased with the performance of the NEDs and wanted to emphasis their observations about the teamwork they observed with the NEDs and the strong connections between individuals.
8. The Nominations and Remuneration Committee met on 25 April to receive the appraisals of myself and six NEDs (Geoff Lewins, Deborah Good, Lynn Andrews, Ashiedu Joel, Tony Edwards and Ralph Knibbs) and to gain assurance that the process outlined and agreed by the Council of Governors, had been followed accordingly. The Committee also received my annual review of Board composition of skills and time commitment and membership of committees.
9. I met with Susan Ryan, the Lead Governor, and Hazel Parkyn, Deputy Lead Governor, on 23 April as part of our monthly update meetings. 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 is dealing with. We discussed the CQC visit and the actions being taken. Denise Baxendale, Membership and Engagement Manager, was also in attendance. 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.
10. On 26 April, I attended a Governor briefing on our recent CQC visit and the requirements of us as a Trust and the actions that we have put in place to meet the requirements. Dave Mason, Interim Director of Nursing, Allied Health Professionals (AHP) and Patient Experience, led the briefing supported by Arun Chidambaram, Medical Director. I would like to thank our Governors for their insights and the assurance that they sought from the Trust.
11. It is with great sadness, I write to inform of the untimely passing of Lynda Langley, our previous Lead Governor. Lynda was a Governor for six years and in that time proved to be a dedicated Lead Governor. Through the pandemic she came to the fore. She regularly checked in with Governors on a one-to-one basis and was incredibly active in keeping everyone connected and engaged despite there being no opportunity to meet. She was also responsible for my appointment as Trust Chair. Our deepest condolences to her husband, Steve and her family and colleagues, she will be greatly missed.

12. The next meeting of the Council of Governors will be on 7 May, following the Public Board meeting. The next Council of Governors meeting will then be on 3 September.

Board of Directors

13. Slightly earlier than previous years, I met with Ralph Knibbs, Senior Independent Director (SID) on 1 March, for my annual appraisal. This is a robust process with 360-degree feedback sought from NEDs, Executives, Governors, external colleagues and other internal colleagues. A report on the process and outcome of the appraisal is collated by the SID and presented to the Council's Nomination and Appointments Committee on 25 April and then the Council of Governors.
14. I too have undertaken NED appraisals during March and April. NED appraisals also follow a similar process to the Chair appraisal with 360-degree feedback, a review of the objectives set for the last 12 months, setting of new objectives for the next 12 months and identifying any development needs.
15. On 13 March, the Remuneration and Appointments Committee met to review the status of mandatory training for the Board, Board Development, annual review of composition of the Board and to review several year-end processes including Fit and Proper Persons Test compliance report, ahead of the publication of the Annual Report and Accounts. The Committee also reviewed its effectiveness and its Terms of Reference.
16. Also, on 13 March, the Board had a development session with senior members of the CQC Regional Team who explained the new approach to inspections. It was a very informative meeting and one that the Board found very useful.
17. On 17 April, the Board Development session focused on the CQC requirements following a visit and an informal session on the Trust Financial Operational Plan, including the new guidance that was received just prior to the expected submission date. The Board discussed the NHS England (NHSE)/Integrated Care Board (ICB)/Joined Up Care Derbyshire (JUCD) System requirements, as well as a sense check of where we are as an organisation and what we need to do further.
18. On 23 April, I undertook Mark Powell's annual appraisal, and agreed with him his objectives for 2024/25, thereby completing all the appraisals that I am responsible for.
19. There were a number of confidential Board meetings in April including an extraordinary confidential Board meeting on 25 April to consider matters related to the financial plan and the Trust's Operational Delivery Plan and to approve the final sign off of the 2024/25 plan submission to NHS England.
20. I have also continued to meet with NEDs individually.

System Collaboration and Working

21. On 7 March, I supported North Staffordshire Combined NHS Foundation Trust in the recruitment of their Trust Chair, as the Independent Chair Member on the interview panel.
22. On 12 March, I attended the JUCD Pharmacy Away Day with the Trust's Chief Pharmacist, Stephen Jones. It was insightful for me to hear about the workforce issues in Pharmacy and the plans for recruitment, retention and development of the workforce.
23. On 13 March, I was part of the stakeholder panel for the recruitment of the University Hospitals of Derby and Burton (UHDB) NHS Foundation Trust's Chair.
24. I met with Paul Devlin, Trust Chair at Nottinghamshire Healthcare NHS Foundation Trust, on 2 April and we discussed the challenges mental health provider trusts are facing as well as opportunities in the wider System.

25. Mark Powell and I continue to have our four-way meetings with Tracy Allen, Chief Executive Officer, and Julie Houlder, Trust Chair, at Derbyshire Community Health Services NHS Foundation Trust (DCHS). We discussed System issues and responses and our continued efforts to improve the care and experience of people with learning disabilities and the joint venture.

26. 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.

Regulators, NHS Providers and NHS Confederation and others

27. On 6 March, I attended the NHS Provider Board meeting, which focused on the organisation's business plan, priorities for the year and approval off the financial plan.

28. On 8 March, I attended the Midlands Inclusive Leadership and Accountability Conference with Rebecca Oakley, Interim Director of People and Inclusion, and Tom Harrison, Head of Equality, Diversity and Inclusion. It was pleasing to see our System was well represented with colleagues from UHDB, Chesterfield Royal Hospital NHS Foundation Trust and DCHS. The event was very well-attended, and it was a good opportunity to hear from other providers about what they were doing. It was also very disappointing to hear that with each cycle of NHS reorganisation the number of black and minority ethnic (BAME) people in leadership has dropped, despite the Equality Impact Assessments (EIA) showing that this would be the outcome. It would appear that there was no accountability for the decisions made despite the EIA.

29. On 24 April, Arun Chidambaram, Medical Director, and I attended the NHS Confederation Annual Mental Health Network Conference in Leeds. We heard from the Shadow Minister for Mental Health, Abena Oppong-Asare, MP, on the priorities of a Labour Government, which included early intervention in children's mental health, no longer using prisons and police custody as places of safety and the disproportionate detention of black men in secure services and the inappropriate detention of people with learning disabilities and autism through the reform of the Mental Health Act.

30. I attend fortnightly briefings from NHSE (NHS England) for the Midlands region, which has been essential to understand the progress of the management of some considerable system challenges including plans for recovery, financial plans and performance.

31. 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.

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	X
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long term sustainability.	X

Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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 ensured 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 – 7 May 2024

Chief Executive's Update

Purpose of Report

This report provides an update on current local issues and national policy developments since the last Board meeting. The detail within the report is drawn from a variety of sources, including Trust internal communications, local meetings and information published by NHS England, NHS Providers, the NHS Confederation and Care Quality Commission (CQC).

The report is intended to be used by the Board of Directors to inform and support strategic discussion. The Board should note that the report reflects a wider view of the Trust's operating environment and serves to horizon scan for risks and opportunities that may affect the organisation.

National Context

2024/25 Operational and Financial Planning Submission

At the beginning of April NHS England published its Priorities and operational planning guidance for 2024/25, recognising the significant progress made in 2023/24 and setting out how we will continue to recover core services and make progress in delivering key commitments. The guidance rightly sets a number of Mental Health, Learning Disability and Autism and children and young people priorities for the NHS.

I reported in March that, whilst waiting for the guidance, we were already developing our priorities for 2024/25 including:

- Areas for continued investment linked to Mental Health Investment Standard and other national priorities
- The development of our capital investment priorities, in addition to the continued Making Room for Dignity developments across the estate and in consideration of our other digital needs
- Developing our cost improvement plans in supporting and ensuring we deliver value and reduce waste.

We will submit our plan to the Integrated Care Board (ICB) by 26 April and complete the formal submission on 2 May. An Extraordinary Trust Board meeting agreed the plan on 25 April and a retrospective report will also be provided to the Finance and Performance Committee, where details of the final Derbyshire ICB and system plan will be shared.

Our plan includes a commitment to deliver the Long-Term Plan priorities for Mental Health, Learning Disability and Autism and children and young people. Alongside this is our financial plan for 2024/25, which shows we will have a deficit position during 2024/25. This will be a significant challenge during the year, managing the demands for our services, meeting national priorities whilst seeking to develop and deliver a longer-term financial strategy that moves us towards financial balance.

Care Quality Commission

On Tuesday, 9 April, the Care Quality Commission (CQC) commenced an unannounced inspection of the Trust's acute mental health services. At the end of the inspection, we received some initial feedback, where the CQC highlighted a number of areas for improvement, including some immediate environmental changes to ensure patient safety.

The Trust is committed to making all improvements outlined by the CQC and has taken immediate action to put the necessary requirements in place. We are providing regular updates and meeting with the CQC on a weekly basis to share progress and provide assurance on the actions received. The Trust is also working with colleagues at Derby and Derbyshire Integrated Care Board (ICB) and NHS England (NHSE) to ensure good communication and external support is in place alongside this improvement programme.

Following their visit in April, the CQC also shared positive feedback, particularly about the caring and sensitive interactions they had witnessed between staff and patients. We expect to receive a full report from the CQC later this spring.

Government response to rapid review into data on mental health inpatient settings

At the end of March 2024, the Government responded to the rapid review into data on mental health inpatient settings. The review was commissioned following a number of undercover investigations in 2022 that raised serious questions about the quality of care and safety of individuals receiving care in these settings. The review recommended several improvements in the way local and national data is gathered and used to monitor and improve patient safety in mental health inpatient pathways. The Government supported the recommendations and set out how the recommendations complement existing work by NHS England to improve inpatient safety and therapeutic care, including within the three-year Mental Health, Learning Disability and Autism inpatient quality transformation programme. We are part of this national quality improvement programme and will be seeking to use the support available to help improve our acute inpatient services.

The report sets out a range of expectations that Providers are required to consider and have in place by July 2024. These include:

- 'Measuring what matters' – this will be supported by NHSE who are delivering a programme of work to agree the most impactful metrics in spotting early warning signs of quality and safety
- Review approach to Board reports to ensure they can identify, prevent and respond to patient safety risks in inpatient mental health settings
- Review lived experience at Board level and, where required, communicate how it will be strengthened and review approaches to gathering and acting on patient experience measures in inpatient mental health settings
- Leaders should prioritise spending time on inpatient wards to gather informal intelligence from patients and staff about their experience, including unannounced visits
- Board members should have the skills and capacity to identify, prevent and respond to risks to patient safety.

We already have several of these recommendations in place but need to ensure that we meet all recommendations in the timeframe stipulated. The Quality and Safeguarding Committee will oversee this requirement and provide assurance to the Board.

Economic costs of mental ill health

A new report commissioned by the NHS Confederation Mental Health Network, sets out that mental ill-health costs the nation £300 billion annually, with these costs spread between individuals, their families, business, and Government. The Confederation argues that the only way to address these costs is through a long-term mental health strategy, as outlined in their joint mentally healthier nation report in 2023.

CQC guidance on assessing well-led

CQC recently published guidance on assessing the well-led key question. The guidance has been developed jointly by CQC and NHS England and its aim is to support trusts to understand what it means to be a well-led Trust and reflects shared expectations across the Regulators. It is structured around the eight quality statements for well-led, as set out under the new single assessment framework, and recognises the impact that good leadership has on staff morale and patient experiences of care.

The Trust is reviewing the guidance in preparation for a future Trust-wide, well-led assessment, which will have a predominant focus on leadership, culture and governance and will result in new ratings for trusts.

National cross-sector Attention Deficit Hyperactivity Disorder (ADHD) taskforce

NHS England is launching a new ADHD taskforce, alongside the Government, to improve care for people living with the condition. The new taskforce will bring together expertise from across a broad range of sectors, including the NHS, education and justice, to better understand the challenges affecting those with ADHD and help provide a joined-up approach in response to concerns around rising demand.

Reducing Health Inequalities

NHS Providers has published a new guide for Board members outlining their role in reducing Health Inequalities. The guide outlines why trusts should act on health inequalities, includes a vision for what good looks like, a self-assessment tool for trusts to use to determine where they are in their journey and a list of suggested objectives for Board members. We will review the guide considering the work we are already undertaking across Derby and Derbyshire to proactively tackle local health inequalities, using data and insights for quality improvement.

Reducing Health Inequalities will be a key part of new Trust Strategy and forms an important part of the development of our Clinical Strategy as well.

Maximising the potential of digital in mental health

The NHS Confederation Mental Health Network has published a report which outlines the challenges, benefits and opportunities of digital mental health and explains how it can improve mental health care and population mental health. This report re-enforces our commitment to evidence based digital transformation at the Trust.

Local Context

Our Trust and Staff

New and developing services

Our **Making Room for Dignity programme** is continuing at pace. Through this programme, we are building new inpatient mental health facilities that will significantly improve the environment for people with acute mental health needs. The new facilities, which are located in Chesterfield and Derby, are progressing well and tours are being regularly held for Trust colleagues and other stakeholders.

The bedrooms in all the new facilities have been designed to ensure service users benefit from a therapeutic environment from the moment they are admitted. The single bedrooms have en-suite showers, giving service users privacy and dignity to begin their recovery. As well as privacy, service users will have much more control over their environments, with the ability to dim the lights, control the temperature and play their own music by connecting their 'phones to the television via Bluetooth.

These innovations are just the start of the therapeutic journey for service users, as occupational therapy and sensory environments will be at the heart of the new facilities. They will have sensory rooms and therapeutic activity rooms. All wards, including those on the upper floor, will have access to outside spaces, calm gardens with scented plants for quiet reflection and outdoor areas with gym equipment. These will maximise wellness, while reducing the use of restrictive practices, medication and seclusion.

The Making Room for Dignity programme was recently shortlisted in the 'project of the year' category at the Health Estates and Facilities Management Association (HEFMA) Awards. The winner will be announced on 9 May.

We continue to promote the **local crisis support services** available for people with immediate mental health needs, including the crisis drop-in services in Buxton, Ripley and Swadlincote, run by Derbyshire Mind and the safe havens in Derby and Chesterfield, run by Richmond Fellowship and P3.

Working with NHS Derby and Derbyshire Integrated Care Board (ICB), which commissions the services, we have generated recent coverage of these open-access services in the Derby Telegraph and on local BBC radio. Although the Trust does not directly manage them, we understand their importance in helping local people who are in crisis, and they complement our mental health helpline. It is this kind of joined-up approach that led to us being highly commended at the national NHS Communicate Awards on 7 March in the 'working in partnership' category.

One aspiration set out in the NHS Long Term Plan is that anyone experiencing a mental health crisis can access mental health support by calling 111 and choosing the option for 'mental health'. They will then be transferred to their local 24/7 mental health helpline. The project is known as **'NHS 111 select mental health'** and the Derbyshire Mental Health Helpline team has been working closely with DHU Healthcare to prepare so that, when the new technology is ready, people calling 111 will be automatically redirected to the helpline for mental health support.

I'm pleased to say that **Derbyshire Recovery Partnership**, our county service to support people needing help with their drug or alcohol use, has had its contract renewed. The service, which we run in partnership with local charity Derbyshire Addictions Advice Service, national charity, Phoenix Futures, and education specialist, Intuitive Thinking Skills, has been awarded a new three-year contract by Derbyshire County Council, with the option of extending for another seven years. This reflects the excellent work being done by the Derbyshire Recovery Partnership team, who have helped hundreds of people in Derbyshire overcome problems with drugs and alcohol since the service's launch.

We have also been raising awareness of the **expansion of our specialist Eating Disorders** service. This expansion has taken place in incremental steps over recent months, thanks to additional national funding. Residents in over half of Derbyshire, including the High Peak, North-East Derbyshire and the city of Derby, can now get an enhanced level of support if they have an eating disorder, as the referral criteria for the service has been extended, meaning GPs and other health professionals can refer adults with an eating disorder based on a wider range of criteria beyond just their weight or body mass index (BMI). The expanded support will continue to be rolled out throughout the year and it is anticipated that all parts of Derbyshire will be covered by the end of 2024.

Across the city and the whole of the county, extra money is also being made available to our partner, First Steps, to expand the number of skills group training sessions for parents and carers of those with an eating disorder.

Our Older Adult Day Services team has launched a new Dementia Hub to provide information and advice to people who are living with, or supporting someone with, dementia. The hub will provide information and support under one roof and is being run once a month in partnership with organisations including Alzheimer's Society, University Hospitals of Derby and Burton NHS Foundation Trust, Derbyshire Community Health Services NHS Foundation Trust, Making Space and Derbyshire Carers Association. The hub will be held on one Thursday per month from 9.30am to 11.30am and will alternate between two locations – Dovedale Day Service in Derby and Midway Day Service in Ilkeston. The hub is open to any local residents with dementia, and their carers and families. The next session takes place at Dovedale Day Hospital on 23 May, and places can be booked by calling the Day Services team on 01332 866980, option 1.

Recognising the achievements of our staff

We have continued to recognise exceptional work by Trust colleagues through our DEED (Delivering Excellence Every Day) staff recognition scheme, especially the work of those colleagues chosen as the winner of 'DEED of the month'. In February 2024, the DEED of the month was jointly shared by three teams, the Early Interventions team south, Physical Health Monitoring team and the Hope & Resilience Hub team, for successfully working together to begin a course of medication for an individual with treatment-resistant schizophrenia at home, rather than requiring him to be admitted to an inpatient unit; this reduced the discomfort and inconvenience for the patient and freed up a bed for someone who needed acute inpatient care.

In March 2024 the winner was Emma Sharratt, a Web Developer within the Trust's Information Management and Technology team. Emma was praised for creating an innovative platform which allows staff to gather information about performance and standards linked to the support of carers and families in our services.

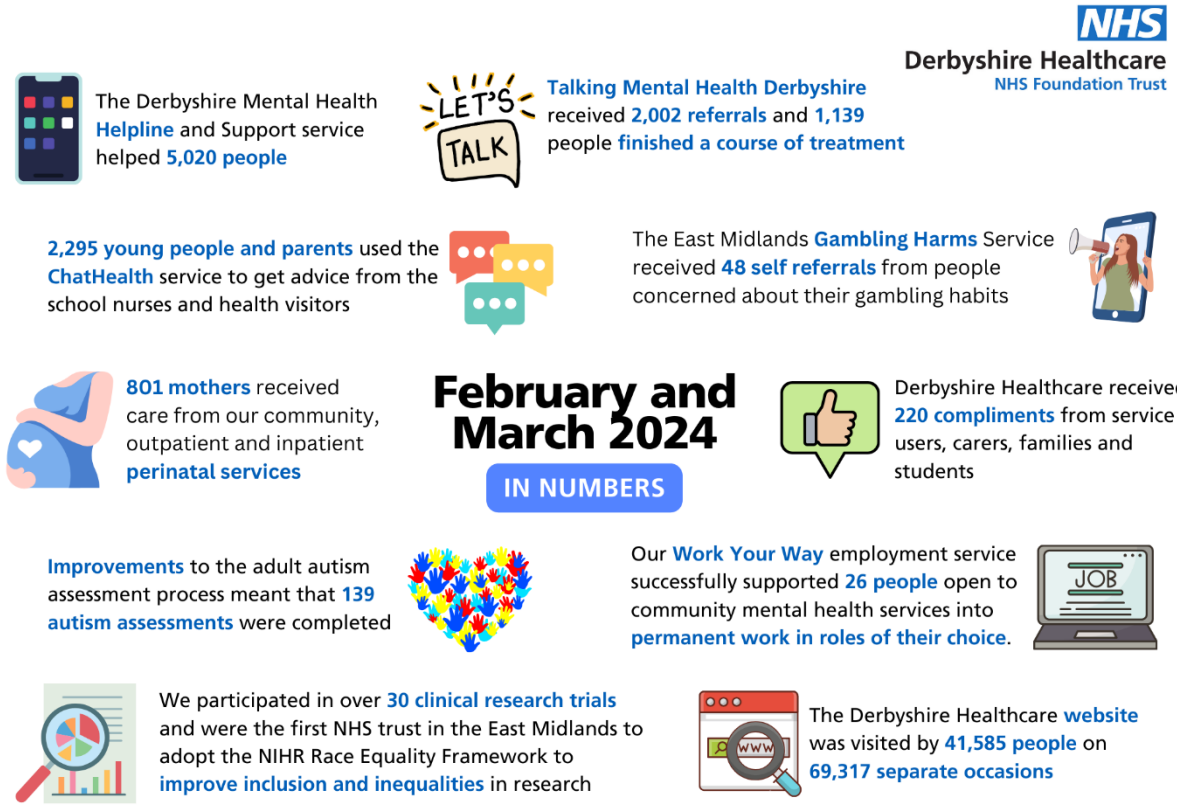
Two of our consultant Psychiatrists have been celebrated in the news recently. Firstly, Dr Rais Ahmed has been appointed to a senior role by the Royal College of Psychiatrists to promote medical leadership and improve patient care across mental health services. Rais will be the Associate Registrar for Leadership and Management from April 2024 for a five-year term; the role includes chairing the Royal College of Psychiatrists' Leadership and Management Committee as well as being part of the College Council, and Rais will promote the importance of good clinical leadership and medical management to effective mental health services.

Professor Subodh Dave, meanwhile, is taking part in a series of marathons and long-distance runs across the world, to raise money for charity. Subodh, who is also Dean of the Royal College of Psychiatrists, is determined to complete a monthly marathon and long distance run every month for 12 months and should complete this challenge in June 2024. Subodh is raising money for Doctors in Distress. We are fortunate to have both Rais and Subodh working for our Trust and caring for our local communities.

One of the Trust's clinical psychologists has been awarded a prestigious national clinical-academic fellowship to help develop a new care pathway for people with complex emotional needs experiencing a mental health crisis. Dr Liam Ennis has secured a National Institute for Health and Care Research (NIHR) Doctoral Clinical-Academic Fellowship. Liam, who has worked for the Trust for five years, will continue his clinical development with Derbyshire Healthcare during the three-year fellowship. This is very important research, as patients with complex emotional needs often have a poor experience of using emergency mental health services, and colleagues can feel uncertain on how to help.

Trust Activity

The infographic below shows some of the different ways we have supported local people during February and March 2024, and some of the achievements of Trust teams.



Board of Directors and Council of Governors

Vikki Ashton Taylor recently began in post as the Trust's Deputy Chief Executive and has already led several all-staff engagement sessions with Trust colleagues. Vikki joined the Trust's Board of Directors in June 2022 as Director of Strategy, Partnerships and Transformation. As of 1 April 2024, Vikki has also become the Trust's Chief Delivery Officer, combining the system and strategy-focused responsibilities from her previous role with being the overall lead for our operational 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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	X
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long-term sustainability.	X

Risks and Assurances

Our strategic thinking includes an assessment of the national issues that will impact on the organisation and the community that we serve.

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 report describes emerging issues 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 and 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.

Recommendations

The Board of Directors is requested to scrutinise the report and seek further assurance around any key issues raised.

Report presented and prepared by: **Mark Powell**
Chief Executive Officer

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2024

Integrated Performance Report

Purpose of Report

The purpose of this report is to provide the Board of Directors with an update of how the Trust was performing at the end of March 2024. The report focuses on key finance, performance, and workforce measures.

Executive Summary

The report provides the Committee with information that demonstrates how the Trust is performing against a suite of key operational targets and measures. The aim of which is to provide the Board a greater level of assurance on actions being taken to address areas of underperformance. Recovery action plans have been devised and are summarised in the main body of this report. Performance against the relevant NHS national long term plan priority areas is also included.

Operational Performance

This chapter has been developed to provide a greater level of assurance to the Board on actions being taken to address areas of underperformance. The chapter includes performance against the relevant NHS national long term plan priority areas.

Most challenging areas:

- Waiting times for adult autistic spectrum disorder assessment – **demand continues to outstrip capacity**, resulting in increasing waits.
- Community paediatric waiting times – **ongoing high levels of demand, pathway issues and recruitment challenges.**
- NHS Talking Therapies waiting times have begun to increase for steps 2 and 3, owing to a reduction in capacity. Ongoing discussions with the Integrated Care Board (ICB) to explore options.
- Memory Assessment Service waiting times – waits from referral to actually assessment are currently around 34-35 weeks. There is **ongoing significant demand for the service which exceeds capacity**. Quality improvement work is in progress to optimise performance within existing workforce constraints.
- Inappropriate out of area placements and inpatient bed occupancy levels – enduring high-level of need for inpatient treatment. **A multi-agency discharge event is planned** in order to expedite discharges where appropriate and free up bed capacity in-house.

Most improved areas and areas of success:

- The number of adult autistic spectrum disorder assessments completed each month has increased significantly for the last seven months and the **annual target has been exceeded by 91%**
- Child and Adolescent Mental Health services (CAMHS) waits continue to reduce and over the last 12 months **the average wait to be seen has halved.** The level of assessments completed is now being controlled in order to enable services further down the system to cope with the demand.

- Work Your Way, the Trust's Individual Placement and Support service, helps people using community mental health services in Derbyshire to find work and stay in work. **To date the team has supported 560 people to access the service and has supported 171 people to find permanent roles in jobs of their choice**.
- Dementia diagnosis rate **continues to exceed target.**
- Community perinatal access levels continue to increase and by February 2024 **the full year target has been exceeded**.
- Community mental health **access levels have been achieved** for the last few months.

Finance

At the end of the financial year the position is a deficit of £9.0m. However, allowing for technical adjustments related to impairments and IFRS16 PFI remeasurement, the amended deficit is £4.6m, as previously forecast, against a breakeven plan.

The year-end deficit position of £4.6m is driven by the following:

- Public Dividend Capital (PDC) funding withdrawal of £2.5m
- Patient with a complex eating disorder costs of £2.2m (net of a £500k contribution to date)
- Industrial action of £0.2m
- Pay award cost pressures of £0.2m
- Excess inflation related to the PFI contract of £0.4m
- Management of operational cost pressures offset by vacancies, interest income, cost reductions and release of balance sheet items.

The Board Assurance Framework (BAF) risk that the *Trust fails to deliver its revenue and capital financial plans*, remains rated as **Extreme** for 2023/24 due to the inherent risks that are built into the financial plan along with risks that have emerged during the financial year. A deep dive into this BAF risk was presented to the Audit and Risk Committee in January 2024.

<u>Efficiencies</u>

The plan includes an efficiency requirement of £8.8m, phased equally across the financial year. At the end of the financial year, the full £8.8m of savings have been delivered. However, a significant proportion (76%) of those savings are non-recurrent in nature which is adversely impacting into next financial year.

Key next steps

- **Development of plans to deliver the efficiency requirements for 2024/25.**

<u>Agency</u>

Agency expenditure for the full year totals £8.8m against a plan of £5.3m, an adverse variance to plan of £3.5m. This includes £2.8m of additional costs to support a patient with complex needs on one of the wards. The two highest areas of agency usage continue to relate to Consultants and Nursing staff.

Agency expenditure has been running at an average of £0.5m per month over the last four months, which is a significant reduction on the earlier months of the financial, with the highest level at £1.0m in August.

The agency expenditure as a proportion of total pay for March is 4.3%. The agency plan for the year is set at 3.5% of total pay expenditure, which is just below the target set by NHSE in the planning guidance of 3.7%.

Out of Area Placements

The plan for out of area expenditure has been reduced by £1.0m in 2023/24, as part of the £8.8m efficiency programme. At the end of the financial year, expenditure on out of area placements exceeded the reduced plan by £2.9m. The number of placements has continued to increase during 2023/24. This is likely to continue into the early months of next financial year.

Capital Expenditure

Capital expenditure at the end of March, is above plan by £3.2m. This is driven by additional PDC funding of £1.5m, £0.9m additional self-funded expenditure and £0.8m of expenditure related to operating leases.

Further adjustments for remeasurement of lease liabilities and terminations of leases reduced the capital position down to £2.8m above plan.

The capital expenditure was delivered aligned to the Trust CDEL limit, when accounting for some late system wide ICB agreed adjustments. Therefore, this was considered a positive outcome, delivering aligned to forecast and agreement. This has also had a positive impact on reducing our carried forward cost pressure in relation to the new build.

Better Payment Practice Code (BPPC)

In March, the target of 95% was exceeded by value by 97.9% but was very slightly under at 94.7% on volume.

Cash and Liquidity

Cash at the end of March has reduced to £33.6m but remains no cause for concern at this present time.

People

Annual Appraisals

Appraisal levels continue to remain under- compliant, however, significant positive progress continues month on month. The low compliance rate within Corporate Services remains a particular challenge. However, measures put in place continue to support gradual improvements, seeing an increase 1.5% since the last reporting period. A specific plan is now in place to support the two lowest performing corporate areas.

Annual Turnover

Overall turnover continues to reduce month on month and is now running at 12.04%, just fractionally over the 12% upper tolerance limit. Turnover remains in line with national and regional comparators.

Compulsory Training

Overall, the 85% target has been achieved for the last 22 months. Operational services are currently 91.5% compliant and Corporate services are at 86%. Whilst overall compliance of the 22 training elements remains high, there have been challenges with two role-specific compulsory training elements which are classroom based and plans are now in place to work towards bringing them back within target.

Staff Absence

The annual sickness absence rate is running at 6.03% and compared to the same period last year is 0.40% lower. Anxiety, stress or depression related illness remains the highest *reason for sickness* absence.

A Clinical Psychologist, who is aligned to the Employee Relations team, continues to support absences relating to anxiety, stress or depression related illness, with a particular focus on early intervention. However, the contract ends in July. A formal review of all long-term cases each month is now a standing action.

Proportion of Posts Filled

At the end of March, 95% of funded posts overall were filled.

Bank and Agency Staff

Agency usage continues to fall, but remains high and further work is required, particularly on long term medical agency usage, to reduce this further. Compared to the peak in agency usage in autumn 2022 through to autumn 2023, agency-spend and usage is significantly lower. The Authorisation Panel to oversee agency requests across the Trust continues to remain in place and the eradication of all non-clinical agency use continues to be enforced.

Supervision

Compliance continues to remain a challenge in both clinical supervision (78%) and management supervision (82%) over the last 12 months and efforts continue towards achieving the 100% target. The results of the 360 Assurance audit of supervision processes are expected shortly. The overall objective of the audit was to assess the actions the Trust is looking to improve supervision performance and accurate recording of supervision time for both clinical and non-clinical staff, and to recommend further actions to improve the position.

Quality

This report will give a bi-monthly update on the Trust's progress against key clinical performance indicators as identified in the main body of the report.

Between January and March 2024, an average of 112 compliments per month were received which is in line with common cause variation. In relation to patient feedback, there are now over 100 teams signed up to the electronic patient survey and there have been 599 patient feedback responses since the implementation in September 2023. This is over a 100% improvement in some services.

The number of complaints received reduced from 22 to 11 and is under the Trust target of 12 complaints. The proportion of patients under the care programme approach who have had their care plan reviewed within 12 months has increased by 9% between January and March 2024 and is currently at 74% compliant against the target of 85%. However, it should be noted that the community mental health teams are 85% compliant on average it is expected that all teams will be at 85% compliance by the end of May 2024.

The number of patients who are clinically ready for discharge (CRD) is currently at 11%, above the target of 4% with the lack of identification of appropriate housing, establishing funding, and availability of social care placements the main barriers for discharge. A twice weekly CRD meeting is in place and the Trust have appointed a Strategic Integrated Flow Lead who chairs a weekly meeting designed to improve flow, which includes social care stakeholders. The impact of this is monitored in the monthly Acute and Assessment Services Operational meeting. A multi-agency discharge event is to be held week commencing 29 April across the two Adult Acute units.

Patients open to the Trust in settled accommodation has reduced from 50% to 48% between January and April 202 and the number of patients open to employment has continued to remain consistent at 12% since August 2022.

This measure continues to be monitored by individual services and a report which informs teams if there are gaps in the current Data Quality Maturity Index information recorded on referral is available to Ward and Service Managers who have been asked to review this report weekly and action any gaps identified.

The number of medication incidents between January and March 2024 has fallen from 83 to 53 (36%) and continues in line with common cause variation. It should be noted that the medication incidents reported are largely of low-level harm.

The Number of DATIX incidents occurring recorded as moderate at catastrophic harm have increased from 53 to 82 between January to March 2024. Analysis suggests that this is due to an increase in the number of incidents routinely reported by staff and a rise in incidents recorded as "self-harm" and physical assault from patients to staff, mainly on the female Acute wards and medical incidents on the Older Adult wards. This data is monitored by the Patient Safety team and the Heads of Nursing/Practice and learning from incidents is fed back to individual teams along with action plans to address any issues which are monitored via Divisional monthly Clinical Operational Team meeting (COAT).

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	X
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long-term sustainability.	X

Risks and 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 common cause 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 relevant parts of the Oversight Framework and the provision of regulatory compliance returns.

Public Sector Equality Duty & 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:

Vikki Ashton Taylor
Deputy Chief Executive and Chief Delivery Officer

James Sabin
Executive Director of Finance

Rebecca Oakley
Interim Director of People, Organisational Development and Inclusion

Dave Mason
Interim Director of Nursing, Allied Health Professionals and Patient Experience

Report prepared by:

Peter Henson
Head of Performance

Rachel Leyland
Deputy Director of Finance

Rebecca Oakley
Interim Director of People, Organisational Development and Inclusion

Liam Carrier
Interim Deputy Director of People & Inclusion

Joseph Thompson
Assistant Director of Clinical Professional Practice

Performance Summary

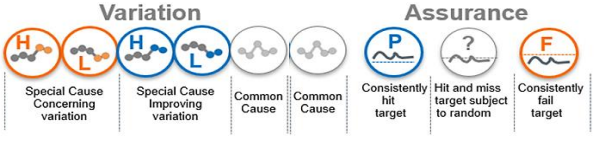
Areas of Improvement	Areas of Challenge
Operations	
• Adult ASD assessments completed • Psychology waiting times reducing • CAMHS waiting times maintained • Early intervention in psychosis waiting times • Dementia diagnosis rate achieved • Perinatal access rate achieved • Community mental health access achieved • Individual placement and support • Three-day follow-up of discharged inpatients	• Community mental health waiting times • Adult ASD assessment waiting times • Community paediatric waiting times • NHS Talking Therapies waiting times • Memory Assessment Service waiting times • Inappropriate out of area placements • Inpatient bed occupancy levels
Finance	
• Efficiency • Agency expenditure • Better Practice Payment Code	• Financial deficit • Adult acute out of area expenditure • Liquidity
People	
• Annual appraisals • Compulsory training • Reduction in agency staff use • Supervision continues to improve	• Staff absence • Bank staff use
Quality	
• Duty of candour incidents • Care plan reviews on improving trajectory	• Clinically ready for discharge • Incidents of moderate to catastrophic harm • Falls on inpatient wards • Care hours per patient day

Assurance Summary

A. Operations

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1a	Waiting list - adult CMHT - average wait to be seen		F	8	4	6	10	8
1b	Waiting list - older adult CMHT - average wait to be seen	L	P	2	4	2	3	2
2a	Waiting list - ASD assessment - average wait to be seen	L		62		66	74	70
2b	Waiting list - ASD assessment - number waiting at month end	H		2,151		2017	2251	2134
2c	ASD assessments	H	?	65	26	11	57	34
3a	Waiting list - psychology - average wait to be seen			16		0	30	15
3b	Waiting list - psychology - number waiting at month end	H		530		671	905	788
4a	Waiting list - CAMHS - average wait to be seen	L		10		16	24	20
4b	Waiting list - CAMHS - number waiting at month end	L		325		381	539	460
5a	Waiting list - community paediatrics - average wait to be seen	H		45		26	33	29
5b	Waiting list - community paediatrics - number waiting at month end	H		2,331		2052	2434	2243
6	Outpatient appointments cancelled by the Trust		?	8%	5%	2%	13%	7%
7	Outpatient appointment "did not attends"		P	12%	15%	10%	15%	12%
B1	3 day follow-up		?	88%	80%	77%	96%	86%
D1	Community Mental Health Access (2 plus contacts)	H	F	11,905	11,899	9541	10278	9909
E1	Children & Young People Mental Health Access (1 plus contact)	H		3,465		2975	3160	3068
E4	Children & Young People Eating Disorder Waiting Time - Routine		P	95%	95%			
E5	Children & Young People Eating Disorder Waiting Time - Urgent		P	100%	95%			
G3	Early intervention 14 day referral to treatment - complete		P	85%	60%	64%	105%	84%
G3	Early intervention 14 day referral to treatment - incomplete		P	71%	60%	60%	113%	87%
H0	IAPT 6 week referral to treatment		F	70%	75%	54%	71%	62%
H1	IAPT 18 week referral to treatment	L	P	99%	95%	98%	101%	99%
H2	IAPT 1st to 2nd Treatment over 90 Days	H	?	39%	10%	6%	25%	16%
H7	IAPT patients completing treatment who move to recovery		?	51%	50%	43%	60%	51%
I1	Individual Placement and Support Access	H	?	560	343	148	414	281
K2	Total inappropriate out of area bed days	H	F		0	1,432	2,243	1,838
K2	Average patients out of area per day - adult acute	H	F	20	0	2	16	9
K2	Patients placed out of area - adult acute	H	F	32	0	3	25	14
K2	Average patients out of area per day - PICU	H	F	22	0	9	21	15
K2	Patients placed out of area - PICU	H	F	31	0	16	34	25
L1	Perinatal Rolling 12 Months Access	H	F	10.1%	10%	5%	6%	5%
L2	Perinatal Access Year to Date	H	F	1,025	1,070	251	611	431
N4	Data quality maturity index	L	P	99%	95%	99%	99%	99%

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

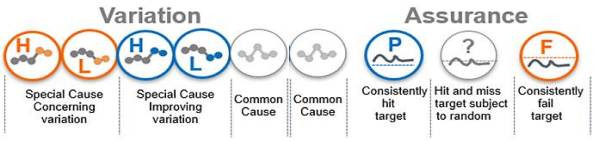
B. People

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Annual appraisals			88%	90%	78%	83%	80%
2	Annual turnover			12%	8-12%	12%	14%	13%
3	Compulsory training			91%	85%	87%	90%	88%
4	Staff absence			5%	5%	5%	8%	6%
5	Clinical supervision			82%	95%	74%	79%	77%
6	Management supervision			78%	95%	71%	78%	74%
7	Filled posts			95%	100%	90%	96%	93%
8	Bank staff use			5%	5%	4%	7%	6%

C. Quality

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Compliments received			90	119	72	165	118
2	Formal complaints received			9	13	4	32	18
3	Proportion of patients clinically ready for discharge			11%	3.5%	4.1%	11.6%	7.9%
4	CPA reviews			67%	95%	62%	77%	69%
5	Patients in employment			12%		9%	13%	11%
6	Patients in settled accommodation			49%		32%	48%	40%
7	Number of medication incidents			87		51	113	82
8	No. of incidents of moderate to catastrophic actual harm			94	48	26	87	56
9	No. of incidents requiring Duty of Candour			0	1	0	5	1
10	No. of incidents involving prone restraint			10	12	0	24	11
11	No. of incidents involving physical restraint			75	46	33	113	73
12	No. of new episodes of patients held in seclusion			15	14	3	35	19
13	No. of falls on inpatient wards			29	30	16	55	36

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

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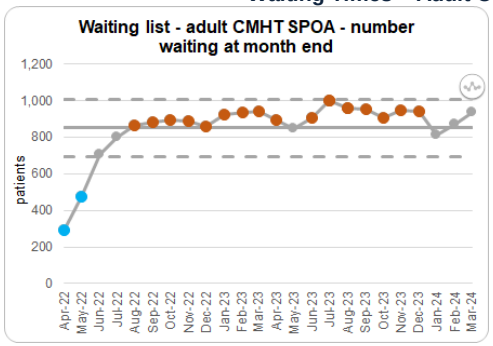
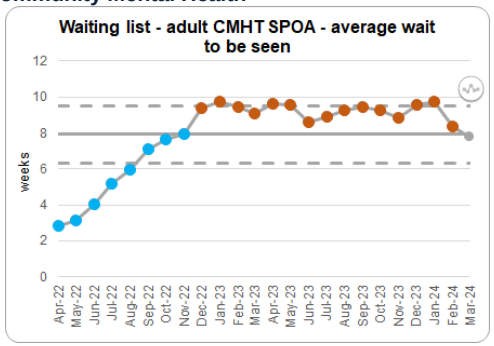
Derbyshire Healthcare
NHS Foundation Trust

Operations

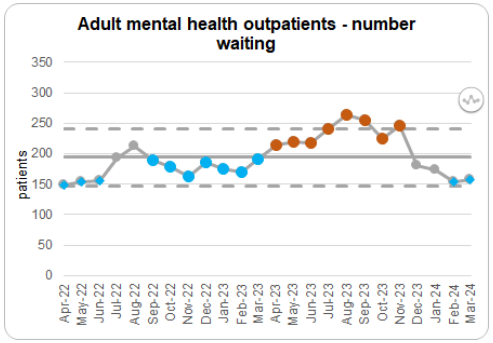
Operational Performance

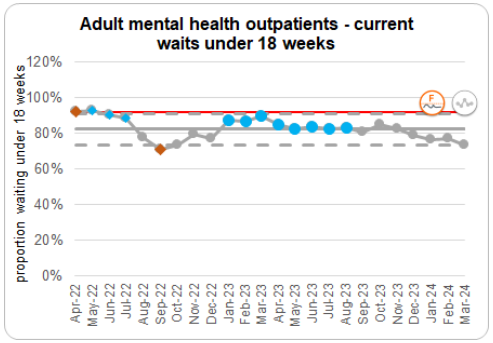
Waiting Times – Adult Community Mental Health





SPOA = single point of access – the route for external referrals into the services





Summary

For adult CMHT, the average wait to be seen is around 8 weeks. The outpatient waiting lists have reduced for the last 4 months, but the proportion of people waiting over 18 weeks remains high.

The working age adult community teams continue to receive more referrals in comparison with the older adult teams, and more referrals in comparison to discharges. Working age adult teams also hold a significant number of patients over the age of 65, accounting for 4% of the total caseload and these continue to be reviewed on an individual basis to assess the most appropriate service to meet their needs.

In the most recently published national benchmarking data, the Trust's median days between referral to community mental health team and first contact was 27 days, which was above the peer median of 27 days. Median length of stay in community mental health services from referral to discharge was 148 days, which was considerably higher than the national median of 58 days. (https://model.nhs.uk/)

Reasons for underperformance

The delay in recruitment to the wave 3 transformation sites, owing to a reduction in the funding and the need to review the workforce plans to fit within the financial envelope, has started to negatively impact on capacity to be responsive to the demand of referrals. The additional funding for extra workforce has been reduced by £400k and is 9 months behind the recruitment trajectory against the additional Community Mental Health Framework (CMHF) transformation investment. This has resulted in some teams having to mobilise the new short-term Living Well model without the additional resource in place owing to these recruitment delays and reduced workforce plans.

Recovery action plan

The Adults of Working Age Community Mental Health Services division have developed a productivity plan and associated recovery action plan. To address the waiting lists, reducing numbers waiting and length of time waiting, there is a focus on productivity within all parts of the service pathway to ensure we increase flow, reduce unwarranted variation, and get best value for money:

3-month plan – 31/1/2024:

- Targeted messaging – accountability, back to basics, getting it right
- Implementation of MaST
- Setting expectations – number of contacts; caseload numbers vs productivity
- Understanding reporting and variance
- Increased face to face training and support around recording in SystmOne
- Commence scoping for screens in team bases to display compliance with KPIs*
- Proactive facilitation of safe discharges in order to create CPN/OT capacity

6-month plan – 30/04/2024:

- Consistent continued messaging around accountability, back to basics, getting it right
- Embedding MaST into business as usual
- Regular monitoring of performance against agreed expectations for contacts, caseloads and productivity
- Consistent use of the Employee Improvement Policy and Procedure
- Improved data accuracy
- Roll out of screens in team bases displaying data, productivity, and performance*
- Referrals and discharges data is being shared with the clinical leads and service managers as a way of raising awareness. It will also help in management supervision, and to identify staff who need support to discharge (as long as our discharge rate is lower than incoming referrals, it will be hard to reduce the waiting list).
- Our clinical educator has also commenced strength-based approach sessions in order to support enhanced care planning.

12-month plan – 31/10/2024:

- Data, productivity and performance conversations are business as usual via use of screens in team bases displaying relevant dashboards*
- Fully embedded use of MaST
- Optimised caseloads within the long-term offer
- Increased compliance with 4-week referral to treatment
- Accurate waiting lists that are reflected across all reporting dashboards
- Improved staff wellbeing – increase in positive response in staff survey
- Apply the learning from the outpatient caseload management QI project and embed as business as usual
- QI approach to outpatient caseload management

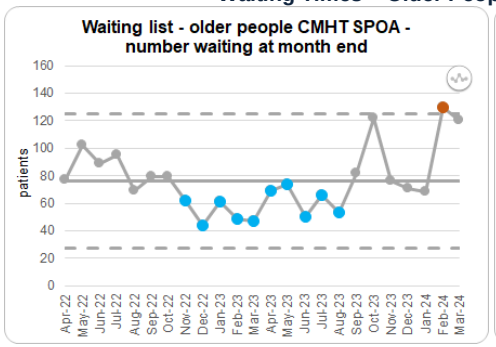
*This project is for Adult and Older Adult CMHTs. Given the current financial position of the Trust, it has been agreed to pause this project whilst Cost Improvement Programmes are worked through. 12 screens have been identified by IM&T that could be repurposed for this project, however, the CMHTs would be charged full price for these screens, which currently there is no funding for. 3 pilot sites have been identified for this project in the first instance if the pilot can go ahead.

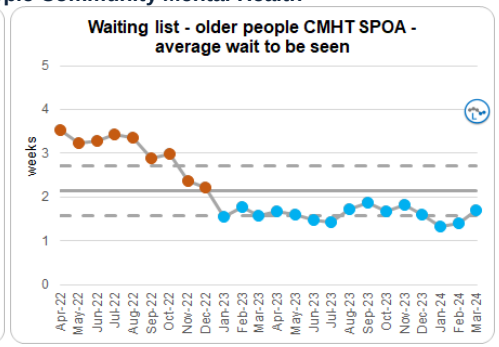
By when we will have recovered the position

The plan is expected to have positively impacted on waiting times by the end of October 2024

Operational Performance

Waiting Times – Older People Community Mental Health





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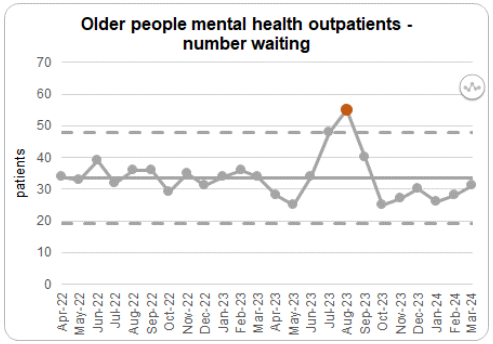
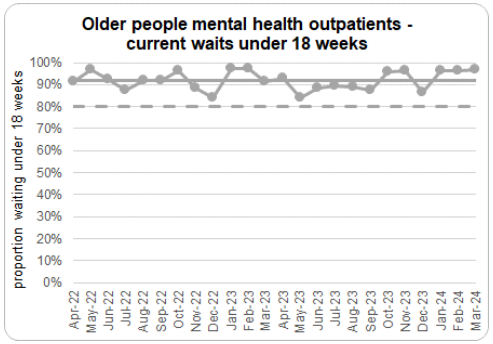
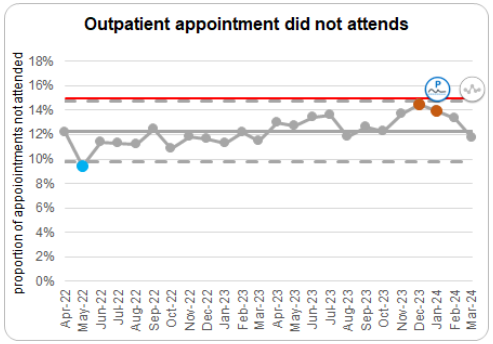




Summary

The number waiting for older people CMHT SPOA has increased in recent months, however the average wait time remains very low. A small number of people are waiting for each older people outpatient service across the County and waiting times remain on target.

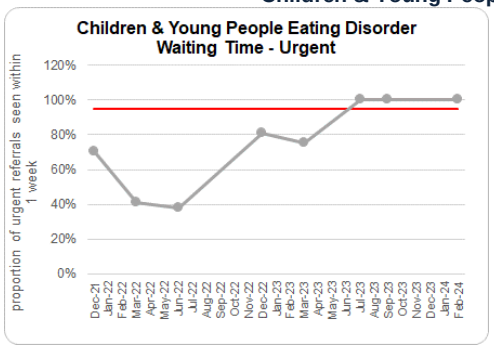
Outpatients

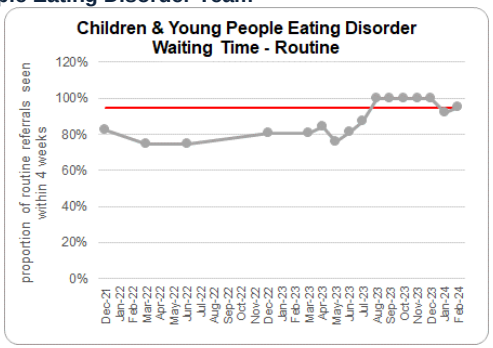


Summary

The level of defaulted appointments (did not attends) has remained within common cause variation, averaging around 12%, and in the current process the trust target of 15% or lower is likely to be consistently achieved. When a person does not attend their appointment, the consultant will attempt to make contact by telephone to conduct the appointment over the phone if appropriate to do so.

Children & Young People Eating Disorder Team



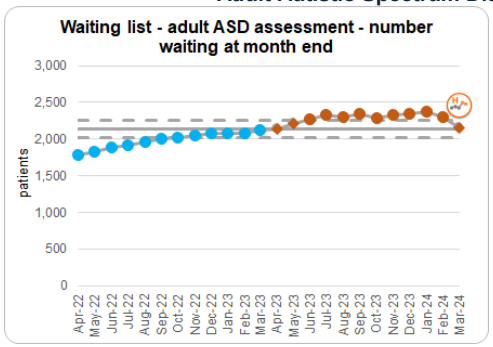


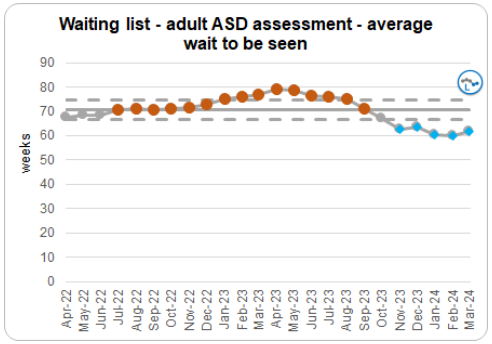
Summary

The waiting time standards are that children and young people (up to the age of 19), referred for assessment or treatment for an eating disorder, should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases, and four weeks for every other case (target 95%). The Trust's Child & Adolescent Eating Disorder Service is generally achieving around 100% for both standards. NHSE have switched to monthly reporting from April 2023 and suppress data if numbers are very low. The Division internally monitors the C&YP Eating Disorder Service waits from 1st to 2nd contact: quarter 1 - 11 days, quarter 2 - 4 days, quarter 3 - 4 days, and quarter 4 – 8 days.

Operational Performance

Adult Autistic Spectrum Disorder Assessment Service





Referrals

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016				18	15	20	23	28	31	26	27	18
2017	19	17	9	20	23	21	25	22	27	43	30	29
2018	29	34	32	41	47	40	62	41	45	54	48	22
2019	92	65	52	50	82	71	77	49	59	34	55	46
2020	83	32	28	45	20	46	17	27	14	48	77	74
2021	43	56	58	59	85	80	64	56	51	70	55	114
2022	62	62	141	74	100	97	50	70	88	65	70	52
2023	40	10	43	42	111	125	122	58	160	116	166	96
2024	165	60	59									

Assessments

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016				19	7	22	5	4	19	20	15	13
2017	35	37	47	22	22	18	30	16	24	34	30	12
2018	20	15	23	18	19	20	22	11	13	14	20	20
2019	33	24	25	24	19	18	15	11	26	30	34	15
2020	28	27	22	1	5	11	20	16	18	29	18	15
2021	20	17	22	22	17	12	14	14	24	24	15	6
2022	12	12	21	13	10	14	8	6	20	22	20	15
2023	22	28	24	22	18	31	30	35	65	53	71	50
2024	66	74	65									

Summary

The number of completed assessments per month has remained high and the full year contractual target was exceeded by 91%, which is a significant achievement.

Demand for the service continues to outstrip capacity (contracted to undertake 26 assessments per month but now receiving around 107 referrals per month this financial year). Please note that an issue has been identified with the way letters have been uploaded to the system which was impacting on reported waits. This has now been corrected, resulting in an increase in the reported number waiting at month end. At the end of March 2024 there were 2,151 adults waiting for assessment.

Recovery action plan fully implemented with successful outcome

The process for assessments has been significantly streamlined to reduce assessment time and create capacity to carry out more assessments hence seeing an increase in recent months.

Ongoing actions to optimise productivity within current resources

- Clinical efficacies: as reported last time, a review of clinical processes to increase the number of ASD assessments completed has resulted in a marked and sustained increase in assessments completed in recent months, with no reported loss of quality or service user satisfaction.
- Support of individuals on the diagnostic pathway remains in place and taking referrals with a focus to increase the numbers of uptake which has been lower than anticipated (some of this due to slow or no responses from those contacted) - whilst this does not reduce wait time for diagnosis, it improves the service user experience and alerts people to options available to them.
- Increased support to individuals pre and post diagnosis is in place and improving their experience, understanding, and is supporting any management of anxiety, reducing the risk of sudden need to access services, earlier awareness can be raised through signposting from the support services to the specialist teams.

Transforming Care Programme

Summary

As of Tuesday 16 April 2024, current inpatient numbers are: ICB = 18, 1 over stretch trajectory; adult provider collaborative = 17, on target trajectory, and Children & Young people = 3, on target trajectory. These are based on the new agreed trajectories for 2024/25.

Actions

Reducing Inflow

- LD&Adult Social Care Support and Intervention Team (SIT) continues to support hospital avoidance with positive impact. (Awaiting future SFD funding from ICB to be confirmed to continue into 24/25)
- Enhanced Community Support (ESC) workstream co-led with revised action plans on Local Area Emergency Protocol (LAEP), Dynamic Support Pathway (DSP) and Care (Education) and Treatment Reviews (C(E)TRs) near completion.
- DSP SOP and linked documentation all signed off with aim to go 'live' in April/May 2024, with a review in 12 months' time allowing time for the new process to become embedded. JUCD webpage currently in development for ease of access across the system. Work to be completed to embed and integrate processes and documentation with system partner software (e.g., SystmOne, Mosaic). There will be promotional work carried out for the DSP, LAEP and C(E)TRs, including the DSP being introduced, through newsletters to other teams including Primary Care. Development of workshops and training started to roll out the new DSP together with new LAEP and C(E)TR processes and how they align across the system.

Improving Flow

- Substantial work undertaken to improve flow with dedicated leads coordinating all the AMH, out of area locked rehabs/ATU and spec com beds and plan repatriation back to Derbyshire. Including setting up community services for individuals including contracting linking in with ICB. Significant improvements in out of area over the last 8 months (June 2023 – 16 March 2024).
- No of discharges into the community by hospital type:
    - Locked Rehab = 5 discharges
    - ATU = 6 discharges
    - Spec Comm = 3 discharges
    - CYP = 2 discharges
- The combined total length of stay (LoS) for all discharges since June 23 is just over 31 years. As part of that total LoS, there have been some significant discharges from Assessment and Treatment Unit (ATU) and Locked Rehab (LR) which totalled Locked Rehab = 7426 and ATU = 3517, there was also provider collaborative patients who combined LoS was 145 days. Progress has also been made on transferring from MSU to locked rehab, with one patient LoS in MSU of 2159 days stepping to LR. In addition to this there was also a step down from Tier 4 to LR. This patient had a LoS in Tier 4 of 841 days (these are not counted in the 30 years above as these patients are still in a hospital setting).

Expediting complex discharges / Improving outflow

- To eliminate MFFDs due to placement availability, system work to improve provider capacity and capability. Stratification and discharge planning workshop took place in November for all ATU, Locked Rehab & Secure inpatients and community placements and this work continues. This is now fed into the Joint Solutions Group (JSG) meeting where it continues to be reviewed to ensure continued progress & links are made to strategic commissioning as needed. The JSG meeting, also allows for any 'themes' that are raised through the DSP, LAEPs, C(E)TRs and hospital discharge planning to be discussed and reviewed.

Annual health checks

Final AHC results in. Number completed 5,000 = 70%, against a target of 5,353.

Operational Performance

Psychology & Psychological Therapies

Introduction
The Division has maintained its excellent reputation in the region for being a fantastic place for psychologists to work and remains the employer of choice. We currently have 2.6% vacancy. We are working hard to manage the shrinking budgets to still maintain our values, support and deliverables. Tweaks to structure have been made to allow reduction in senior leader time across the division.

Workforce update highlights:
Sickness & morale: Sickness within the division has returned to its ongoing low level (4%).

Trainees: taking trainees & delivering training at local universities, continues to form part of our sustainability plan and the income generated improves the continuing professional development (CPD) offering for divisional staff.

LD psychology in the North of the county: We have started the recruitment for posts in the north of the county. We have over half the team now recruited to and due to start in the next two months. We are currently working to recruit the final few posts purchasable within the financial envelope.

Health psychology: Pilot with Team Up Derbyshire: integrating stroke services - mental and physical health. Also; development of psychological wellbeing practitioner roles to work into palliative care at UHDB; & ENT looking to develop end of life care psychology role.

TMHD: See separate report; but notable the changes in delivery impacting over the next 6-12 months will bring likely increases in referrals to other parts of the psychological system.

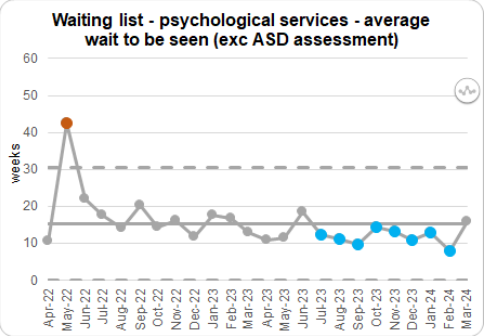
*Rough Sleeping Response***:** In partnership with the police and Derby homes we are providing supervision and RP to this team through two clinical psychologists. The money from the partnership will support internal CPD and staff development.

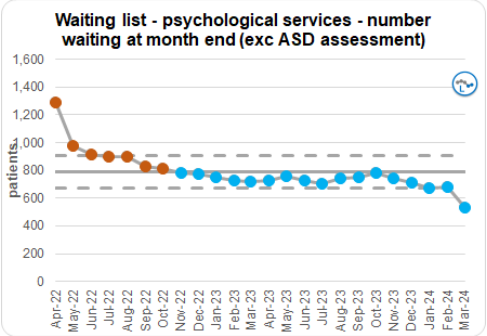
Friends & Family Test
Friends and Family Test, where reported, continues to show excellent feedback. In the last 12 months:

- Cognitive Behavioural Therapy received 32 responses and 100% were positive
- Amber Valley Adult Psychology received 11 responses and 100% were positive
- Psychodynamic Psychotherapy received 2 responses and 100% were positive
- NHS Talking Therapies received 1,762 responses and 98% were positive.
- South & Dales Older Adult Psychology received 2 responses and 100% were positive

Trust wide staff wellbeing
Wellbeing remains a priority for all teams. Our in-house service provision of psychological support is actively working with the sickness specialists within the employee relations team, to plan a pathway to support those people with anxiety / depression / stress at the heart of their challenge. This service continues to support individuals with psychological needs within our workforce but there is risk of loss of this post due to financial constraints. Psychologists embedded in teams are starting to offer RP in line with trauma informed developments and good practice.

Data: there does remain a challenge with gaining accurate data re job role, expectation, head count and training. We are working with the Training & Development team and ESR colleagues to rectify this.





Waiting lists and referrals
Overall, there has been ongoing sustained reduction in the number of people waiting for psychological input from 40 weeks to 16, although this is a slight rise on last month. QI projects (LD, OA & AWA) have supported reduction. Movement of staff, offering different ways of delivering care (e.g. groups) combined with service evaluation has also reduced waiting times. Referral numbers remain high, and the focus will stay on maintaining the average wait to 16 weeks or below. There are no RAP plans active currently.

KPIs
Supervision, appraisal: clinical and managerial supervision remain at 92.7 and 95.2% respectively. IPR completion has risen to above 93%. We continue to push further through governance systems and are tackling recording issues to increase to 100%.

Mandatory training: All areas of mandatory training for the division are above requirement at 90% or higher. Role specific basic life support / resuscitation falls short at 65%. This is being addressed through supervision and monthly governance meetings as a priority over the next 3 months. The overall divisional performance on mandatory training is 92%.

Increasing psychological awareness

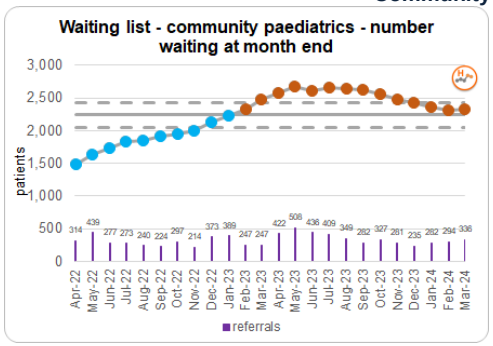
- Bite size psychological teaching sessions continue to have good attendance with a range of topics being delivered. The timetable for 24/25 is now out.
- The trauma informed board has developed the strategy and plans for training regarding Trauma informed working and this has been reviewed and agreed at Trust Leadership Team; now to be reviewed in ELT.

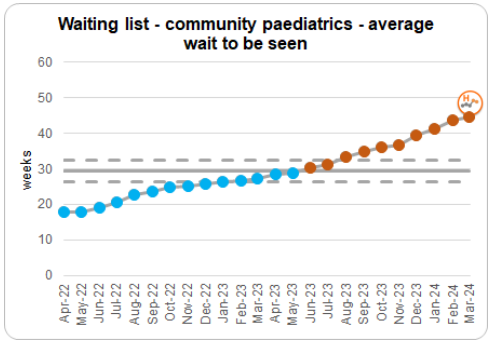
Benchmarking, Productivity & Finance
Financially, we remain within budget, have no unfunded posts or roles, agency or bank. We have submitted a full CIP plan for the required recurrent CIP to 2025. BPS national guidance being used to consider benchmarking, productivity and role delivery.

Safety and quality
We have no outstanding risk assessments of DATIX actions**.** Teams continue to complete a monthly managers update with all performance metrics. Psychological care planning contribution and use of formulation is now a focus.

Operational Performance

Community Paediatrics





Summary

At the end of March 2024 there were 2,331 children waiting to be seen and the average wait time was 45 weeks. The ongoing shortage of ADHD medication has meant that children on specific medications have been reviewed as a matter of urgency as withdrawal has physical health implications. Children on current prescriptions have therefore been prioritised.

Internal factors:

- There is limited triage of cases coming into services prior to them being placed on the paediatricians' waiting lists.
- Difficulty in discharging children under NICE guidance and shared care agreements in relation to medication for ADHD – specialist nursing team caseloads continue to expand causing problems with flow from the Comm Paeds service.
- Community Paediatrician vacancies and skill mix.

External factors contributing to increased demand on Community Paediatricians:

- Prior to March 2021 the referrals received was a level of demand that the service could manage, however Since March 2021 the volume of referrals received has risen and this higher level of demand has persisted to date.
- ASD/ADHD demand for specialist assessment increased 400% from 2018 to 2023 (22/23 4575 referrals per annum) with maximum South Derbyshire system capacity to assess 1900 per year)
- Developmental delay referrals to community paediatricians increased following the pandemic.
- Appointment duration has increased due to the increased complexity of children & young people (CYP) presenting needs post the pandemic.
- Demand for ASD and ADHD assessments is linked to an increase in SEND in schools, school pressures, cost of living crisis and reduced community support.
- ADHD supply issues impacting on demand and management of cases needing to be expedited.

Actions:

- Deputy Area Service Manager is now leading on transformation work for the CYP neurodevelopmental (ND) pathway, an oversight group has been set up for governance and clinical decision making.
- Implementation of the 2022 ND business case
- Senior leadership attendance at system ND meetings to highlight risks and increase the Local Authority, Education and Primary Care accountability for the increasing demand.
- Clinic space remains under constant review.
- Triage work is currently reviewing long waiters, system decision to focus on education / schools in order to prevent referrals by offering advice, support and signposting as needed.

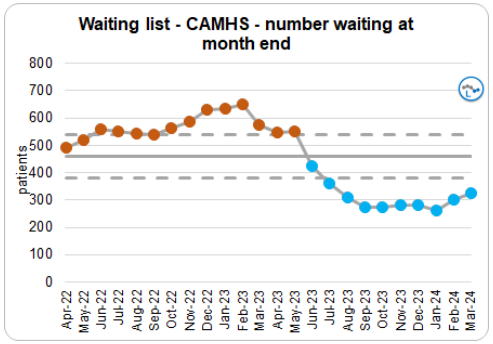
Actions (cont.):

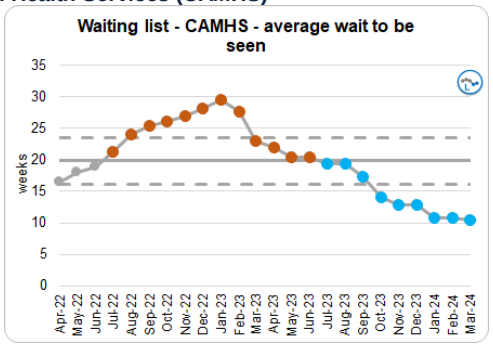
- Review of vacant consultant posts and workforce continues, including consideration for skill mixing some of these posts. Working with recruitment team to update job descriptions to make them more attractive to potential applicants. Currently advertised posts include Specialty Doctor, Consultant Paediatrician ND & generic work and also Named Doctor for safeguarding – consultant.

Trajectory for community paediatric wait times:

Wait times for Community Paediatrics are likely to continue to rise. Our challenge is to reduce the growth/speed at which this takes place.

Child & Adolescent Mental Health Services (CAMHS)





Summary

At the end of March 2024, 325 children were waiting to be seen and the average wait time was 10 weeks.

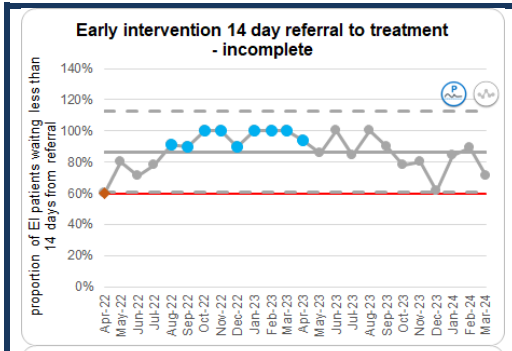
Actions

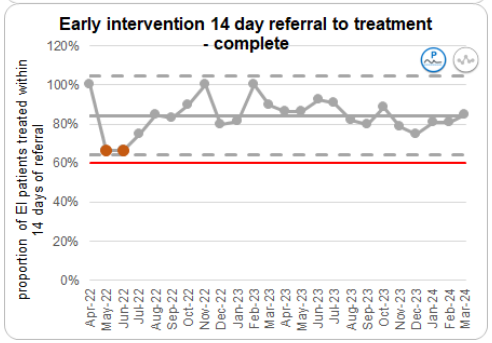
- The triage and assessment team are continuing to positively impact on external waiting times and are adhering to the Trust waiting well policy. As reported last month, the team has reduced the number of assessments the clinicians are doing per week from 8 to 6, in order to relieve pressure on services further along the pathway by reducing flow. This has resulted in an increase in the number of people on the waiting list for assessment. This will be assessed at regular intervals.
- Business case worked up with the ICB to access long term plan children & young people (CYP) services transformation money for 2024/25.
- Waits and CAMHS performance oversight in COAT and reported to Trust Leadership Team. Also oversight at the CYP Mental Health Board.
- Escalation via the ICB Fragile Services Committee – monthly updates provided.

Recovery timescales:

Average wait is below 18 weeks however a national target of 4 weeks is being requested by the system – suggested timeframe for delivery with the proposed additional funds is 18 months.

Operational Performance

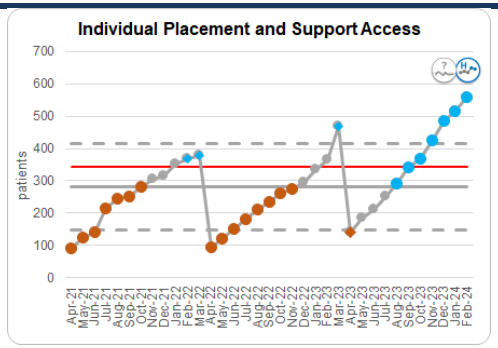




Summary

Patients with early onset psychosis are continuing to receive very timely access to the treatment they need. Occasionally delays result from difficulties contacting patients to arrange appointments, or patients not attending their planned appointments.

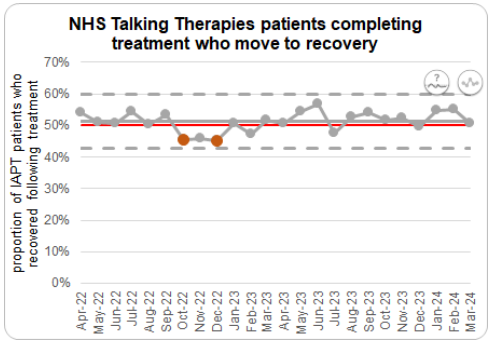
The service continues to be extremely responsive and over the past 2 years has consistently achieved or exceeded the national 14-day referral to treatment standard of 60% or more people on the waiting list to have been waiting no more than 2 weeks to be seen.



Summary

Work Your Way is a team of employment specialists and peer support workers helping people using community mental health services in Derbyshire to find work and stay in work.
The team is continuing to be extremely productive and in the financial year to date (Feb 24) has supported 560 people to access the service, according to the NHSE official data, and supported 171 people to find permanent work in roles of their choice.

NHS Talking Therapies

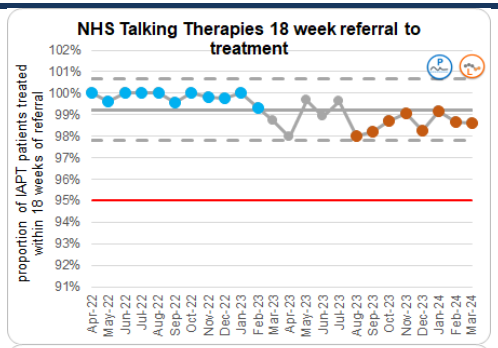


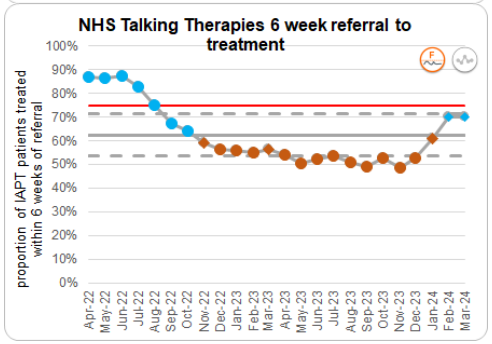
Summary

Recovery rates exceeded the 50% at year end with a recovery rate of 50.47% in March and a full year achievement of 52.49%

Actions

- Monthly performance reports are shared with individual managers, and with the Head of Psychological Therapies. Recovery action plans are shared at TMT meetings.





Summary

- 18-week referral to treatment performance continues to exceed target. The target is 95%.
- The 6-week wait for referral to assessment/ 1st treatment has now shown improvement and is closer to the target. This is due to the improvements in assessment wait times at the beginning of treatments for those discharged.

Reasons for underperformance

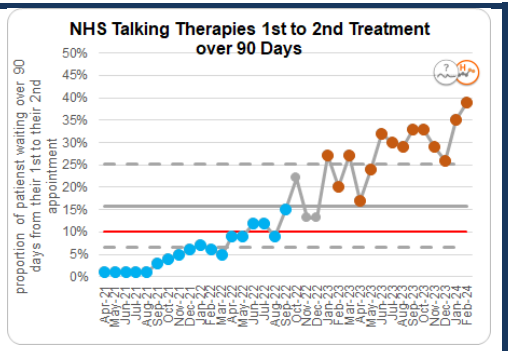
- Referrals average between 1000 and 1100 per month, however the reduction in capacity within sub-contractors (8.3 WTE CBT therapists), increased maternity leave, and the loss of Step 3 staff in the Trust service means that the CBT and trauma wait lists continue to increase.

Actions

- In house productivity reporting against agreed therapist targets has improved booked contacts.
- Step 2 Psychological Wellbeing Practitioners are all in post and continue to maintain the referral to assessment waits at around 3 weeks now.

By when we will have recovered the position

- End of Quarter 1 2024



Summary

1st to 2nd treatment waits remain significantly high and continue to increase for CBT and trauma work.

Recovery action plan

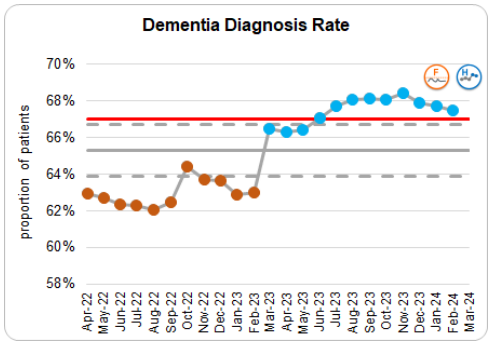
- Wait list ratification, contacting longest waiters to confirm they are still willing to wait.
- Supportive caseload management frameworks introduced to give better scrutiny of productivity re average contacts.
- IESO, one of our sub-contractors continues to have some spare capacity for CBT treatment and awareness sessions at regional staff meetings have taken place.
- Maintain a focus on attendance and reduction of DNAs. New, more assertive DNA guidance has been rolled out in the service.
- Further information is circulated on booked contacts versus agreed targets broken down by clinician and month to promote individual improvements in performance.
- Review of severity criteria for the service to re-balance wait lists with reduced severity and increased discharges will be proposed.
- Bookable appointment slots rolled out to all PWP assessors, these now allow for re-booking of appts and confirmation of appt dates and times.
- Average wait times for referral to assessment and referral to treatment are now shared with commissioners awaiting publication on the ICB website to promote patient choice. These have not been published as yet, however.

By when we will have recovered the position

- Reductions in capacity for CBT cannot be mitigated without significant redesign of the service offer. Ongoing discussions with the ICB to explore options.

Operational Performance

Dementia Diagnosis Rate



Summary

There has been a national drive to increase the proportion of people estimated to have dementia, who have a coded diagnosis of dementia. The target for Derby & Derbyshire ICB has been achieved since June 2023.

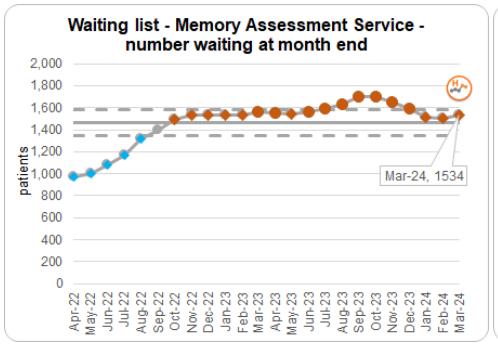
Dementia Diagnosis Benchmarking Data

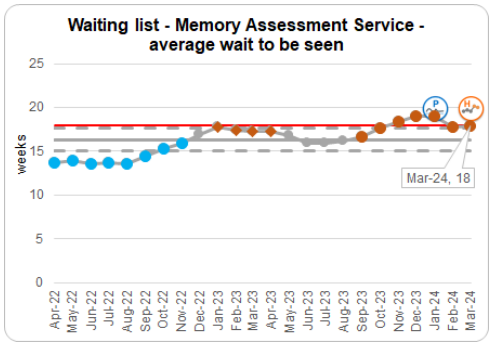
Type	Code	Diagnosis rate
National	ENG	64.5
ICB	QF7	75.5
ICB	QOP	73.2
ICB	QWE	72.1
ICB	QNC	71.9
ICB	QT1	70.3
ICB	QKK	69.7
ICB	QWO	68.9
ICB	QE1	68.4
ICB	QUY	68.3
ICB	QHM	68.1
ICB	QHG	67.5
ICB	QMJ	67.5
ICB	QJ2	67.5
ICB	QNQ	67.1
ICB	QYG	66.8
ICB	QXU	66.7
ICB	QJM	65.8
ICB	QH8	65.5
ICB	QK1	65.3
ICB	QRV	65.1
ICB	QM7	64.4
ICB	QUA	63.8
ICB	QR1	63.5
ICB	QPM	63.5
ICB	QNX	63.1
ICB	QU9	61.9
ICB	QRL	61.8
ICB	QMM	61.2
ICB	QOC	61.1
ICB	QMF	60.4
ICB	QHL	60.4
ICB	QJG	60.2
ICB	QT6	59.6
ICB	QOX	59.2
ICB	QKS	59.1
ICB	QUE	59.1
ICB	QOQ	58.6
ICB	QJK	57.7
ICB	QWU	57.1
ICB	QVV	56.5
ICB	QSL	54.8
ICB	QGH	53.9
Region	NORTH WEST	69.4
Region	NORTH EAST AND YORKSHIRE	67.2
Region	LONDON	66.9
Region	MIDLANDS	64.1
Region	EAST OF ENGLAND	62.9
Region	SOUTH EAST	62.5
Region	SOUTH WEST	59.7

Primary Care Dementia Data, February 2024 - NHS England Digital

The diagnosis rate in Derby & Derbyshire compares very favourably with other areas.

Dementia Diagnosis Waiting Times





Summary

At the end of March 2024 there were 1,534 people on the waiting list, with an average wait of just under 18 weeks, which includes people currently waiting as well as those who were assessed in month. Waits from referral to actually being assessed are currently around 34 -35 weeks.

Reasons for underperformance

- There continues to be an extremely high demand for the service which exceeds capacity.
- The prevalence of dementia is predicted to increase significantly by the end of the decade so the situation in unlikely to improve.

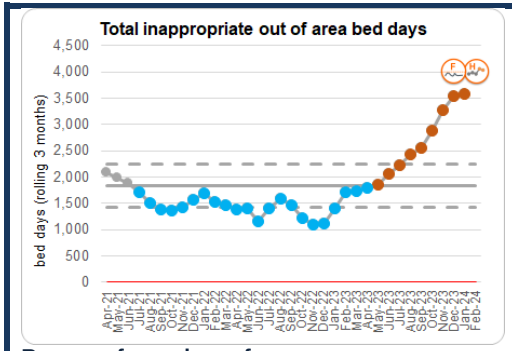
Action plan

- Completion of quality improvement project to maximise and make best use of current resource, to ensure maximum capacity and quality of current provision. The focus currently being on the medical workforce and diagnostic capacity.
- MAS 24 has now been fully absorbed into the CMHT Care Homes Project.
- Reducing the DNA rate.
- Work is underway on the Dementia Assessment Pathway (DAP). Revised referral information has been communicated out to all referrers and implemented from 01/04/2024. Triage training has been delivered to all the CMHT's whose SPOA are working hard to ensure that those being referred into services are in the correct pathway. MAS are supporting with this piece of work.
- Weekly emails to staff with individual performance data to ensure individual accountability for service provision.
- Regular monitoring of wait times and data cleansing.
- Continued focus on staff wellbeing and support.
- Complex case/ under 55 pathway review
- Medical workforce review

By when we will have recovered the position

Quality improvement actions to optimise performance within the current service offer and financial envelope will be fully implemented by September 2024.

Operational Performance

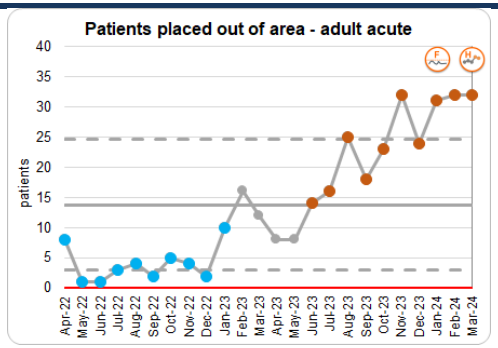


Reasons for underperformance

This is a national measure giving a combination of inappropriate out of area adult acute placements and inappropriate out of area psychiatric intensive care unit placements, calculated on a rolling 3 months' basis. There is an ongoing high level of demand for acute and PICU beds. The level of acuity remains persistently high, resulting in the need for PICU beds and represented by the increase in admissions under the Mental Health Act. There are no PICU beds in Derbyshire at this time and therefore all patients placed in PICU are placed in out of area beds. Currently adult acute wards are working on capacity of around 108% as leave beds are utilised to support additional admissions. This has been a consistent factor for most of the year. The opening of additional Step-Down beds has not impacted this and there is now a move back to spot purchase which will reduce the amount of availability. The impact of the additional crisis house on admissions is also yet to be established. The level of acuity also results in people often taking longer to recover. The crisis teams continue to work with higher than usual caseloads in an attempt to avoid admissions to hospital wherever possible and appropriate.

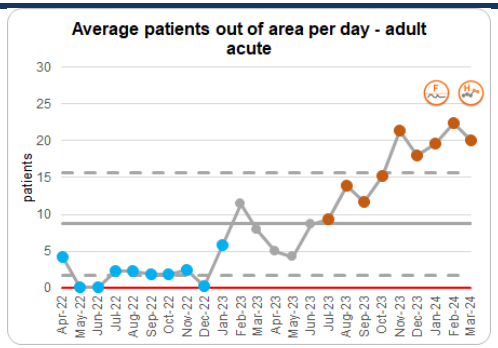
Recovery action plan

- The opening of the Ripley and Swadlincote crisis café was delayed but opened in December 2023. Additional comms needed re all crisis alternatives, to embedded in care plans and contingency planning.
- Work in progress to move inappropriate OOA patients to male ward at Sherwood. 12 beds to be utilised by 06/05/2024
- Fiona White and Dr Rais Ahmed have been appointed to roles to support the improved flow of patients into and out of hospital.



Actions (cont.)

- The demand for inpatient beds for LD&A patients continues. Changes to the pathway to improve assessment and decision making have been implemented which have helped to manage this to ensure community alternatives are explored prior to admission.
- Increasing amount of clinically ready for discharge – escalation meetings with social care now in place.
- The demand for inpatient beds for LD&A patients continues. Changes to the pathway to improve assessment and decision making have been implemented which have helped to manage this to ensure community alternatives are explored prior to admission.
- Liaison with the ICB regarding commissioning of inpatient service for people living in High Peak
- Flow structure to be implemented to provide a multi-agency response to the admission and discharge challenges.
- Implementation of community based Clozaril initiation, avoiding need for admission to hospital.
- Gatekeeping function and purposeful admission to comply with the crisis fidelity model. Full roll out planned for 1st April 2024.
- Enhance the impact of the Emotional Regulation Pathway to support prevention of admission to hospital and/or facilitate early discharge.
- Derbyshire Mental Health Response Vehicle is due to be implemented in June 24. This will be one vehicle staffed by a paramedic and a mental health nurse.

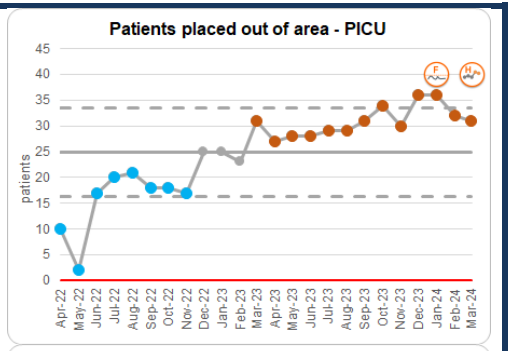


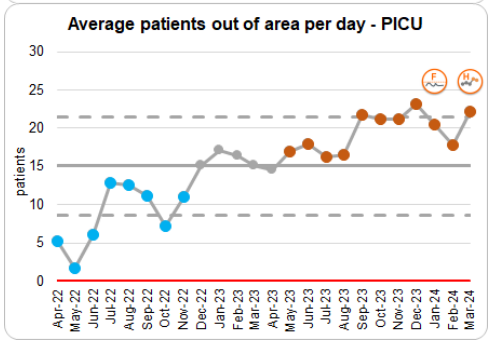
Actions (cont.)

- Street triage pilot due to end 31.03.24 has been extended till 31.05.24, with 1 car as opposed to 2 staffed by police officer and mental health nurse. Expected to stand down when Response Vehicle is established Both services operate 7 days a week covering 4pm to midnight.
- To implement MAST in CMHTs ensuring focused input to those at greatest need and risk of admission.
- To enhance the inpatient offer regarding Trauma Informed Care - to pilot on ward 33.
- Cascade a communication to staff seeking a focus/support to improve flow and reduce inappropriate out of area placements.
- Cascade specific communication to medics
- Review, refine and cascade OPEL differentiated actions.
- Actively increase the use of crisis beds.
- Develop and implement criteria led discharge guidance.
- Initial one-off review/scrutiny of inappropriate out of area patients by a medic.
- Immediate review of all inpatients who are post planned discharge date.
- Immediate review of admission list.
- Expedite moving inappropriate out of area patients to Sherwood
- Scope and set up a multi-agency discharge event (MADE) – to be held week commencing 29 April 2024 – in order to expedite discharges where appropriate and free up bed capacity in house.

By when we will have recovered the position

- End of March 2025





Summary

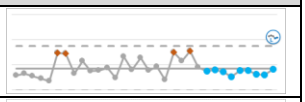
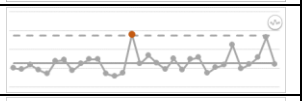
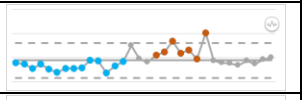
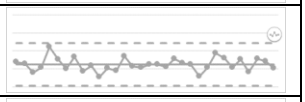
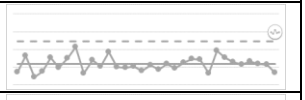
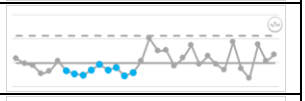
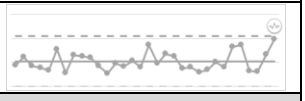
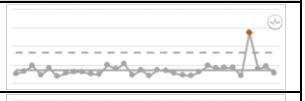
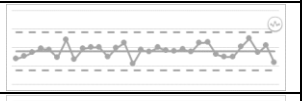
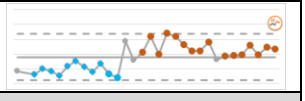
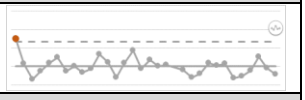
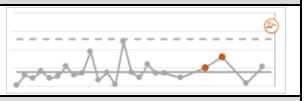
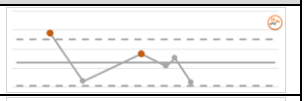
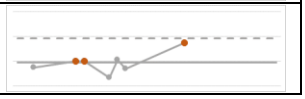
There is no local PICU provision, so anyone needing psychiatric intensive care must be placed out of area, however, work continues on the provision in Derbyshire of a new build male PICU and an enhance care ward for females.

Actions

- Provision of a PICU and enhanced care ward in Derbyshire in order to be able to admit to a unit that forms part of a patient's usual local network of services in a location which helps the patient to retain the contact they want to maintain with family, carers and friends, and to feel as familiar as possible with the local environment – work in progress.
- To generate improved flow and admission capacity in adult acute inpatients, working closely with community teams, creating capacity to repatriate PICU patients when appropriate to do so and a reduction in requirement for psychiatric intensive care.

Operational Performance

Length of stay (days)

Clinical area	Beds	Bed occupancy Mar-24	Average duration of stay to date (days) of current inpatients	Average length of stay (days) Mar-24 discharged	Change versus previous month discharged	Change over time – average length of stay of discharged inpatients
Adult Acute						
Morton	20	104%	58	42	↗	
Pleasley	21	98%	86	60	↘	
Tansley	21	101%	55	50	↗	
Ward 33	20	104%	101	51	↘	
Ward 34	20	111%	72	34	↘	
Ward 35	21	104%	61	66	↗	
Ward 36	21	113%	83	98	↗	
Older People						
Tissington	18	98%	73	56	↘	
Cubley Female	18	66%	69	59	↘	
Cubley Male	18	80%	60	116	↘	
Perinatal						
The Beeches	6	78%	46	29	↘	
Rehabilitation						
Cherry Tree Close	23	74%	309	n/a	n/a	
Low Secure						
Curzon Ward	8	94%	437	n/a	n/a	
Scarsdale Ward	10	83%	906	n/a	n/a	

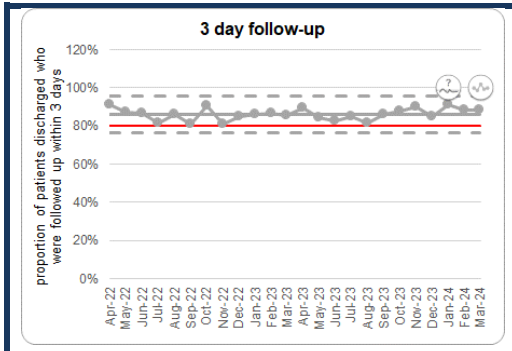
Explanatory note: where occupancy is over 100% this means that patients are on periods of trial home leave and their beds are being used for new admissions while they are at home. Leave beds used are predominantly safe planned leave, so leave would normally be extended, where safe to do so, to prevent 2 patients being in one bed. Patients are encouraged to not spend too much time in their room, so even if a patient was to return, we would have the day to look at where we can shift beds around. It is a constant daily challenge for the Bed Management Team, who do a sterling job.

NHS England measure and publish discharges per 100,000 population of adult acute inpatients with a length of stay of 60 plus days and of older adult inpatients with a length of stay of 90 plus days. The latest published position was as follows:

Indicator	Target	Actual	National Benchmark	Latest period
Adult Acute Long LoS (60+ days)	8	12	10	Jan-24
Older Adult Acute Long LoS (90+ days)	8	11	11	Jan-24

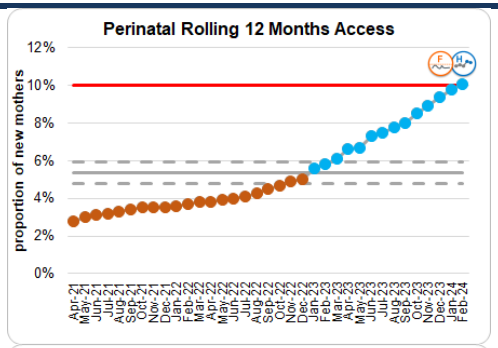
Research based on Erlang's queuing theory suggests that with the size of our bed base there should be a maximum occupancy of 85% in order to have readily available beds to enable management of acutely ill patients to occur in a safe and appropriate setting, and in order to protect both patients and staff from untoward incidents arising from busyness. https://www.priory.com/psychiatry/psychiatric_beds.htm

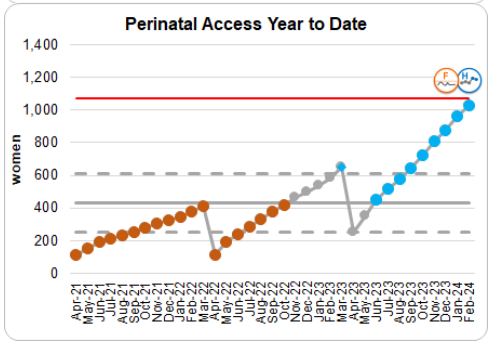
Operational Performance



Summary
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 potentially at their most vulnerable. The national standard for follow-up has been exceeded throughout the 24-month period.

Actions
- Regular audit of follow-ups to ensure improved accuracy of reporting.
- Completion of breach reports for any follow-ups that were not achieved to enable learning from breaches.





Summary
This is a measure of the number of women accessing services in the 12-month period as a percentage of Office for National Statistics (ONS) 2016 births (target 10%). There has been a significant increase in access when compared with last financial year.

The number of live births in Derby & Derbyshire has been lower each subsequent year than when the target was set, which makes it more challenging to achieve as there are fewer and fewer mothers who potentially need perinatal mental health support. 2022 data has now been published and there were over a thousand fewer births than when the target was set:

Live Births	Derby	Derbyshire	Total	Difference v 2016
2022	2864	7217	10081	-1033
2021	2896	7366	10262	-852
2020	2908	7002	9910	-1204
2019	3009	7336	10345	-769
2018	3174	7416	10590	-524
2017	3184	7563	10747	-367
2016	3294	7820	11114	

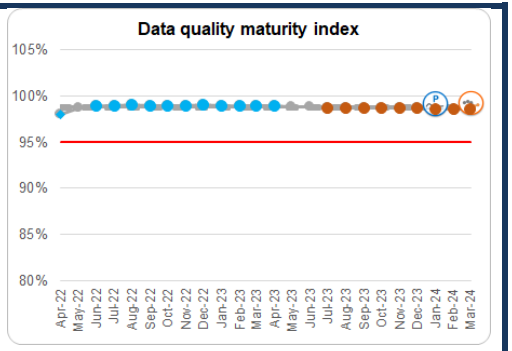
The full year 10% target has been achieved in February 24 (10.1%) as a result of significant developments and quality improvement activities within teams.

Referrals into the service have been positively impacted by the introduction of self-referral processes, stakeholder engagements and community outreach workstreams.

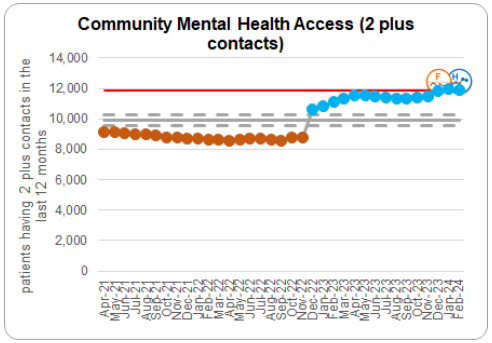
Capacity continues to be demonstrated within the system to offer over 90 assessments a month. Maintenance of the target requires recruitment into current vacancies which are paused as per Trust financial position.

Actions needed to maintain target

- Agreed CPN job plans and target caseloads to be maintained.
- Teams to be fully recruited to.
- Specialist assessor role across North and South teams.
- Further stakeholder event, to ensure referrers are up to date with care pathways and referral processes.
- Service to continue strategic direction to address health inequalities and potential barriers to access.
- Recovery action plan in place regarding community waiting lists for community teams.
- Waiting well offer in place to support patients whilst on the waiting lists.
- DNA action plan



Summary
The level of data quality maturity is consistently high. It is expected that the national target will continue to be exceeded.



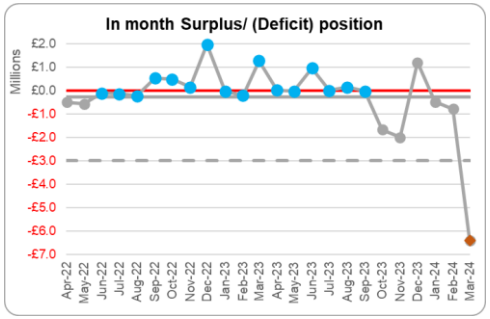
Summary
The Trust was set a challenging target to increase the number of adults and older adults receiving 2 or more contacts in a year from community mental health services to 10,044 by the end of March 2023, which was an increase of 14% on current performance. A recovery action plan was put in place and successfully implemented, resulting in activity exceeding the target for each of the last 4 months of the financial year.

This financial year the year-end target has been increased to 11,899. Services remain on target to achieved it by year end and have exceeded target level in the latest published data.

Derbyshire Healthcare
NHS Foundation Trust

Finance

Financial Performance



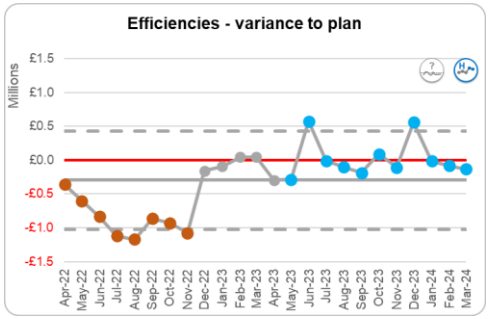
Summary

At the end of the financial year the position is a deficit of £9.0m, however adjusting for technical adjustments related to impairments and IFRS16 PFI remeasurement, the adjusted deficit is £4.6m as previously forecast against a breakeven plan.

The deficit position of £4.6m is driven by the following:

- PDC funding withdrawal £2.5m
- Complex patient additional cost £2.2m (net of income contribution)
- Industrial action £0.2m
- Pay award cost pressure £0.2m
- Excess inflation related to PFI £0.4m
- Management of operational cost pressures offset by vacancies, interest income, cost reduction and release of balance sheet

The Board Assurance Framework (BAF) risk *that the Trust fails to deliver its revenue and capital financial plans for 2023/24,* remains rated as EXTREME due to the financial risks above.

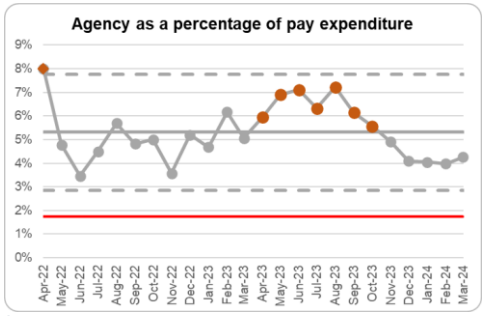


Summary

The plan includes an efficiency requirement of £8.8m phased equally across the financial year. The requirement of £8.8m has been delivered in full at the end of the financial year, however a significant proportion of savings are non-recurrent in nature.

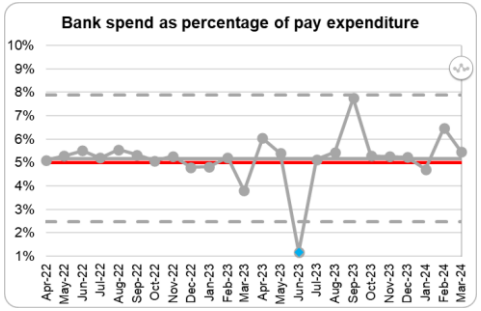
Focus is now on developing the full programme of savings for 2024/25, with a focus on recurrent delivery.

Delivery of the transformation initiatives contributing to the efficiency programme is being overseen by a weekly Transformation Programme Delivery Group. The group seeks assurance that initiatives are on track and identifies additional support and intervention where schemes are off trajectory. Initiatives which are off trajectory and/or forecast to be off trajectory are expected to provide a situation, background, assessment, and recommendation report including suggested mitigations to take forward.

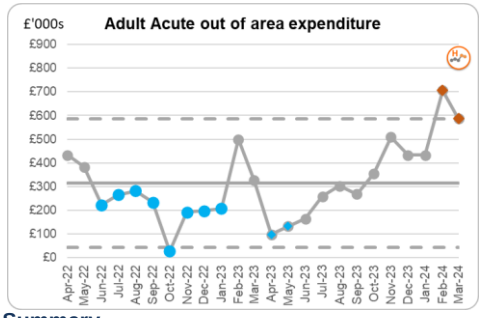


Summary

Agency expenditure YTD totals £8.8m against a plan of £5.3m, an adverse variance to plan of £3.5m. This includes £2.8m of additional costs to support a complex patient. The two highest areas of agency usage continue to relate to consultants and nursing staff. The agency expenditure as a proportion of total pay for March is 4.3%. The agency plan for the year is set at 3.5% which is just below the target set by NHSE in the planning guidance of 3.7%.



Bank expenditure YTD totals £8.4m against a plan of £7.8m, an adverse variance to plan of £0.6m. In July there was an accrual release for backdated pay which then was partially reversed in September due to an agreement to backdate the Band 2-Band 3 increase to April 2022.

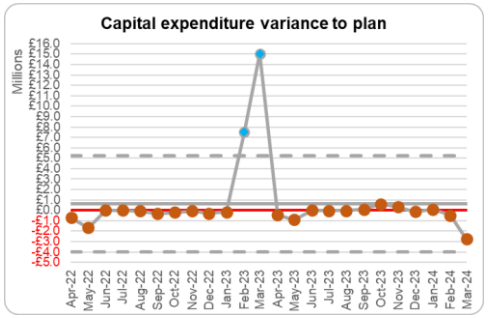


Summary

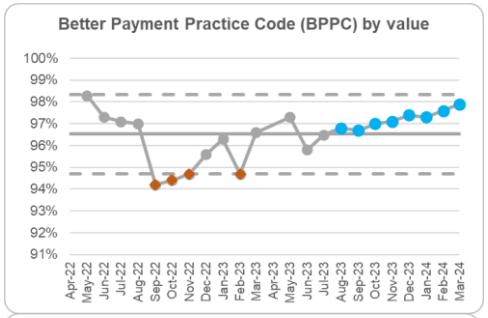
The plan for out of area expenditure has been reduced by £1.0m in 2023/24 as part of the £8.8m efficiency requirement.

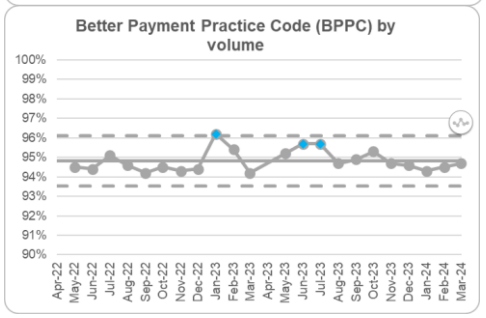
Expenditure on out of area placements has continued to rise throughout 2023/24. At the end of the financial year there was an overspend against the reduced plan of £2.9m.

Financial Performance



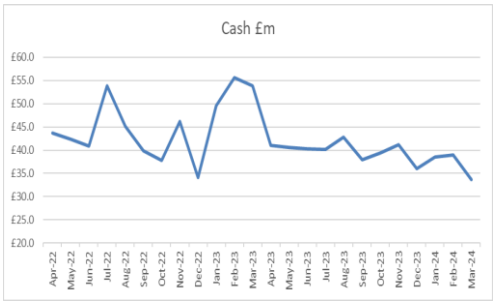
Summary
Capital expenditure at the end of March is above plan by £3.2m. This is driven by additional PDC funding of £1.5m, £0.9m additional self-funded expenditure and £0.8m of expenditure related to operating leases.
Further adjustments for remeasurement of lease liabilities and terminations of leases reduced the capital position down to £2.8m above plan.



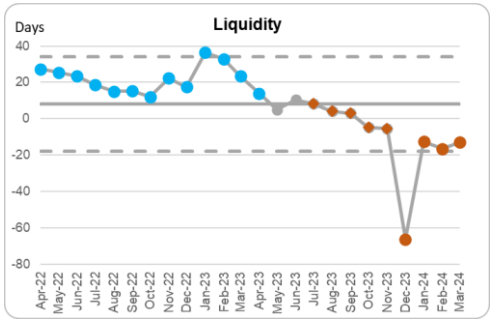


Summary
The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices.

At the end of January, the value of invoices exceeded the target at 97.9% and by volume was slightly under the target at 94.7%.



Summary
Cash increased in February 2023 and March 2023 due to the additional funding for the Dorms capital projects that was drawn down. Cash then reduced in April and May due to payment of capital invoices. Cash at the end of March reduced to £33.6m. The in-year reduction is driven by the reduction in capital accruals and the level of capital expenditure planned for 2023/24.

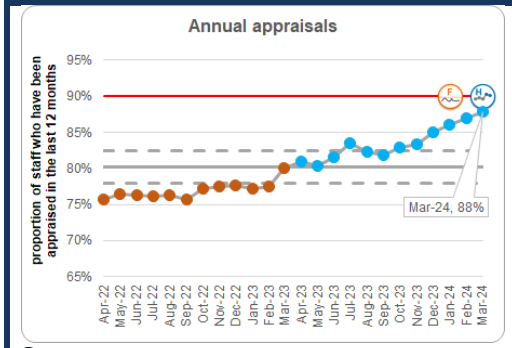


Summary
The chart above shows the liquidity levels over the last two years. Liquidity levels were high in 2021/22 however in 2022/23 the liquidity reduced until the last quarter due to the timing of cash receipts related to the centrally funded capital schemes for the eradication of dorms. The Public Dividend Capital (PDC) drawdown requests caught up in January which drove the increased level in January. The PDC drawdown for 2023/24 came into effect in June. Liquidity level reductions were included within the plan.

Derbyshire Healthcare
NHS Foundation Trust

People

People Performance



Summary

Operational Services currently at 89.9% and Corporate Services at 77.5%, against a target of 90%. Overall, significant improvement has been seen month on month for the last 12 months.

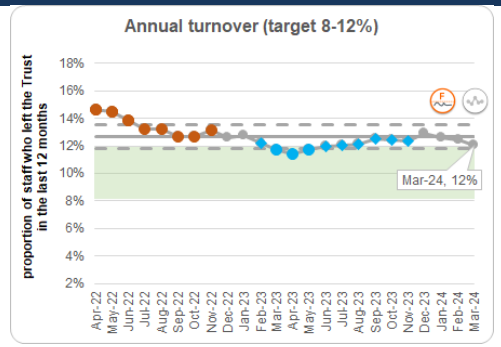
Actions

To both maintain and improve compliance the following actions have been completed or remain in progress to assist managers:

- Horizon scanning of appraisal dates that will expire over the next three months has been completed by contacting both managers and employees directly.
- A targeted campaign of appraisals that have already lapsed has been completed
- Work continues to address data quality challenges with recording of appraisal dates within the Electronic Staff Record (ESR) system
- Compliance also continues to be monitored by the People & Culture Committee and through the Trust Leadership Team Committee.

Compliance rates within Corporate Services have increased by 1.5% since the last reporting period, however, more needs to be done to increase this further. The two services within Corporate Services with the lowest compliance are Nursing & Quality directorate at 48% and Estates & Facilities at 74% and the following measures are now in place to increase compliance:

- Reports on lapsed appraisals sent to operational managers to request completion dates along with support to record on ESR.
- Regular oversite and monitoring with local operational managers to agree plans increase compliance rates.

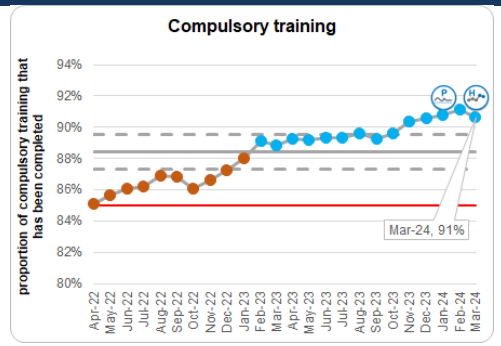


Summary

Overall turnover has been slightly above 12% for the last 9 months but remains in line with national and regional comparators. Turnover has decreased month on month since December 2023 and is now running at 12.04%.

Actions

- The latest staff survey results for 2023/24 were released in January 2024 and are now forming part of an overall action plan at Trust and Divisional levels to improve retention and reduce turnover.
- Work continues to strengthen and grow wellbeing champions in every team to support health and wellbeing, the impact on teams who have already increased champions has been evidenced in their improved staff survey health and wellbeing results.
- A review of staff benefits to support engagement and retention has commenced, which includes a review of the Trusts salary sacrifice schemes. A new intranet page is being developed to promote all options and packages available on one page for ease of use.
- The Trust continues to run a vacancy control panel to monitor all recruitment activity.



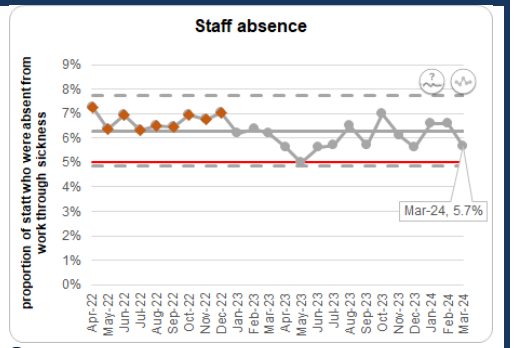
Summary

Overall, the 85% compliance target has been achieved for the last 24 months. Operational Services are currently 91.5% compliant and Corporate Services are 86%.

Actions

Whilst overall compliance with the 22 training elements remains high, we continue to work closely with operational colleagues to ensure compliance in all mandatory and role specific training is both maintained and improved where needed. The following actions have been implemented to support this:

- A review and monitoring of all 'did not attend' (DNA's) occurrences is now regularly fed back to ensure all employees re-book in a timely manner.
- A targeted campaign of prioritising compulsory training elements that have been out of date the longest has been undertaken.
- The Training and Education Group continue to oversee and review training compliance, changes and challenges.



Summary

Sickness absence remains slightly above target and has averaged 6.3% over the 24-month period. In March 2024 the overall absence rate was 5.68% (Operational 5.7%, Corporate 5%).

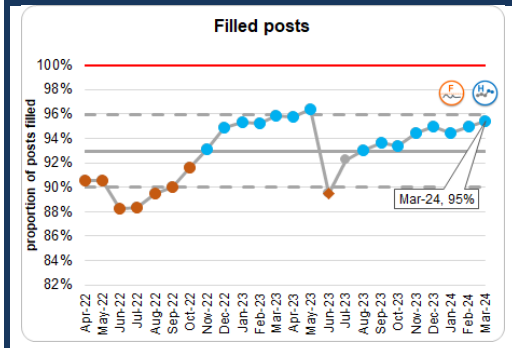
Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by cold, cough, flu – influenza and this remains unchanged as the highest two reasons for absence since the last reporting period. The 3rd highest reason for absence is now chest & respiratory problems.

Long-term sickness absence represents 54% of all sickness absence and short-term represents 46%. Compared to the previous reporting period, both long term and short-term sickness absence have decreased.

Actions:

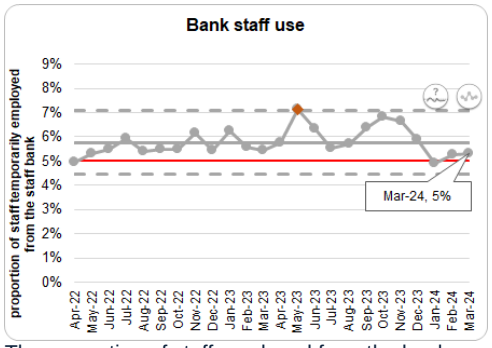
- A review is currently taking place with a view to ensure early intervention takes place earlier.
- All long-term absences are now reviewed each month with the Acting HRD and ER lead to ensure a supportive and robust approach is being taken to managing all absences.
- An event was held at Cubley Court to raise awareness of musculoskeletal (MSK) issues and how to avoid them took place following an increase in MSK absences in the area. This included a series of stands, activities and advice.

People Performance

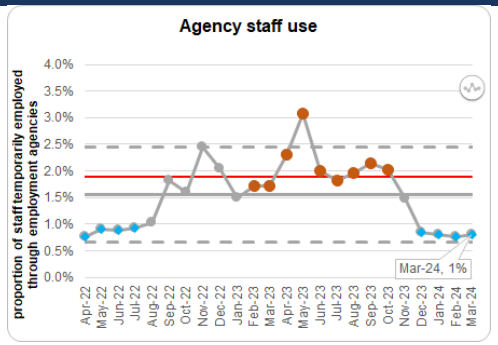


Summary
At the end of March 2024, 95% of posts overall were filled.

Actions
- Work continues towards planning for successfully recruiting into the Trust's key transformation project 'Making Room for Dignity' programme.

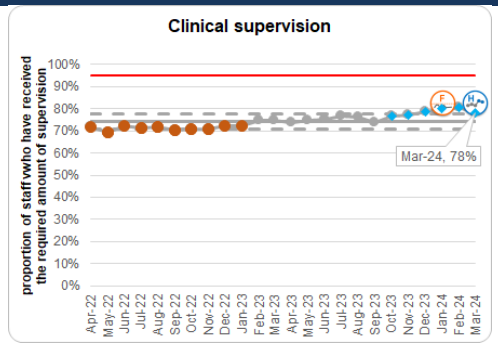


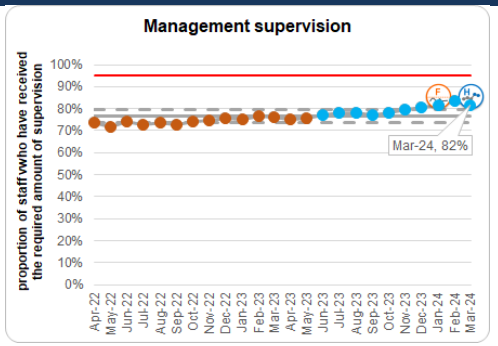
The proportion of staff employed from the bank ranges from 4-7% per month. Bank staff are predominantly employed on inpatient wards. Reasons for temporary staffing include cover for vacancies, sickness and maternity leave, and for increased levels of observations.



Summary
Agency usage has fallen significantly for the last 4 months.

Actions
The actions previously identified below, continue to remain in place and operational as business as usual.
- Weekly Authorisation Panel continues to oversee agency requests across the Trust.
- All admin and clerical agency usage remains eliminated.
- All facilities and IT agency usage remains eliminated.
- Clear protocols are in place to cover the circumstances where the various levels of agency workforce (including Thornbury) relate to enhanced, safer and emergency staffing levels.
- Ongoing actions are taking place to support the reduction in medical agency, these include creative recruitment campaigns, alternative workforce roles where appropriate and continued increase of availability of temporary staffing through the Trust's medical bank function.





Summary
Overall compliance is 78% for clinical supervision and 82% for management supervision. As seen with compulsory training and appraisals, Operational Services continue to perform at a considerably higher level than Corporate Services for both types of supervision (management: 85% versus 63% and clinical: 81% versus 28%).

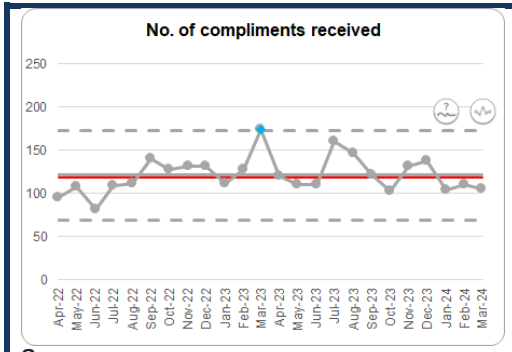
Actions
In Operational Services, incremental progress continues to be made, which is statistically significant. Review of progress takes place at operational meetings and via weekly reporting to senior operational management for ongoing monitoring and action.

An audit of supervision processes has now been completed, undertaken by 360 Assurance. The audit objective was to assess the actions the Trust is taking to improve supervision performance and accurate recording of supervision time for both clinical and non-clinical staff. The outcome of the audit is expected shortly and is likely to recommend further actions to improve the position.

The audit covered the following areas:
- Understanding the Trust's system for recording supervision
- Confirming what arrangements are in place to remind staff supervision should take place
- Confirming responsibilities of line managers/staff for initiating, documenting and recording supervision
- Assessing the arrangements that the Trust has put in place to improve the percentage of staff receiving supervision.

Quality

Quality Performance



Summary

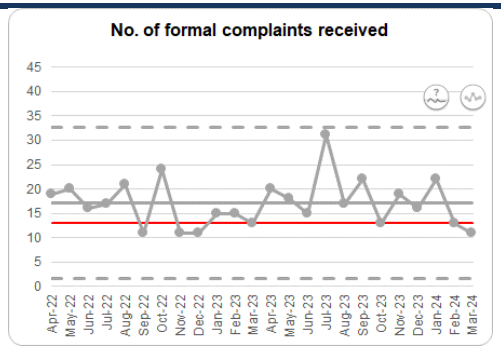
Between January and March 2024, the number of compliments recorded remained within common cause variation between 104 and 120.

Actions

- The Heads of Nursing/Practice (HoN/P) have been asked to provide assurance that compliments are being accurately recorded and that a clear process is identified. Recording of compliments is explored within the Divisional "Clinical Reference Groups" to encourage staff to record compliments and for teams to consider the method of compliment recording. This is monitored through the quarterly Patient Experience Committee report.

- An option for teams to use an Electronic Patient Survey (EPS) was rolled out across the Trust from September 2023 due to additional support provided to add teams on to the platform. As of April 2024, there are over 100 teams (including sub-teams) that are live on the platform, with 599 patient feedback responses across the teams received to date.

- The EPS platform gives teams the opportunity to create a QR code which allows service users to feedback directly to the team. service receivers are also given the opportunity to feedback verbally and via paper forms if this is preferred. A thematic review of the feedback from the EPS along with any actions or learning identified by services is included in the quarterly Patient Experience Committee report.

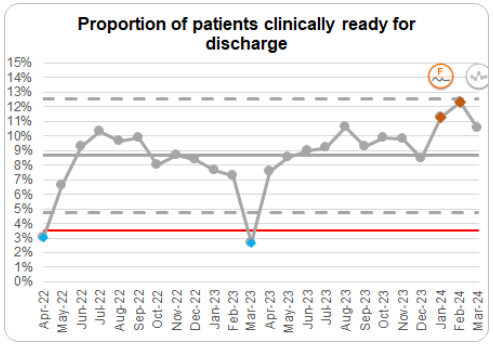


Summary

The number of complaints reduced from 22 to 11 between January and March 2024 and is currently under the Trust target of 12 complaints and below the mean of 19.

Actions

The complaints team monitor complaints and where specific themes are identified, these are passed on to the HoN/P Team and explored in a quarterly Patient Experience Committee (PEC) report which is sent to both the PEC and the Trust Quality and Safeguarding committee for assurance.

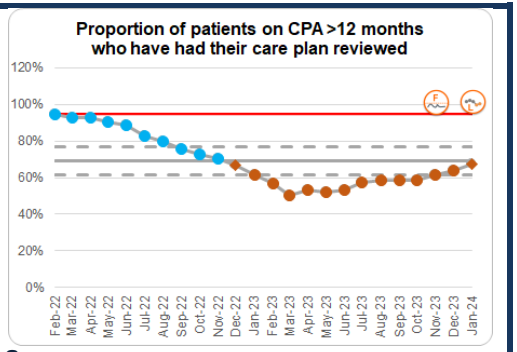


Summary

Between January and March 2024, the number of service users meeting the criteria as Clinically Ready for Discharge (CRD) (formally called Delayed Transfer of Care (DTOC), increased to 14% in February and decreased to 11% in March 2024. The most common reason for patients meeting the criteria for CRD is the lack of identification of appropriate housing, establishing funding, and availability of social care placements. Other barriers to discharge over the past three months include issues of who needs discharge meeting Court of Protection criteria.

Actions

- The Trust has a twice weekly CRD meeting where any barriers to discharge are identified and discussed to support resolution.
- The Older Adult division continue to work in collaboration with Joined Up Care Derbyshire to identify patient centred solutions for those service users awaiting placements that meet their needs.
- The Trust has appointed a Strategic Integrated Flow Lead who chairs a weekly meeting designed to improve flow, which includes social care stakeholders. This is expected to resolve barriers more quickly so patients can be discharged to environments that meet their needs.



Summary

The current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months is 74%, an increase of 9% between January and March 2024.

Staff vacancies, sickness, industrial action, and patient acuity have all contributed to the percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months.

Actions

Compliance around CPA has been the subject of a commissioned 360 review by an external company and is part of an action plan to improve compliance in fundamental care standards including CPA.

The Trust services have identified action plans to improve care plan, risk screen and CPA compliance as below:

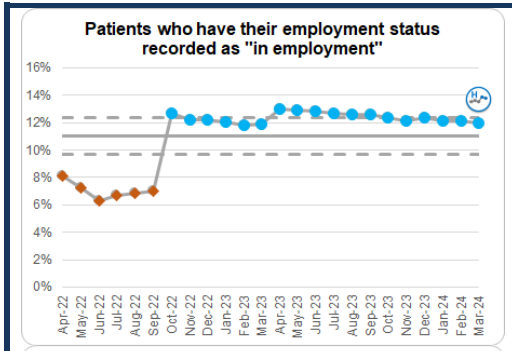
.

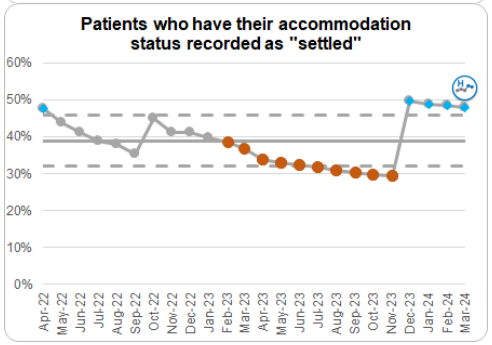
- A new data platform was introduced to the Trust in November 2023 so each team has been asked to review the new report and cleanse the data to ensure that non-eligible patients are excluded.

- A process for monitoring compliance and quality has been implemented in each division and monitored via the monthly Fundamentals of Care meeting, (in Inpatients, the Clinical Reference Group) and the Divisional Clinical Operational Assurance Team (COAT) meetings.

- The Community Mental Health team had a target to achieve 85% compliance by April 2024. As of March 2024, they are 85% compliant on average, with an expectation that all teams will be at 85% by the end of May 2024.

Quality Performance



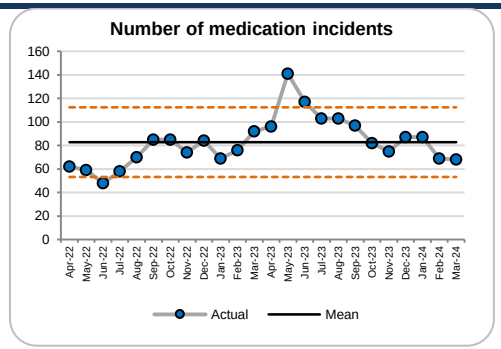


Summary

Patients open to the Trust in settled accommodation has reduced from 50% to 48% between January and April 202 and the number of patients open to employment has continued to remain consistent since August 2022.
This measure continues to be monitored by individual services.

Actions

- A report has been developed which informs teams if there are gaps in the current Data Quality Maturity Index information recorded on referral and Ward and Service Managers have been asked to review this report weekly and action any gaps identified. This will be monitored via monthly service specific operational meetings.

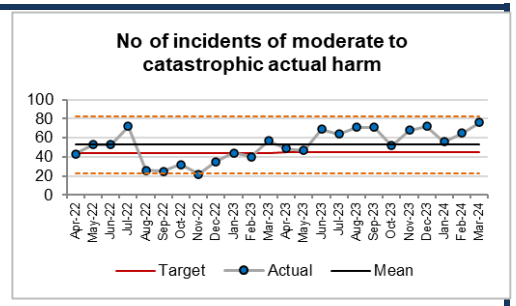


Summary

The number of medication incidents between January and March 2024 has fallen from 83 to 53 (36%) and continues in line with common cause variation. It should be noted that the medication incidents reported are largely of low-level harm.

Actions

- To support services, the Pharmacy team have developed a medicine ward folder where the medicine management quick reference guides relating to key policies and procedures has been made available to all inpatient areas of the Trust.
- To improve medicine temperature monitoring a task and finish group including heads of nursing, pharmacy and clinical leads started in January 2024 and is expected to reduce the number of incidents recorded following its conclusion. This is expected to have an impact from May 2024
- DHCFT Pharmacy are feeding back to ward managers on a quarterly basis about shared learning from Monthly meetings with Chesterfield Royal Hospital pharmacy.
- A Process for Clozapine initiation, monitoring and bloods, Storage of medicines and Temperature monitoring has been developed and was ratified by the medicines management committee in January 2024
- The number of medication incidents is reviewed via the monthly medication management subgroup and is reported on within the quarterly thematic “Feedback Intelligence Group” (FIG) report by the Heads of Nursing/Practice and is included in the Serious Incidents Bi-monthly report. Any actions identified are reviewed via the medicines management subgroup and the Serious Incidents Bi-monthly report is taken quarterly to the Quality & Safety Committee (QSC) for assurance.



Summary

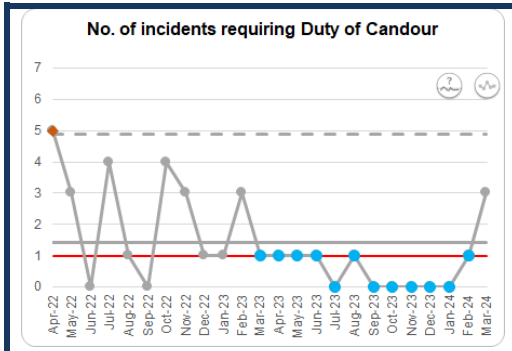
This data demonstrates the number of DATIX incidents occurring recorded as moderate at catastrophic harm. From January to March 2024, incidents have increased from 53 to 82.

Analysis suggests that this is due to an increase in the number of incidents routinely reported by staff following support from the Patient Safety team and a rise in incidents recorded as “self-harm” and physical assault from patients to staff, mainly on the female acute wards.

The increase in self-harm incidents is attributed to a high number of repeated incidents involving to a small group of patients. This is consistent with anecdotal reports from staff that acuity on the inpatient wards is increasing and this is most prevalent on the female acute wards. There has also been increased reporting from the mental health helpline and support service.

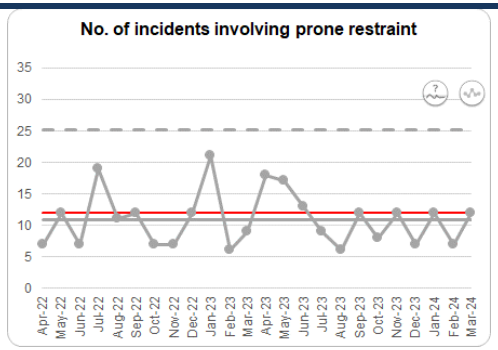
There have also been incidents reported from the Older Adult service in relation to medical issues and falls which is consistent with the increase of falls reported over the past three months.
This data is monitored by the Patient Safety team and the Heads of Nursing/Practice and learning from incidents is fed back to individual teams.

Quality Performance



Summary
Between January and March 2024 the number of incidents meeting the threshold for Duty of Candour (DoC) has increased from 1 to 3. The Trust Family Liaison Office has created information leaflets and standing operating procedures to support staff in completing duty of candour communications. Furthermore, these are reviewed twice weekly within serious incident groups.

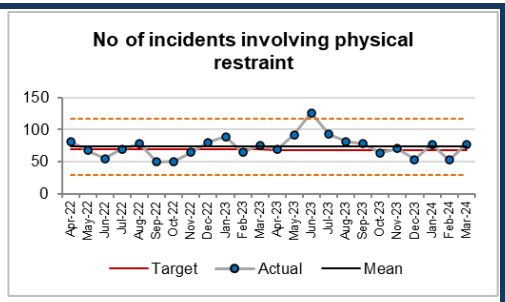
Actions
- Training around accurately reporting DoC continues within clinical teams and the Family Liaison Officer with support from the patient safety team review each DoC incident as they occur and request support from the HoN team as required.



Summary
Incidents of prone restraint have consistently fluctuated between 6 and 12 between August 2023 March 2024. This is in line with the Trust target of 12 incidents

Actions
- Following a successful funding bid from the South London and Maudsley Trust (SLaM) the Assistant Director for Digital Clinical Practice is leading a project to introduce simulation-based training and the first session is due to take place in May 2024 following engagement sessions in April 2024. This will include interventions that would be expected to maintain low levels of prone restraint.

- The PSST have developed training around alternative injection sites and a poster produced in collaboration with the pharmacy department is now available to staff identifying which route common medications can be given. The training is due to start in April 2024. These interventions are expected to further reduce the need for prone restraint.

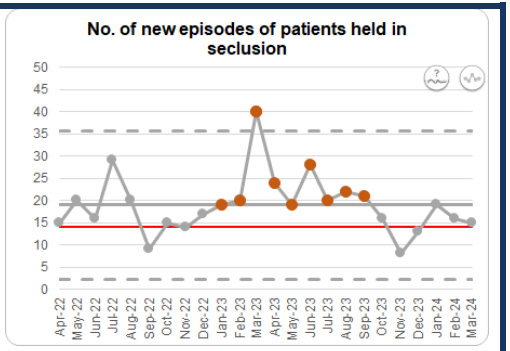


Summary
Physical restraints have fluctuated between 74 and 30 incidents between January and March 2024 and are above the Trust target of 69 incidents with the female Acute wards and Older Adult wards identified as having the most incidents attributed to them as in previous months. Recruitment continues to improve in the inpatient services which means less bank and agency staff are being used.

This is continuously reviewed within the Reducing Restrictive Practice Group and the Trust Positive and Safe Support Team continue to offer extra training sessions to improve training availability for staff.

Actions
- The Trust Positive and Safe Support team continues to offer supplementary training sessions to improve training availability for staff and compliance with positive and safe training is currently at 74% for teamwork and 67% for breakaway training. The slower than anticipated increase in compliance was due to the new staff group being added to the mandatory cohort who are all non-compliant until they have received the training and a number of school holidays which have meant more staff on leave and less up taking training over the past two months. It is expected that both breakaway and teamwork training will reach 85% by July 2024.

- The PSST continue to spend time in clinical areas to support and train clinical staff, live during practice.



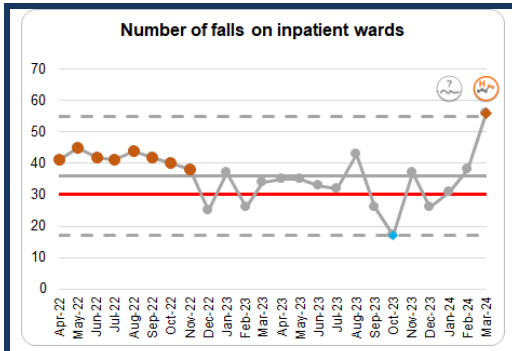
Summary
Seclusions between January and March 2024 have increased by 15% from 13 to 15 episodes of seclusion. This is in line with common cause variation.

Actions
- Episodes of seclusion will continue to be monitored via the reducing restrictive practice group.

- A review focused on peer support including debrief is expected to have an impact on reducing the number of seclusion incidents when it is completed in June 2024.

- This review will be presented, and progress monitored through the monthly Trust Reducing Restrictive Practice Group

Quality Performance



Summary

The number of falls recorded between January and March 2024 has increased from 31 to 55. This increase is due to several repeated incidents attributed to a small group of patients with challenging conditions.

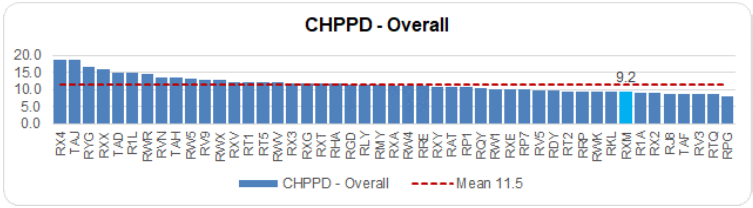
Actions

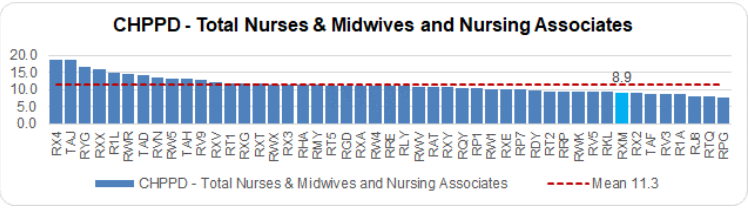
- These patients all have fall prevention care plans in place and a dedicated falls prevention Physiotherapist returned following a long absence in April 2024.
- The number of falls reported is monitored via the Falls Lead Occupational Therapist, Head of Nursing and Clinical Matron and learning from the bi-weekly falls meeting is reviewed in the monthly Divisional COAT meeting. Following this meeting any outstanding actions are reviewed and new actions allocated dependent on the need of the patients.

Care Hours per Patient Day (CHPPD)

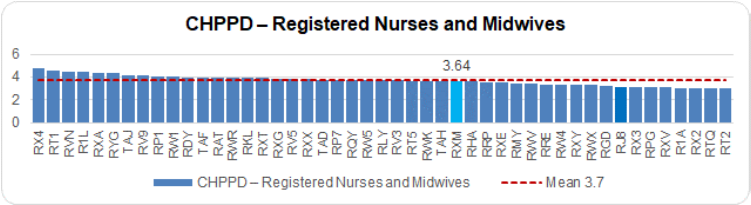
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying 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.

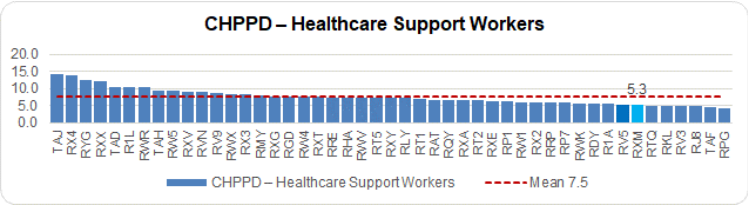
The charts below indicate that the Trust's CHPPD overall achieved 9.2 hours, which was below average when benchmarked against other mental health trusts in the country. For total nurses and nursing associates the Trust achieved 8.9 hours against the national average of 11.3 hours:





For registered nurses the Trust achieved 3.76 hours against the national average of 3.6 hours. For healthcare support workers the Trust achieved 6.11 hours against the national average of 7.5 hours:





https://www.england.nhs.uk/publication/care-hours-per-patient-day-chppd-data/

Quality Performance

Friends and Family Test

NHS England have resumed publication of the friends and family test data. The latest position for mental health Trusts was as follows:

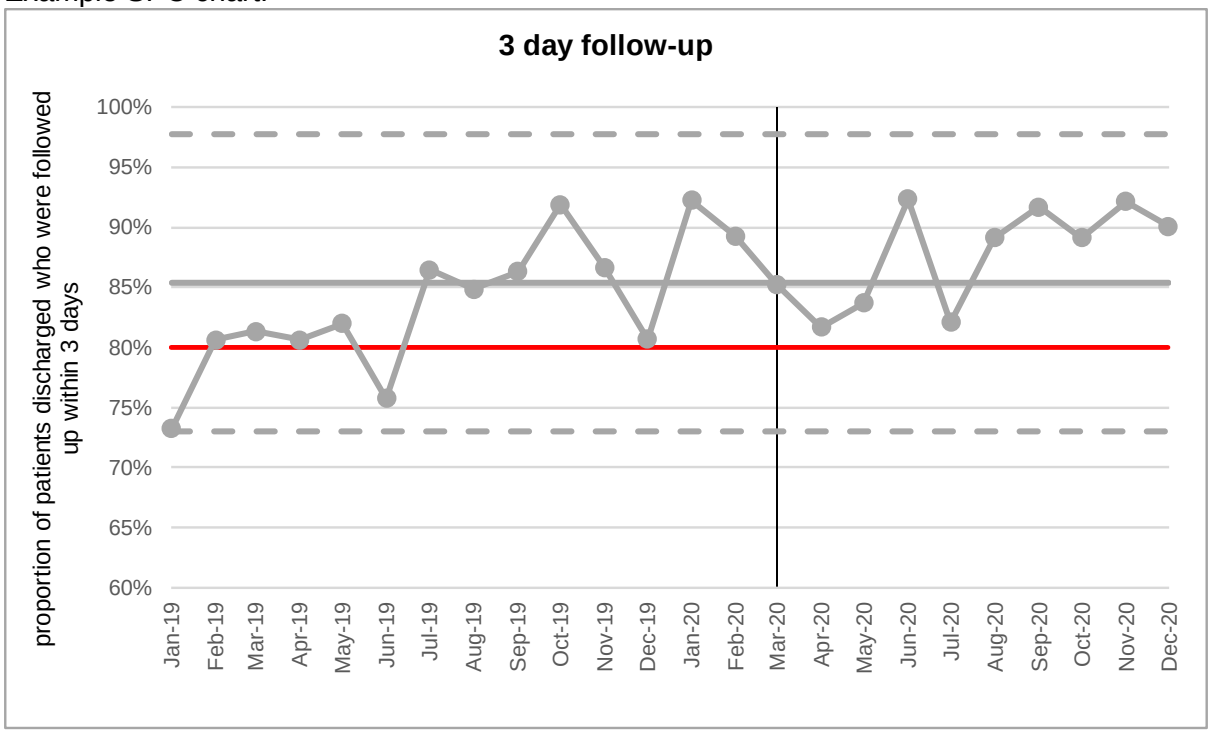
Trust Code	Total Responses	Total Eligible	Percentage Positive	Percentage Negative	Mode of Collection						
					Mode Electronic Discharge	Mode Electronic Home	Mode Paper Discharge	Mode Paper Home	Mode Telephone	Mode Online	Mode Other
	23,168	865,817	87%	6%	1,803	266	5,873	1,708	414	8,687	1,781
	22,425	854,271	87%	6%	1,655	266	5,715	1,708	414	8,601	1,474
	23,168	865,817	87%	6%	1,802	266	5,819	1,641	414	8,681	1,413
RR7	14	142	100%	0%	0	0	14	0	0	0	193
RY4	5	749	100%	0%	0	0	0	0	0	5	0
RYK	23	1,930	100%	0%	0	0	0	0	0	0	0
NDK	5	10	100%	0%	0	0	5	0	0	0	0
O2F3D	112	241	100%	0%	0	0	112	0	0	0	0
NNF	155	2,838	98%	0%	0	0	41	0	0	86	0
NQL	96	3,557	98%	0%	0	0	0	0	0	0	0
R1F	79	2,339	97%	0%	0	0	0	79	0	0	0
RV9	258	5,032	97%	1%	0	0	258	0	0	0	0
R1L	94	15,522	97%	2%	0	0	25	0	0	69	5
TAJ	207	17,311	96%	0%	0	0	0	0	0	0	0
RT2	1,002	12,160	96%	1%	0	0	623	0	54	186	0
RNK	67	2,759	96%	0%	*	*	*	*	*	*	0
RW4	795	20,859	95%	1%	372	0	246	0	0	177	0
RXL	125	1,460	94%	0%	0	0	0	74	0	50	43
R0B	168	1,993	94%	2%	0	0	123	0	0	45	0
RX3	1,612	149,411	94%	1%	284	0	1,163	0	0	91	0
RWV	204	5,867	94%	0%	0	0	0	47	3	154	0
R1C	271	2,117	92%	3%	0	152	0	0	0	58	0
RXG	389	13,161	91%	4%	26	0	0	132	0	231	0
RP7	986	5,001	91%	1%	16	0	114	0	0	851	*
RLY	237	13,356	91%	4%	0	0	0	147	0	88	*
RT1	192	10	91%	3%	50	0	0	69	0	70	*
RGD	161	7,530	90%	6%	0	0	0	39	0	122	*
RHA	109	15,134	90%	8%	0	0	0	86	0	9	43
RQ3	59	23	90%	7%	59	0	0	0	0	0	2
RDY	269	6,919	90%	6%	0	38	0	28	0	202	0
RXA	671	13,088	90%	4%	*	*	*	*	*	*	0
RXX	322	9,190	89%	4%	38	0	27	0	0	253	447
RXE	471	19,470	89%	6%	0	0	80	0	0	0	0
RXV	447	35,316	89%	5%	0	0	0	0	0	0	0
TAF	213	1,629	89%	3%	11	0	0	31	0	171	0
RWX	516	29,860	89%	3%	71	0	17	0	0	428	0
RRP	653	8,989	89%	4%	0	0	653	0	0	0	0
TAH	54	3,997	89%	4%	*	*	*	*	*	*	0
RQY	692	21,536	89%	5%	401	0	0	0	0	0	0
RVN	604	6,384	89%	4%	0	0	96	384	0	124	0
RY6	60	1,149	88%	10%	0	0	0	0	0	60	0
RW5	1,442	45,985	88%	7%	115	0	0	0	346	981	0
RXM	268	17,951	88%	5%	0	0	141	0	0	127	0
RTQ	290	3,902	87%	6%	0	0	0	0	0	290	207
RXY	452	14,541	87%	6%	0	0	422	0	0	30	23
RRE	365	25,206	86%	9%	0	0	0	0	0	322	0
RX4	538	35,107	86%	8%	0	0	345	0	0	0	0
RAT	604	7,355	84%	8%	0	0	0	0	0	604	143
RWR	688	12,602	84%	8%	0	0	282	0	0	146	0
RXT	375	19,772	84%	7%	0	0	323	0	0	52	0
RX2	742	12,873	83%	10%	0	0	0	0	0	742	0
RTF	46	868	83%	7%	0	0	0	0	0	0	0
RV5	420	38,915	82%	5%	0	0	127	0	0	293	0
RP1	117	8,383	81%	15%	41	0	0	68	0	6	*
RMY	368	28,325	80%	14%	*	*	*	*	*	*	*
RPG	856	15,401	80%	8%	75	76	130	130	0	160	0
RV3	261	25,782	79%	6%	3	0	70	0	0	188	28
TAD	89	10,040	79%	10%	79	0	2	0	2	6	0
NR5	227	2,325	78%	7%	0	0	0	0	0	0	0
RWK	523	34,777	77%	10%	0	0	0	40	0	379	0
RW1	1,314	11,174	74%	19%	0	0	358	287	0	669	183
RT5	509	11,674	73%	17%	13	0	0	0	9	56	96
NMJ	148	2,115	64%	13%	148	0	0	0	0	0	0
RKL	122	10,332	63%	25%	0	0	22	0	0	100	0

Data source: https://www.england.nhs.uk/wp-content/uploads/2024/04/fft-mh-feb-24.xlsm

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



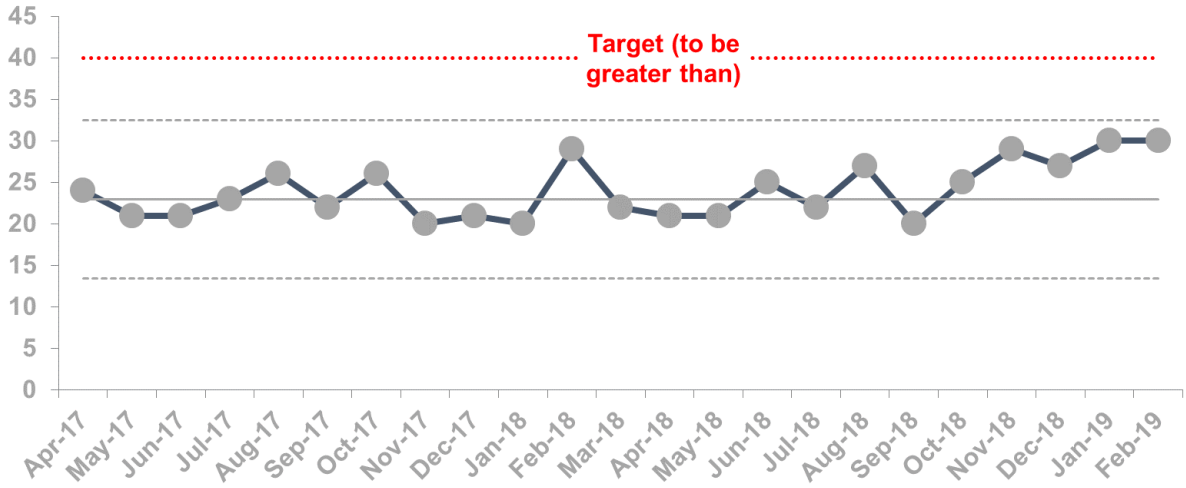
- The red line is the target.
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example.
- The solid grey line is the average (mean) of all the grey dots.
- The grey dotted lines are called process limits, or control limits.

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.

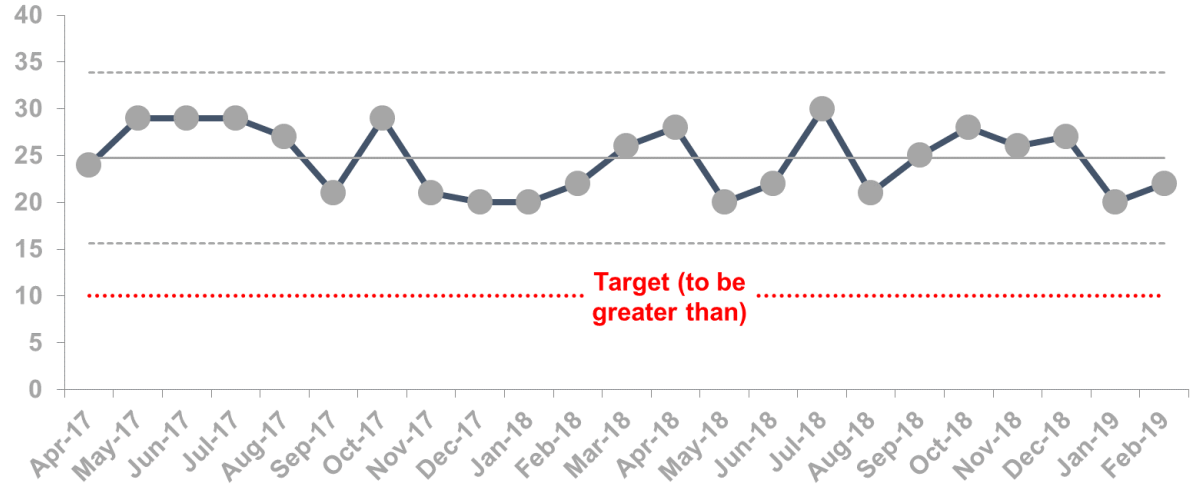
Things to look out for:

1. A process that is not working



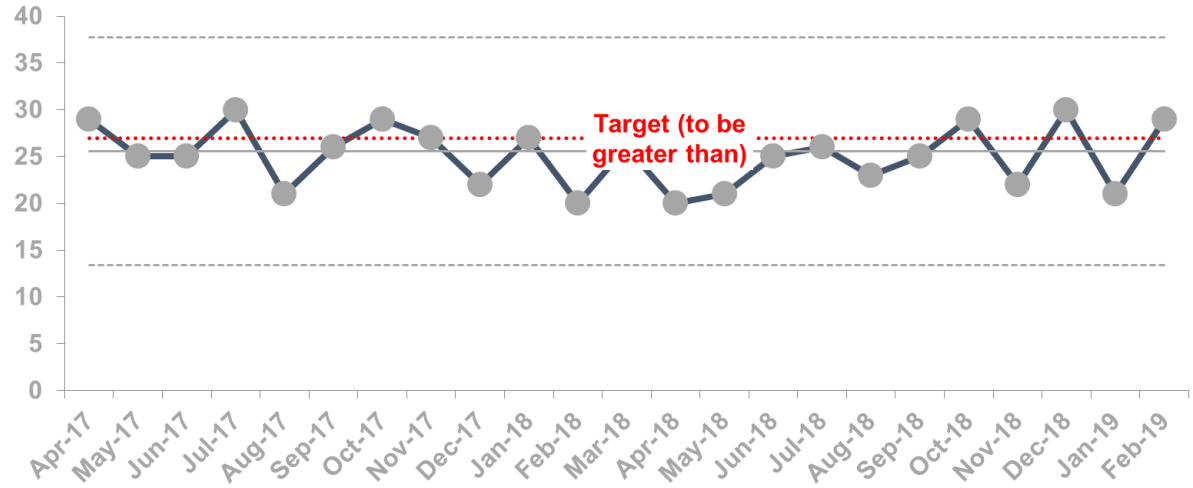
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

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

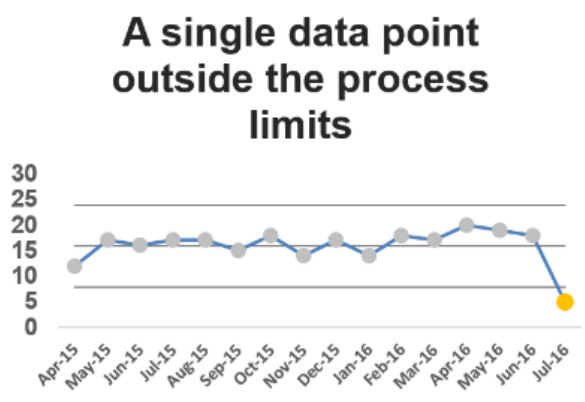
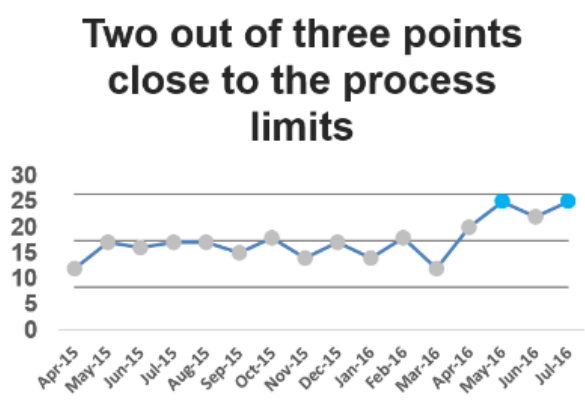


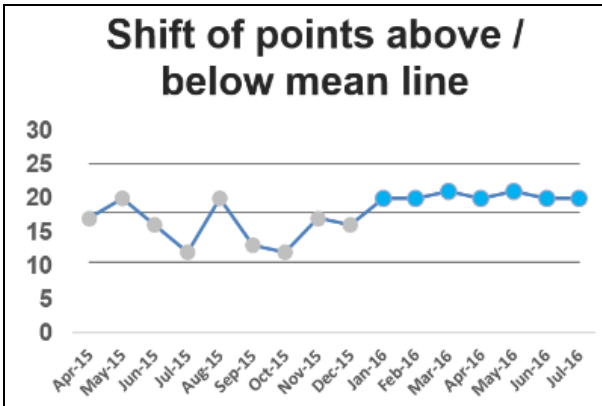
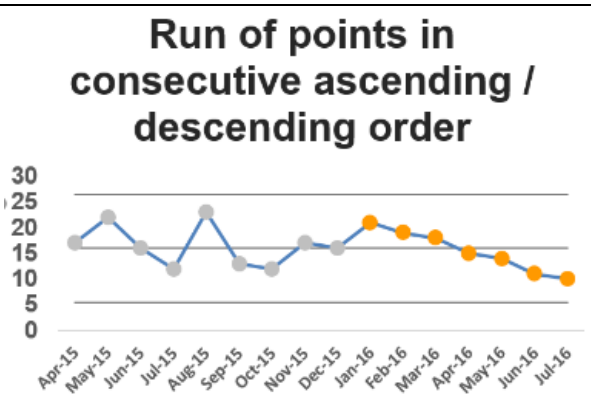
In this example the target line sits between the 2 grey dotted lines. As it is normal for the grey dots to fall anywhere between the 2 dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned if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

	
In this example the July 16 perfomance is significantly lower than expected and falls beneath the lower grey dotted line.	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.

	
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.	A run of 7 points in consecutive ascending or descending order is significant. In this example things are getting worse over time.

Frequently seen in the NHS:

"**Spuddling**" - To make a lot of fuss about trivial things, as if they were important.

Spuddling leads to tampering and tampering nearly always increases variation.

Sometimes the first and most important thing we need to react to is the degree of variation in a process.

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2024

Financial Plan Update

Purpose of Report

Following agreement of the financial plan on the 25 April at the Extraordinary (EO) Confidential Board meeting, to formally report the submission of a final deficit plan of £6.4m.

Executive Summary

The previous draft submission, agreed at the EO Board meeting was a £7.9m deficit. Within this, there was the need and expectation of a Cost Improvement Plan (CIP) delivered at 5%.

However, this was prior to the allocation of some non-recurrent Integrated Care Board (ICB) system funding of c£1.5m (share of income distributed in line with system agreement based on agreement reached on the 26 April). **This reduced our final planned deficit to £6.4m.**

- We submitted various templates as required to the ICB on the 26 April and 29 April
- This is ahead of the final submission on the 2 May 2024 in line with national timescales.

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 creating a compassionate, skilled, and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive, and are valued.	
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long-term sustainability.	X

Risks and Assurances

- The risks relate to the achievement of the financial plan and the risk to non-delivery of a breakeven statutory duty. This will be linked to the system wide plan and the national response to the final position. The Trust is not alone in having to work on a multi-year sustainability plan
- Risks relate to the identification and delivery of CIPs whilst ensuring the Quality and Equality Impact Assessment (QEIA) process is concluded satisfactorily
- Risks need to be managed in relation to the ongoing monitoring of the impact on patient services and quality, post QEIA to ensure clinical care standards are satisfactory and not adversely impacted compared to the plans. There is also the need to monitor staff health and wellbeing during these challenging times.
- Heavy reliance on continued progress of Out of Area (OOA) and agency/excessive staffing reductions in addition to effective rostering will form a key component of the success and potential failure of the plan.
- Future industrial action would have an adverse impact and is not planned for.
- It is acknowledged, further in year action is needed and further work is ongoing to continue our move towards financial sustainability.

Consultation

- Decisions taken forward with regards to potentially challenging CIPs around notice or decommissioning would require further system discussion. These are unlikely to need formal consultation though.
- As the longer term and more transformational change plans are developed, staff engagement and consultation will be needed on a case-by-case basis dependant on sites and services affected.

Governance or Legal Issues

In line with national guidance and under the oversight of the ICB. Also forms part of wider system planning submission.

Public Sector Equality Duty & 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 the CIP plans will follow the formal QEIA process.

Recommendations

The Board is requested to note the previous agreed revised deficit plan of £7.9m and the improvement to a final deficit plan of £6.4m linked to a late, non-recurrent income allocation adjustment agreed via the ICB on 26 April.

Report prepared and presented by: **James Sabin, Executive Director of Finance**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – May 2024

Trust Strategy Update
2022–2025: 2023/24 Quarter 4 Progress Report

Purpose of Report

To provide the Board with an update on progress in delivering the priority actions identified in the Trust Strategy.

Executive Summary

The Trust Strategy was published in 2022 having been approved by the Board in July 2022, following an engagement process with staff. It sets out four strategic outcomes to deliver great care, be a great partner, a great place to work and to make best use of our resources.

Following feedback from staff, the strategy was updated to reflect the organisational reset in quarter 3 2023/24. The updated strategy retains the agreed vision, values and strategic objectives, whilst simplifying our priorities, in response to feedback received by colleagues, ensuring clarity on our work for the year ahead. The agreed priorities are set out in appendix 1, which highlights those priorities that have been delivered to date, priorities that are partially completed, and priorities that are in progress but with significantly more work to enable delivery by the agreed delivery date.

At the heart of the Trust Strategy was, and continues to be, a collective commitment to continue improving our organisational culture, and to embedding new ways of working where our values and 'people first' approach are central to all we do. In addition, over the life of this strategy we continue to deliver our commitment to inclusion for our patients, our colleagues and our communities.

Discussions about the development of a new Trust Strategy started in October 2023, at the Staff Conference focused on 'time to reset'. In this session colleagues highlighted a number of areas for improvement, which were taken forward as initial feedback on the development of a new set of strategic priorities. Where possible, focused messages were shared with staff on these topics in response to the questions raised, for example, this included our approach to patient safety, our approach to blended working and wider approaches to quality improvement.

Focused staff engagement on the development of a new Trust Strategy started in February 2024. To date this has included three Trust-wide engagement sessions on each of the following topics, culture, health inequalities and vision and values. Each topic was also supported by an online questionnaire for any colleagues who were unable to attend a session to submit their views.

Attendance at the events was good, with over 120 colleagues attending each of the online sessions. There was significantly lower attendance at the events that took place in person, which has shaped the ongoing engagement process. An initial session took place with the Board of Directors on 14 February and many Non-Executive Directors (NEDs) and Executive Directors have participated in the open engagement sessions.

Engagement on the Trust's brand identity starts this month and will continue during April and May, ahead of the Staff Conference taking place. Wider engagement with Trust governors, staff networks and patient and carers groups has taken place during April.

Focused sessions to engage with external stakeholders including partner organisations are scheduled to take place on 16 June 2024. It is intended to launch a new Trust strategy in September 2024.

The Board is asked to note the 2023/24 Q4 progress in delivering the priority actions as set out in the updated Trust 2022–2025 Trust Strategy, and the progress to develop a new Trust Strategy.

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	X
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long-term sustainability.	X

Risks and Assurances

Aligns with and seeks to deliver against the Trust's strategy.

Consultation

- Staff engagement to inform the updated strategy, as a result of the organisational reset
- Ongoing staff engagement to enable and report delivery of individual priority actions.

Governance or Legal Issues

None identified.

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 Trust's strategy embeds the Trust's commitment to Equality, Diversity and Inclusion.

Recommendations

The Board of Directors is requested to note the 2023/24 Q4 progress in delivering the priority actions as set out in the updated Trust 2022–2025 organisational strategy and the progress to develop a new Trust Strategy.

Report presented by: **Vikki Ashton Taylor**
Deputy Chief Executive and Chief Delivery Officer

Report prepared by: **Vikki Ashton Taylor**
Deputy Chief Executive and Chief Delivery Officer

Anna Shaw
Deputy Director of Communications

Priorities we will deliver in 2023/24

Improve processes for those experiencing stress in and out of work

Successfully implement and lead the provider collaborative for Perinatal inpatient services

Deliver perinatal community mental health access standard of 10% of prevalence

Work in partnership to progress the harmonisation of Learning Disabilities and Autism services

Making Room for Dignity: Improve the safety, privacy and dignity of patients through our Making Room for Dignity programme

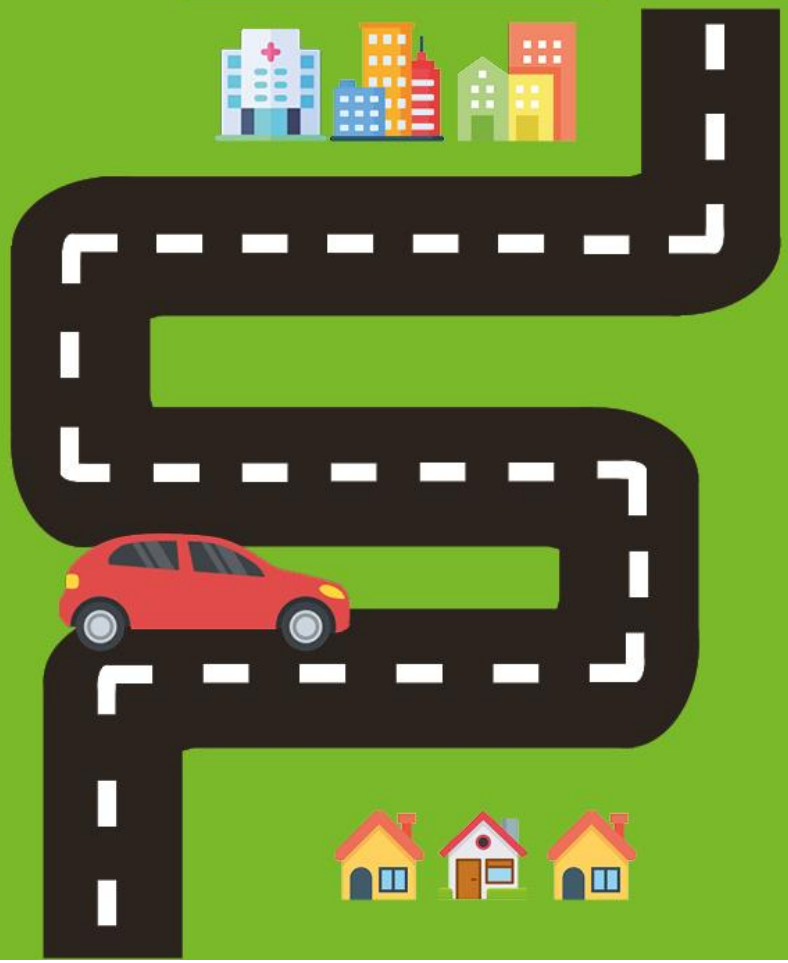
Develop a consistent approach to people-centred leadership

Develop a workforce plan

Each division will have its own specific quality requirement standards

Deliver a less than 32 days average length of stay on our acute mental health wards

These priorities were partially completed in 2022/23 and will be completed during 2023/24



Deliver electronic prescribing and transfer prescriptions element of the OnEPR programme

Recover dementia diagnosis rates to national target of 67%

Improve recruitment and retention to support new services and ensure safer staffing levels

Deliver our Long Term Plan Commitments including Transforming Care Partnership (TCP) and Living Well

Be a compassionate and inclusive organisation where staff feel they belong, thrive and are valued

Optimise the use of SystmOne across the Trust

Focusing on the safety domain of practice and preparing for changes in mental health legislation

Deliver planned financial efficiencies to ensure the Trust is a sustainable organisation. Agree our 3-5 year financial plan

Completed

Partially completed

In progress

Progress in Delivering 2023/24 Priorities – Quarter 4 Update

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Making Room for Dignity: Improve the safety, privacy and dignity of patients	Partially completed. Construction / refurbishment commenced at all sites. Recruitment commenced for posts required early to shape new services: Bluebell Ward, Walton Hospital Derwent Unit, Chesterfield Royal Hospital Audrey House Enhanced Care Unit Carsington Unit, Kingsway Hospital Kingfisher House PICU, Kingsway Hospital Jasmine Ward, Radbourne Unit Orchid Ward, Radbourne Unit – pending additional capital	Ongoing August 2024 November 2024 November 2024 November 2024 March 2025 Spring 2025 March 2026	Finance & Performance Committee People & Culture Committee
Deliver Perinatal community MH access standard of 10% of prevalence	Delivered. The target is measured on a rolling 12 month period. The full year 10% target has been achieved in February 2024 (10.1%)	Delivered	Finance and Performance Committee
Develop a consistent approach to people centred leadership	Partially completed. Leadership development strategy and approach being presented at May People and Culture Committee for final discussion. Leadership expectations and accountability framework form a key part of this strategy and engagement has commenced with leaders in their development. Ongoing leadership programmes on offer to colleagues and bespoke team development in place	September 2024	Quality and Safeguarding Committee People and Culture Committee
Deliver less that 32 days average length of stay on our acute MH wards	In progress. There is work underway to reduce the average length of stay. Launch of Gatekeeping Framework and Purposeful Admission commenced with progress being made re trauma informed care in adult acute inpatient. As a result improvements have been noted and average length of stay has reduced to 48 days. Achieving 32 day average length of stay will be a challenge.	March 2025	Finance and Performance Committee
Each division will have its own specific quality requirement standards	Partially completed. The focus has been on ensuring that Services are meeting fundamental standards. Self Assessment against CQC's single assessment framework has been established alongside the development of a quality surveillance tool to identify hotspots.	April 2024	Quality and Safeguarding Committee

Progress in Delivering 2023/24 Priorities – Quarter 4 Update

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Work in partnership to progress the harmonisation of learning Disabilities and Autism services	Delivered. A MoU has been developed between executive leaders across the organisations to provide a joined-up approach for citizens, a common vision, objectives and purpose and improved quality, pathways or access to care for patients and carers. An integrated leadership structure has been implemented via a single Head of Service Derbyshire Healthcare NHS Foundation Trust (DHcFT) employee)	Delivered	Trust Board
Improve processes for those experiencing stress in and out of work	Delivered. In house staff Clinical Psychologist in place and offering support to colleagues both in and out of work. This is to complement the existing offer via Employee Assistance Programme (EAP) and Resolve. Alignment with long term absences in place.	Delivered	Quality and Safeguarding Committee
Successfully implement and lead the provider collaborative for perinatal inpatient services	Delivered. Approval granted by NHS England for Derbyshire Healthcare NHS Foundation Trust (DHcFT) to become Lead Provider in October 2023. Formal governance arrangements are now established in relation to contracting and quality oversight.	Delivered	Quality and Safeguarding Committee People and Culture Committee
Deliver electronic prescribing and transfer prescriptions element of the OnEPR programme	Delivered. Successful implementation and roll out. Optimisation work underway to improve standard operating procedures in services where improvement opportunities have been identified.	Delivered	Finance and Performance Committee
Recover dementia diagnosis rates to national target of 67%	Delivered. The diagnostic rate is above target (67.4%) and has remained over target month on month following extensive continuous quality improvement work undertaken by the team.	Delivered	Finance and Performance Committee

Progress in Delivering 2023/24 Priorities – Quarter 4 Update

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Focusing on the safety domain of practice and preparing for changes in mental health legislation	Partially completed. Embedding the effectiveness of the Patient Safety Incident Response Framework (PSIRF) work is underway with further improvements planned to improve the timeliness of reviews and the sharing of learning. Changes to the mental health legislation have been significantly delayed therefore there is uncertainty currently about the likely amendments and the timetable for change.	July 2024	Quality and Safeguarding Committee
Improve recruitment and retention to support new services and ensure safer staffing levels	Delivered. New approaches developed and embedded that consider a more creative and innovative way to attract and recruit and allow a more diverse pool of candidates both at application through to appointment. Ongoing work to improve retention in place, targeting key professions and teams where turnover is above Trust average.	Delivered	Quality and Safeguarding Committee People and Culture Committee
Be a compassionate and inclusive organisation where staff feel they belong, thrive and are valued	Partially completed. Strengthened organisational communication and engagement channels to colleagues, including introducing a face to face leadership forum. The staff survey 2023 measures indicate improvements across our key engagement and belonging measures. Bespoke team development programmes arranged where there have been areas of concern or development needed for the team to move to a more compassionate and inclusive approach. We have further work to do to strengthen our approaches on discrimination and bullying which will form part of our strategy in 2024/25	September 2024	Quality and Safeguarding Committee People and Culture Committee

Progress in Delivering 2023/24 Priorities – Quarter 4 Update

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Deliver planned financial efficiencies to ensure the Trust is a sustainable organisation. Agree our 3-5 year financial plan	In progress. Delivered on the reset and forecasted outturn position. CIP delivery in 2023/24 is on track in quantum terms but off track from the point of recurrency. We have the lowest rate of recurrency across Derbyshire providers, at only c25%. A stepped change on progress is needed in 2024/25 if we are to make inroads into the underlying deficit. The Trust's 5-year plan has been completed based on simplistic national assumptions (high level and basic) as part of an ICB wide submission. (Board sign off 27 February). The full Trust Long Term Financial Model updated 5-year financial plan is still outstanding. This is likely to be progressed during June – September given delayed planning process and a year 1 focus in March and April. Cost Improvement Programmes (CIPs) of at least 5% per annum for 3 years are the minimum expectation. Whilst we are concluding our plan for 24/25, the deficit plan due for submission on the 2nd May continues to demonstrate a longer-term plan is required to return to financial balance and sustainability. The medium-term options are being scoped further to consider potential financial impact, and priority of any potential wider transformation and service change.	September 2024	Finance and Performance Committee
Optimise the use of SystmOne across the Trust	Partially completed. Ongoing training to staff and review of standard operating procedure content and application to improve data quality. Focus on inpatient wards following CQC visit.	September 2024	Finance and Performance Committee
Deliver our Long term Plan commitments including TCP and Living Well	Delivered. The Living Well final wave (wave 3) fully mobilised in quarter 4. Focus now on optimising benefits of new model of care. Full System Development Funding (SDF) mapped out and awaiting approval for 2024/25 to deliver on TCP. System partners engaged with and working with health to ensure objectives and deliverables are realistic, achievable and in line with National Health Service England (NHSE) Learning Disability and Autism (LDA) priorities.	Delivered	Finance and Performance Committee

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2024

Making Room for Dignity (MRfD) Programme Progress

Purpose of Report

This report is to update the Board of Directors and provide assurance with progress on the Making Room for Dignity (MRfD) Programme.

Executive Summary

The MRfD Programme has three strategic aims, which are to eradicate:

- dormitory wards for adult inpatient mental health provision;
- mixed age group wards for adult inpatient mental health provision; and
- the use of inappropriate Out of Area PICU beds

through delivery of six interdependent projects, phased over the next two years.

Refurbishment of the Bluebell Ward at Walton Hospital, Chesterfield, is now into its sixth month, to provide a purpose designed 12-bed facility for older adults. Stepnell Construction will complete the refurbishment in July 2024 and the unit will go-live on 2 September 2024, completing the eradication of mixed-age group wards.

70% of the dormitory eradication is delivered through the two new build adult acute units: the Derwent Unit in Chesterfield and the Carsington Unit in Derby. IHP have made significant progress with both buildings, despite delays due to bad weather in 2023. Both units are due to go-live in November 2024.

The refurbishment of Ward 32 at the Radbourne Unit commenced in November 2023, to provide a 17-bed ward for female service users with single ensuite rooms. Parts of the refurbishment have had to be redesigned by our construction partner Kier, due to issues identified when the interior of the ward was stripped out for work to commence. Solutions to the issues have been identified, the designs are currently being amended and the refurbishment programme is being updated.

Eradicating the use of inappropriate out of area specialist beds is delivered through the refurbishment of Audrey House as an 8-bed Enhanced Care Unit and the building of Kingfisher House, a 14-bed Psychiatric Intensive Care Unit, both on the Kingsway site in Derby. The Audrey House refurbishment has been completed by our construction partners, Arden FES, with final 'snagging' being completed currently. The specialist service will be going live in November 2024. IHP are building Kingfisher House adjacent to the Carsington Unit, with a build completion date of December 2024 and go-live March 2025.

The 'branded' recruitment programme continues for the additional clinical staff required for the new and refurbished units, with the majority of posts due for recruitment in this financial year. In addition to these, the Recruitment team has been actively recruiting to existing vacancies.

Significant progress has been made with service and cultural transformation plans and a phased implementation will take place during the next seven months.

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	X
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long term sustainability.	X

Risks and Assurances

- Construction contracts for the AAUs and PICU were signed in April 2023
- Construction contract for Bluebell Ward signed October 2023
- Construction contract for Ward 32 signed November 2023
- The capital construction costs are funded, with a number of cost pressures resulting from hyperinflation in construction market material costs, and delays primarily due to bad weather, being managed by the MRfD Programme Delivery Team
- The Programme Delivery Team have been successful in seeking VAT abatement for the new build adult acute unit construction costs.

Consultation

- There is a 'Making Room for Dignity Programme Board' on which a Non-Executive Director sits, alongside other Trust and stakeholder colleagues, which receives regular updates, considers key programme issues and receives updates from the associated workstreams in the programme
- Engagement in the programme activities is well developed and embedded into the Programme with our EQUAL patient and carer representation group advising on building design and equipment
- The project team meets with local, regional and national NHSEI colleagues on a regular basis and will continue to do so for the life of the Programme.

Governance or Legal Issues

- Completion of the MRfD Programme projects is fundamental to eradiation of dormitories and eradication of inappropriate out of area specialist placements, both of which are regulatory requirements by the CQC and NHS England policy.

Public Sector Equality Duty & 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:

Ensuring that Equality, Diversity and Inclusion (EDI) benefits are well thought-out and securely delivered in this wide-ranging programme of work will maximise the overall benefits to patient experience and outcomes and will be included throughout the programme.

EDI stakeholder engagement/inclusion in the programme activities are well developed and embedded into the Programme with our EQUAL patient and carer representation group and a dedicated People Division Lead for the Organisational Development and Change Management elements of the Programme.

Inclusion factors to take into account include, but are not limited to, those relating to:

- gender-related benefits or dis-benefits, including those for people with trans and non-binary gender identities
- physical and other disabilities; benefits or dis-benefits in accessibility, outcomes and/or experiences
- autism-friendly environments
- supporting religious or belief activities within inpatient facilities
- challenging hetero-normative assumptions in design and service delivery
- maximising the opportunity for new and flexible working considerations in transformational planning and service delivery.

Actions to Mitigate/Minimise Identified Risks

- Involvement of service users and EDI representation has helped ensure the Programme Delivery Team consider inclusion risks and consider how best to take action to mitigate them.
- Each project within the Programme has a detailed EQIA completed which has been reviewed and accepted by the Derby and Derbyshire EQIA panel with regular reviews for each scheduled in.

Recommendations

The Board of Directors is requested to note the progress to date and assurance on delivery of the MRfD Programme.

Report presented and prepared by: **Andy Harrison**
Senior Responsible Owner, Acute Care Capital Programme

Making Room for Dignity

NHS
Derbyshire Healthcare
NHS Foundation Trust

Making Room for Dignity

Programme Update May 2024

DHCFT @derbyshcft
www.derbyshirehealthcareft.nhs.uk

Making a positive difference

Making Room for Dignity Programme

Background

The MRfD Programme has three strategic aims, to:

- ❑ **eradicate dormitory wards for adult inpatient mental health provision**
- ❑ **eradicate mixed age group wards for adult inpatient mental health provision**
- ❑ **eradicate the use of inappropriate Out of Area PICU beds.**

Making Room for Dignity

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Making Room for Dignity Programme

Eradicate dormitory wards:

- ❑ **Derwent Unit in Chesterfield**
- ❑ **Carsington Unit in Derby**
- ❑ **Both AAUs: 54-bed single ensuite rooms**
- ❑ **Significant progress by IHP since last update**
- ❑ **Both units will complete autumn 2024**
- ❑ **Units will go-live in November 2024**

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Making Room for Dignity Programme

Eradicate dormitory wards:

Making Room for Dignity

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Making Room for Dignity Programme

Eradicate dormitory wards:

Making Room for Dignity

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Making Room for Dignity Programme

Eradicate dormitory wards:

- **Refurbishment of Ward 32, Radbourne Unit**
- **Kier construction partner**
- **Commenced November 2023**
- **Completes / go-live Spring 2025**
- **89% of dormitories eradicated at this point**
- **Final 17-bed ward: completes January 2026 and goes live March 2026.**

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Eradicate mixed age group wards:

- ❑ **Refurbishment of Bluebell Ward**
- ❑ **Purpose designed facility for older adults**
- ❑ **Stepnell Construction refurb partner**
- ❑ **Commenced November 2023**
- ❑ **Refurbishment completes July 2024**
- ❑ **Unit goes live 2nd September 2024**

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Eradicate use of Out of Area PICU beds:

- ❑ **Refurbishment of Audrey House**
- ❑ **Purpose designed enhanced care unit**
- ❑ **Arden FES construction partner**
- ❑ **Refurbishment completed**
- ❑ **Unit will go-live in November 2024**

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Eradicate use of Out of Area PICU beds:

- ❑ **Kingfisher House**
- ❑ **Purpose designed 14-bed PICU**
- ❑ **IHP construction partner**
- ❑ **Build completes December 2024**
- ❑ **Unit will go-live in March 2025**

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Making Room for Dignity Programme

MRfD Project	Additional Staffing	
Dormitory Eradication	**WTE**	
Older Adult Service Relocation	33.58	Safer staffing for stand-alone MH ward
Chesterfield Adult Acute Unit	32.11	Additional staff needed for maintaining safe staffing levels moving from dormitory layout wards to single ensuite room layout
Kingsway Adult Acute Unit	27.27	
Radbourne Unit	15.33	
New Specialist Services		
Acute-Plus Unit	55.16	New service – staffed at NAPICU levels
Psychiatric Intensive Care Unit	71.28	New service – staffed at NAPICU levels
Total	234.73	

Making Room for Dignity

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Principle 1: The person will be at the centre of their own care and will contribute to it.

Principle 2: We will promote stabilisation and safety for all our service users within a dignified and person-centred model.

Principle 3: The model & staffing will allow the person "with the most appropriate skills to meet the needs of the person" (MHA) to be appointed to lead their care alongside the multi-disciplinary team.

Principle 4: Mental and physical health are equally important components of overall health and should be treated as so throughout.

Principle 5: Evidence based best practice will be used to support patients.

Principle 6: Trauma sensitive ways of working will be embedded within the model and how we deliver care. : All staff will be trained in the principles of Trauma Informed Care.

Principle 7: Care will be formulation led according to need. Medically led and psychologically led care will be available from the multi-disciplinary team (MDT); all voices within the MDT will contribute to care.

Principle 8: Emotion management will be supported through a wide range of techniques, including therapeutic activities, easy and immediate access to physical exercise, sensory and calming opportunities, quiet environments, low stimulus and access to outside spaces; according to need.

Principle 9: We will do our best to ensure that the multi-disciplinary team (MDT) involves everyone relevant to the person's care that they wish to be there and that all voices are heard equally – for example carer's.

Making a positive difference

Patient Flow Pathways

Crisis Prevention and Early Intervention:	• Crisis Resolution and Home Treatment Teams (CRHT); Crisis Helpline; Primary Care Providers.
Assessment and Stabilisation:	• Psychiatric Liaison Services; Inpatient Units.
Treatment and Rehabilitation:	•Inpatient Units and Community Mental Health Teams; symptoms and support recovery; Specialist Services e.g. substance misuse or eating disorders; Multidisciplinary Assessment and Treatment (to include Psychiatric Evaluation; Nursing Care; Trauma Informed Care; Medication Management; Therapeutic Interventions).
Community Integration and Support:	• Discharge Planning utilising focused on transitioning to community-based support; continued support from Community Mental Health Teams (CMHT); Occupational Therapy support; Social Services collaboration; Peer Support Programs/Networks; Outpatient Services;
Family and Carer Involvement:	• Family and Carer Support Services
Wellness and Preventive Care:	• Health Promotion; Preventive Care Services;
Monitoring, Evaluation, and Continuous Improvement:	• Data and Quality Improvement Teams monitor outcomes and patient experiences, evaluating the effectiveness of the flow pathway and implementing continuous quality improvement initiatives.

Making Room for Dignity

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Making Room for Dignity Programme

	Go-Live	Dorms Eradication
Older Adults Bluebell Ward	2 Sep 2024	29% (100% OAs)
Derwent Adult Acute Unit	Nov 2024	40%
Carsington Adult Acute Unit	Nov 2024	78%
Radbourne Unit: Ward 32	Spring 25	89%
Radbourne Unit: Ward 35	Mar 2026	100%
		Specialist Services
Audrey House Enhanced Care Unit	Nov 2024	36% (F)
Kingfisher House Psychiatric Intensive Care Unit	Mar 2025	100% (M)

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Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2024

Corporate Governance Report

Purpose of Report

To note the assurance on Board Committee year end reporting, to approve the revised suite of Terms of Reference (ToRs) for Board Committees and to receive the Trust sealings report.

Executive Summary

Assurance is provided from the Audit and Risk Committee on the year-end governance reporting from Board Committees. All the Board Committees reviewed their ToRs during their 2023/24 year-end effectiveness reviews, and these are attached for the Board's approval. There are only minor changes proposed, mainly to ensure consistency across the Committees. Of note this year has been:

- Reiteration of the standard requirement of a minimum of three working days for advance issue of agenda packs, although flexibility will be maintained for extraordinary circumstances for late papers, in consultation with the Committee Chair. This is now standardised across all Committees.
- Amended wording, "Meetings may be held face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously".
- Amended job titles, membership and portfolio areas to reflect the modified leadership and Committee structures from 1 April 2024. Also updated were references to the oversight of collaboratives and alliances in the context of wider system working.

The year-end report for the Audit and Risk Committee is also presented to the Board which summarises how the Committee has discharged its remit during 2023/24 and is in addition to the assurance summary reports which have been presented to Board meetings throughout the year. Committees will be reviewing how their effectiveness is determined in readiness for the 2024/25 review, including the use of a survey/checklist that could be adapted from the one already used by the Audit and Risk Committee as part of the HMFA NHS Audit Committee Handbook.

The Trust Sealings register is also attached for information.

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	X
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long-term sustainability.	X

Risks and 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 by the Corporate Governance Framework.

Consultation

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 year-end governance reports are in line with governance best practice. The HMFA 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:

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 which is now built into ToRs.

Recommendations

The Board of Directors is requested to:

1. Approve the suite of Terms of Reference for Board Committees (Appendix 1)
2. 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 2023/24 and receive the year-end report of the Audit and Risk Committee (Appendix 2)
3. Note the Trust seal report (Appendix 3).

Report presented by: **Justine Fitzjohn,**
Director of Corporate Affairs and Trust Secretary

Report prepared by: **Justine Fitzjohn**
Director of Corporate Affairs and Trust Secretary

Jo Bradbury
Corporate Governance Officer

1. Year-end governance reporting from Board Committees and approval of Terms of Reference (ToRs)

At its meeting on 25 April 2024, the Audit and Risk Committee received the full year end summaries for all of the Board Committees as well as their Terms of Reference (ToR).

All Board Committees have reviewed their activity during the past year 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.

The Audit and Risk Committee received assurance from the summary reports that the Committees have effectively carried out their role and responsibilities during 2023/24. All the Board Committees have developed a full future year's forward plan.

The suite of ToRs are included as Appendix 1.

The year-end report for the Audit and Risk Committee is also presented to the Board at Appendix 2 which summarises how the Committee has discharged its remit during 2023/24 and is in addition to the assurance summary reports which have been presented to Board meetings throughout the year.

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 2023/24.
- receive the year-end report for the Audit and Risk Committee

2. Register of Trust Sealings

The six-monthly update on the authorised use of the Trust Seal since the last report to the Board on 7 November 2023 is attached for information at Appendix 3.

Recommendation:

The Board of Directors is requested to note the contents of the report.

Appendix 1

Derbyshire Healthcare NHS Foundation Trust

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 Focus.

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, Organisational Development and Inclusion
- Director of Corporate Affairs and Trust Secretary
- Corporate Governance Officer
- Any other person who has been invited to attend the meeting by the Committee so as to assist in deliberations.

3.2 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

4. Quorum

4.1 A quorum shall be three members.

4.2 Meetings may be held face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously.

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

These terms of reference are based in part, on best practice as set out in the Code of Governance[1] 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."

[1] Code of governance for NHS provider trusts. This comes into effect from 1 April 2023 and replaces the 2014 Code of Governance

"Appointments to the Board of Directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for Board and senior management. Appointments should be made solely in the public interest, with decisions based on integrity, merit, openness and fairness. Both appointments and succession plans should be based on merit and objective criteria and, within this context, should promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths, 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 Chief 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. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the Foundation Trust should engage with NHS England to agree the approach.

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.

6.1.8 Ensure that contractual terms on termination, and any payments made, are fair to the individual, and the NHS, aligned with the interests of the patients, that failure is not rewarded and that the duty to mitigate loss is fully recognised, in line with national guidance where appropriate.

6.1.9 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 and collaborate effectively with system partners, 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 Director of Corporate Affairs and Trust Secretary on behalf of the Trust Chair.

7.2 The Committee shall ensure that Board emoluments are accurately reported in the required format in the Trust's annual report.

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. Ideally, this should be no less than three working days although flexibility will be maintained for extra-ordinary circumstances.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Remuneration & Appointments Committee	13 March 2024
Approved by Audit & Risk Committee	25 April 2024
Approved by Board of Directors	7 May 2024

Audit and 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 Director of Finance and Director of Corporate Affairs 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. They should attend when the Committee considers the Annual Governance Statement and the annual report and accounts.

3.3 The External Auditor or their representative should normally attend meetings.

3.4 The Head of Internal Audit or their representative should also attend routine meetings.

3.5 A representative of the local Counter Fraud 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 Director of Corporate Affairs and 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 Chair should meet privately with the external and Internal Auditors.

Access

3.9 The Head of Internal Audit or their representatives, 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 face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously.

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 (eg compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests and adequacy of commercial insurance cover).

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
- 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 and 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 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
- Compliance with the Annual Reporting Manual requirements for the content of the annual report as published by NHS England.

6.21 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

Freedom to Speak Up (Raising Concerns including Protected Disclosures)

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 Director of Corporate Affairs and 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
- Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally, this should be no less than three working days, although flexibility will be maintained for extra-ordinary circumstances
- 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 and Risk Committee	25 April 2024
Approved by the Board of Directors	7 May 2024

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, including procurement
- 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
- National Cost Collection: 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 and 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 and 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 Focus.

1.8 As a Committee of the Board, the Finance and 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 financial and performance 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.

1.10 To receive assurance in relation to the fulfilment of the financial and performance aspects of the Trust role in all collaborative and alliances where it is a partner and incorporates the Trusts role within the following:

- Adult Forensic Secure Provider Collaborative – Impact
- CAMHS Provider Collaborative
- Adult Eating Disorders
- Gambling Harm
- OP Courage

2. Membership

2.1 The membership of the Committee shall comprise:

Non-Executive Directors x three (one will be appointed as the Chair)
Director of Finance

Clinical Operational Managing Director leads
Deputy Chief Executive and Chief Delivery Officer
Deputy Director of Finance
Director of People, Organisational Development and Inclusion

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 The Trust Chair will appoint the Chair of the Committee.

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.

2.5 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. Attendance

3.1 Other staff may be required to attend at the invitation of the Committee.

3.2 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

3.3 The Chief Executive Officer reserves the right to attend any meeting.

4. Quorum

4.1 A quorum shall 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 one of the Clinical Operations Managing Directors or their deputies acting as their direct representative.

4.2 Meetings may be held face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously.

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 of an income and expenditure basis.

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 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 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 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally, this should be no less than three working days, although flexibility will be maintained for extra-ordinary circumstances.

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	19 March 2024
Approved by Audit and Risk Committee	25 April 2024
Approved by Board of Directors	7 May 2024

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 has an objective 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.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Quality and Safeguarding 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 Focus.

1.8 To receive assurance in relation to the fulfilment of the quality 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 Directors x three (one will be appointed as the Chair)
- Director of Nursing, Allied Health Professionals and Patient Experience or a nominated deputy
- Medical Director or a nominated deputy
- Deputy Chief Executive and Chief Delivery Officer or a nominated deputy

2.2 The Trust Chair will appoint the Chair of the Committee

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
- Assistant Director of Legal, Governance and Mental Health Legislation
- Health and Safety Manager
- Safeguarding Children Lead
- Safeguarding Adults Lead
- Chairs or Deputy Chairs of the Clinical Operational Assurance Team (COATs) 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 Finance
- Director of People, Organisational Development and Inclusion
- Deputy Chief Executive and Chief Delivery Officer
- Director of Corporate Affairs and 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 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 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

3.6 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.

3.7 The Committee's Executive Lead (Director of Nursing, Allied Health Professionals and Patient Experience) must be in attendance, or the Medical Director will act as the Committee's Executive Lead.

3.8 Nominated deputies for Executive members will contribute to attendance figures but will not contribute to quorum.

3.9 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 be three members, including at least one Executive Director and two Non-Executive Directors.

4.2 Meetings may be held face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously.

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 ten times a year on a monthly basis except during January and August

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 regulators, NHS England 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 Governance Annual Reports before submission to the Board.

6.5 To have final sign off of the Trust Quality Account.

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 the Trust Quality Operational Group (TQOG) which is established to provide assurance to the Quality and Safeguarding Committee and Trust Board with regards to the quality and safety of patient care delivered by the Trust. The Group will establish a framework to continuously monitor compliance with standards and improve the quality of care.

6.7 To scrutinise the work of the TQOG 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 2014 as amended.

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 Freedom to Speak Up 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, such as those which relate to clinical electronic systems in operation within the services of 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 the 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, 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, eg 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 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 the Trust's care. The Committee will ensure that safeguards are in place that not only protect and promote the welfare of vulnerable children, but that have a significant impact on children'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 **The Health and Care Act (2022)** which establishes a framework that supports collaboration and partnership-working to integrate services for patients. The Committee will ensure measures are in place to maintain oversight of quality and safety, specifically in relation to the duty to facilitate the sharing of information relevant to child safeguarding arrangements.

6.27.4 **Counter Terrorism and Security Act 2015** places a duty on specified authorities (identified in full in Schedule 6 to the Act) to have due regard to the need to prevent people from being drawn into terrorism through the Prevent duty. The Prevent duty requires all specified authorities to ensure that there are mechanisms in place to enable health staff to understand the risk of radicalisation and how to seek appropriate advice and support.

6.27.5 **The Mental Health Act (1983) amended 2007** the Committee will ensure that measures are in place to maintain oversight of compliance with the requirements of the Mental Health Act code of practice (2015).

6.27.6 **Mental Capacity Act 2005** the Committee will ensure that measures are in place to maintain oversight of compliance with the requirements of the Mental Capacity Act code of practice (updated 2020)**,** including the deprivation of liberty safeguards (DOLS).

6.27.7 **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.

6.27.8 **Promote a proactive and preventative approach** to safeguarding through our Flourishing Families agenda.

6.27.9 Ultimately 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.

6.27.10 Ensure the Trust workforce is appropriately trained in safeguarding children and adults to their appropriate level depending on their role and responsibility.

6.27.11 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.

6.27.12 To ensure that the Trust embeds Think Family principles within all aspects of care and service developments to enable 'Flourishing Families'.

6.27.13 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.

6.27.14 To advise the Trust Board of national and local standards and Derby and Derbyshire Safeguarding Board arrangements.

6.27.15 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.

6.27.16 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.

6.27.17 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 Prevent duty, as outlined in the Counter Terrorism and Security Act (2015) and ensure staff implement the duty effectively.

6.27.18 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.

6.27.19 The Committee will oversee and assure itself on the Multi-Agency Risk Assessment Conference (MARAC) agenda, that the Trust is discharging its duty. The MARAC aims to share information to increase the safety, health and wellbeing of victims/survivors - adults and their children; improve agency accountability; and improve support for staff involved in high-risk domestic abuse cases.

6.27.20 Have authority in 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 area's 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
- Arrange 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 area's 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. Ideally, this should be no less than three working days, although flexibility will be maintained for extra-ordinary circumstances.

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	18 April 2024
Approved by Audit and Risk Committee	25 April 2024
Approved by Trust Board	7 May 2024

Derbyshire Healthcare
NHS Foundation Trust

People and 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 and Culture Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee has an objective 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.

1.7 As a Committee of the Board, the People and 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 People Strategy.

2. Membership

2.1 The membership of the Committee will comprise:

- Non-Executive Directors x three (one will be appointed as the Chair)
- Director of People, Organisational Development and Inclusion
- Director of Nursing, Allied Health Professionals and Patient Experience
- Deputy Chief Executive and Chief Delivery Officer

The Deputy Director of Nursing and Quality Governance and Managing Directors are to attend meetings as nominated deputies if the Director of Nursing, Allied Health Professionals and Patient Experience or Deputy Chief Executive and Chief Delivery Officer are unable to attend.

In attendance as core attendees:

- Deputy Director of People, Organisational Development and Inclusion
- Other team leaders may be invited to attend to present on specific agenda items or when relevant at the discretion of the Chair and Director of People, Organisational Development and Inclusion

2.2 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 to 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 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings

3.5 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.

4. Quorum

4.1 A quorum shall be three (not less than two Non-Executive Directors and one Executive Director).

4.2 Meetings may be held face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously.

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

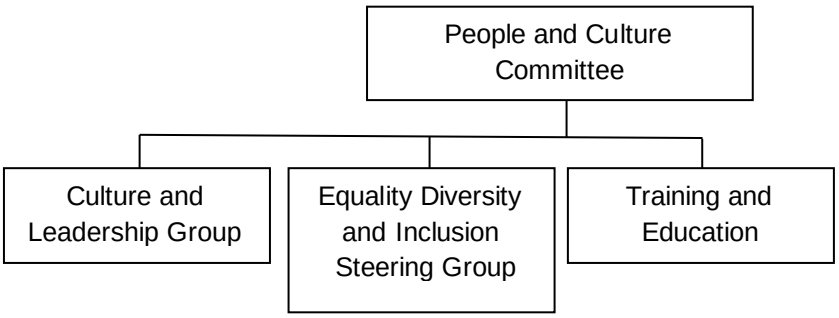
5.1 The Committee will meet on a bi-monthly basis with additional meetings being called when necessary.

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 Trust's 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 reviews and monitors the Workforce metrics and Board Assurance Framework and ensures the Board is kept informed of any significant workforce risks.

6.6 The Committee considers the Board Assurance Framework and high-level risks, in particular as they relate to the remit of the Committee; and complies 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. Ideally, this should be no less than three working days, although flexibility will be maintained for extra-ordinary circumstances.

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	26 March 2024
Approved by Audit and Risk Committee	25 April 2024
Approved by Trust Board	7 May 2024

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 Focus.

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 Directors x three (one will be appointed as Chair of the Committee)
- Medical Director or a nominated Deputy
- Director of Corporate Affairs and Trust Secretary

2.2 The Trust Chair will appoint the Chair of the Committee.

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:

- Assistant Director of Legal, Governance and Mental Health Legislation
- Mental Health Act Manager
- Representative of Associate Hospital Managers
- Director of Nursing, Allied Health Professionals and Patient Experience, when required (refer to quorum at 4.1 below)
- 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.

3.3 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

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.

4. Quorum

4.1 A quorum shall be a minimum of three members including at least two Non-Executive Directors and one Executive Director. If the Medical Director is unable to attend the Director of Nursing, Allied Health Professionals and Patient Experience will be required to attend instead in order to meet the quorum requirements.

4.2 Meetings may be held face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously.

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, eg 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. Ideally, this should be no less than three working days, although flexibility will be maintained for extra-ordinary circumstances.

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	15 March 2024
Approved by Audit and Risk Committee	25 April 2024
Approved by Trust Board	7 May 2024

Board Committee Meeting Year-End Review 2023/24

Audit and Risk Committee

1. Purpose

The Audit and Risk Committee 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 of Directors 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.

It achieves this by:

- Ensuring there is an effective internal audit function that provides appropriate independent assurance to the Committee, the Chief Executive and the Board of Directors
- Reviewing the work and findings of the Trust's External Auditor
- Reviewing the findings of other significant assurance functions, both internally and externally
- Reviewing the work of other committees within the organisation
- Requesting and reviewing reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control
- Reviewing and by delegated authority, approving the annual report and financial statements
- Ensuring that the systems for financial reporting to the Board, including those around budgetary control, are subject to review in order to be sure that they are complete and accurate.

Throughout the year, the Committee considers external audit reports, internal audit reports, and counter-fraud progress reports. All audit outcomes are overseen by monitoring the delivery of internal and external audit report recommendations.

The Committee considers the Board Assurance Framework, Annual Report and Annual Governance Statement and progress with internal and external audit plans. It also receives updates on losses and compensation payments, exit payments, conflicts of interest, tenders and waivers, debtors and clinical audit. The Committee also considers governance and compliance documents as well as oversight of the Trust's commercial insurances.

The Committee assesses the effectiveness of the external audit process by undertaking a self-assessment each year and by meeting with auditors in private. Auditors attend every meeting of the Committee, and the Trust's compliance with the audit plan approved by the Committee is monitored.

2. Authority

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. This includes identification, review and scrutiny of all relevant risks on the Board Assurance Framework (BAF) and reviewing of BAF management and reporting prior to formal reporting to the Trust Board. 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.

The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice.

The Committee is also 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.

The Committee did not identify the need to seek external legal advice or other independent professional advice during the year.

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. The equality impact of all reports to the Committee is considered via the prompt on the report cover sheet template.

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.

In 2023/24 the Committee approved the following:

- Conflicts of Interest Policy and Procedures – April 2023
- Freedom to Speak Up Policy (revision) – April 2023
- The Intellectual Property Policy and Procedures- October 2023
- Accessing Legal Advice Policy and Procedure - January 2024
- Freedom to Speak Up Strategy 2024–2026 (under delegated authority of the Board) - January 2024.

The Committee agreed a revised set of Standing Financial Instructions in April 2023 (having deferred from the previous year) and schedules an annual review of SFIs at its July meeting.

3. Membership of Audit and Risk Committee

The Audit and Risk Committee comprises independent Non-Executive Directors. The Committee members in 2023/24 are listed below:

Name	Title
Geoff Lewins	Committee Chair, Non-Executive Director
Ashiedu Joel	Non-Executive Director
Deborah Good	Non-Executive Director

4. Attendance

An attendance log reflects attendance by members of the Committee, as well as the Director of Corporate Affairs and Trust Secretary and Director of Finance who are required to attend routine meetings of the Committee to support the Chair and Committee members. The Director of Corporate Affairs and Trust Secretary is the nominated Lead Executive for the Committee. Other Executive Directors have attended by invitation to consider areas of risk or operation that are their responsibility.

The Chief Executive as Accountable Officer attended the June meeting at which the Annual Report and Accounts including the Annual Governance Statement were considered, as well as the opinion of the Head of Internal Audit which supports the conclusion within the Annual Governance Statement. The Trust Chair also attended the meeting to consider and approve the Annual Report and Accounts.

The Lead Governor was invited to attend the meeting to observe the final approval of the Annual Report and Accounts but was unable to attend, the Committee Chair offered a follow up meeting.

The External Auditor was represented at all meetings. Internal Auditors attended all meetings of the Committee. A representative of the Counter Fraud Service attended the meetings when counter fraud reporting was scheduled. Both the Internal and External Auditors had the opportunity to meet with the Audit and Risk Committee Chair in private (without Executives present) prior to Committee meetings.

5. Access

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 and are aware of the channels through which this can be achieved. In practice, this has been undertaken through the private meetings held prior to each Committee meeting.

6. Frequency of Meetings

The Committee met on six occasions throughout 2023/24 on 27 April, 25 May, 20 June, 20 July, 12 October and 25 January discharging its responsibilities as set out in the Terms of Reference.

7. Required frequency of attendance by members

According to the Committee's Terms of Reference, members should attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings. In 2023/24, the majority of members achieved in excess of 80% attendance at the meetings of the Committee. All meetings have been quorate (although for one meeting another Non-Executive Director attended to ensure quoracy). Below is the 2023/24 attendance log:

Attendance Record	27-Apr-2023	25-May-2023	20-Jun-2023	20-Jul-2023	12-Oct-2023	25-Jan-2024	Number of meetings attended	Total number of meetings eligible to attend	%
MEMBERS									
Geoff Lewins	1	1	1	1	1	1	6	6	100%
Deborah Good	1	1	1	1	1	0*	5	6	83%
Ashiedu Joel	1	0	1	0	0	0	2	6	33%
Ralph Knibbs						1	1	1	100%
EXECUTIVE ATTENDEES									
Rachel Leyland	1	1	1	1		1	5	5	100%
Jo Wilson					1	1	2	2	100%
Justine Fitzjohn	1	0	1	1	1	1	5	6	83%

8. Duties and Responsibilities

The Audit and Risk Committee has an annual plan of scheduled agenda topics, along with a range of specific issues which are subject to review. A rolling programme of actions is maintained and monitored. The following subheadings, shown in italics, are copied from the Duties and Responsibilities section of the Terms of Reference of the Audit and Risk Committee (attached). The commentary underneath each subheading is drawn from a review by the Director of Corporate Affairs and Trust Secretary of the minutes of all meetings and other relevant information.

The Committee's duties and responsibilities can be categorised as follows:

9. Integrated governance, risk management and internal control

9.1 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.

The Committee has a forward plan that maps out the periodic review of governance, risk and controls, internally and externally (via the audit plan and programmes).

The management of risk underpins the achievement of the Trust's Strategy and related objectives. The Trust's approach to Risk Management is set out in the Risk Management Strategy 2023-2025 which comprehensively brings together the Trust's risk management approach. The Committee received an annual summary of progress against the Risk Management Strategy in October 2023.

It was agreed that annual updates will continue to be received in order to measure progress against the Risk Management Strategy. The Committee accepted the inclusion of the system-based risk impacting on and mitigated by multiple system organisations as a stand-alone risk that is now included in the BAF report for scrutiny but presented apart from risks specific to the Trust's strategic objectives.

The Committee receives quarterly Operational Risk Management reports.

9.2 To consider the Board Assurance Framework and high-level risks, and to comply with any request for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

The Committee has reviewed the format and content of the Board Assurance Framework four times during 2023/24 and has challenged the adequacy of the assurances that have been received. The BAF includes risks and mitigations developed in line with the objectives which support delivery of the Trust Strategy.

The Committee was assured that the Board Assurance Framework process was reviewed, scrutinised and updated in seeking to identify and mitigate risks to achieving the Trust's strategic objectives. There was one deep dive (finance) in January 2024.

9.3 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 Annual Governance Statement was subject to scrutiny and challenge by the Audit and Risk Committee to ensure it met the requirements as set out for the report. The Committee was assured that the report was balanced and fair.

- ***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 principal objectives.***

The Committee has a process for receiving 'Deep Dives' which provides assurance over controls and gaps in assurance with a focus on action plans to manage risks. This approach informs and supports the overall review of the BAF prior to regular submission to the Trust Board. Significant clinical and corporate risks are identified and linked to the BAF risks as part of routine reporting. A six-monthly report links corporate/operational risks to BAF risks.

- ***arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Counter Fraud Authority standards.***

The Trust's Counter Fraud Service was provided by 360 Assurance to the year end. Plans were designed to provide counter-fraud, bribery and corruption work across generic areas of activity in compliance with the latest guidance and standards.

In submitting its counter fraud annual report at the July 2023 meeting this included the NHS Counter Fraud Authority Functional Return. 360 Assurance assured the Committee that that the Trust's counter fraud, bribery and corruption arrangements are embedded. There is a strong anti-fraud, bribery and corruption culture within the Trust and the counter fraud service delivered by 360 Assurance is efficient.

The Committee receives progress reports against delivery of the work plan including compliance against the comprehensive fraud risk assessment. This assessment is also recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers.

The Committee's Executive Lead and Director of Corporate Affairs and Trust Secretary has an additional role as the Trust's Counter Fraud Champion.

- ***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).***

The BAF is a 'live' document and as such is regularly reviewed and updated. The Committee is responsible for reviewing the BAF to assure itself that the BAF appropriately addresses objectives and risks and also to ensure that newly arising risks are identified. The Committee has confirmed that it is satisfied that the BAF shows a clear mapping across all risks identified by the Board of Directors and that good engagement has taken place with the Executive Directors in managing the overarching Risk Register.

9.4 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.

The Audit and Risk Committee secures its oversight on assurance of effectiveness of other committees via each Committee's year-end report. Annual Effectiveness Reports relating to 2022/23 were received by the Committee in April 2023. For 2023/24 they are planned for review by the Committee in April 2024. With the exception of this Committee, year end reviews have been carried out under the lighter governance approach adopted in the pandemic (so just including the Board Assurance Summaries as evidence of compliance against ToRs) this will be reviewed for 2024/25, possibly adapting the checklist approach used by this Committee. Ongoing oversight was secured from the Committee assurance summaries presented to the Trust Board. There have been escalations between Board Committees during the year.

9.5 To monitor corporate governance (eg compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

The Corporate Governance Framework will be presented to the Committee at its May 2024 meeting. The Waiver of Standing Financial Instructions Register reports are received by the Committee every six months.

An annual review of Standing Financial Instructions (SFIs) is built into the Forward Plan.

An external assessment under the Well Led Framework was undertaken in 2023 by the Office of Modern Governance. The assessment of the Trust's governance arrangements was a positive one. During the course of the review the Office of Modern Governance indicated they observed many elements of good or leading-edge leadership and governance practice. This was balanced by the highlighting of areas where a sharpening or subtle refocusing of the Trust approach will accelerate the journey of improvement the Trust is on. These areas were reflected in the recommendations and have been built into the action plan, delivery of which is being monitored by the Audit and Risk Committee.

9.6 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.

See items 9.2-9.3 above.

10. Internal audit

10.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

The Trust takes a risk-based approach to developing the internal audit. The Committee has received assurance that sufficient work has been undertaken for the Head of Internal Audit opinion.

10.2 To oversee on an on-going basis the effective operation of internal audit in respect of:

- ***Adequate resourcing***
- ***Co-ordination with external audit***
- ***Meeting the Public Sector Internal Audit Standards***
- ***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.***

The Committee has a standing item on its agenda to receive a progress report from the Internal Auditors. The internal audit programme was regularly reviewed in year to ensure that it continued to meet the internal audit needs of the organisation.

10.3 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

Much of the work of the Committee is supported by the programme of work for internal audit services, provided by 360 Assurance.

Services have been within an agreed work plan, prepared in consultation with the Executive Leadership Team and approved by the Committee, which seeks to ensure that reviews focus on areas of risk identified by the Trust.

The Internal Auditors progress report lists the outcomes of the completed reviews. Any Limited Assurance report is presented in full to the Committee, the Executive Director Lead is invited to attend the meeting to set out the management response and approach towards the agreed actions. Compliance against actions is monitored through the 'Pentana' system and reported in the Internal Audit Progress Report. The Committee noted the improved position of compliance for 2023/24, which had an out-turn of 100%.

10.4 To consider the provision of the internal audit service, the cost of the audit.

360 Assurance's contract was renewed via direct award and commenced on 1 December 2022– 31 March 2026 with a further two year optional extension.

10.5 To monitor the effectiveness of internal audit and to conduct an annual review of the internal audit function.

Reviewed as part of the annual report presented to the Committee. 360 Assurance issues client satisfaction questionnaires.

11. External audit

11.1 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.

Mazars were appointed on 1 September 2020 under a three-year contract (with a two-year renewal option) performing the external audit of the Trust from 2020/21 onwards. The Council of Governors approved the award for the two years in 2023 and the current contract is due to expire at the end of August 2025.

11.2 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.

Regular reporting to the Committee by the External Auditor as a standing agenda item encompasses updates on the nature and scope of the annual audit to be undertaken.

11.3 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.

A report is presented annually to the Council of Governors on the work of the External Auditors. A positive response was received from the Trust on the annual client satisfaction survey performed issued by Mazar's.

11.4 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.

See 11.1 and 11.2

11.5 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

Implementation of recommendations has been overseen as part of reporting to the Committee on internal and external audit review recommendations.

11.6 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

This policy is in place with the External Auditors.

11.7 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

See items above (11.2, 11.3 11.4) relating to the provision of the External Audit service.

12. Annual accounts review

12.1 To approve the Annual Report and Accounts and Annual Governance Statement on behalf of the Trust Board. In doing so the Committee will determine their completeness, objectivity, integrity and accuracy.

In preparation for approval of the Annual Report and Accounts, the Committee reviewed the relevant disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit Opinion, External Audit Opinion and considered that the Annual Governance Statement was consistent with its views on the Trust's systems of internal control.

12.2 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

The Committee agreed the draft accounting policies for annual accounts 2023/24 in January 2024.

13. Speaking Up

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.

The Committee receives updates on the implementation of the Freedom to Speak Up (FTSU) Policy within the Trust twice a year, in October and April. The reports enable the Committee to review the robustness of policy and procedures.

In October 2023. the Committee received the draft FTSU Reflection and Planning Tool, focusing on the gap analysis for the lower scores, which then formed the basis of the action plan. In January 2024, on delegation of the Board, the Committee completed the tool and approved the FTSU Strategy in order to meet the national deadline of 31 January 2024. A requirement of the Tool was to ensure the Trust's speaking-up policy reflects the 2022 NGO update. This has been completed with the revised policy approved by the Committee in 2023.
The Committee agreed significant assurance in 2023/24 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.

14. Standing orders, standing financial instructions and standards of business conduct

14.1 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.

Apart from SFI, this requirement is covered by the Corporate Governance Framework which is reported and approved by the Committee. The Framework is comprehensively reviewed every 3 years but elements of it are revised more frequently, for example the annual review and approval of Committee Terms of Reference.

14.2 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.

No significant issues were reported during the 2023/24 year. Reports of waiving of the Standing Financial Instructions and Standing Orders (where these have occurred) have been routinely reported to the Committee.

14.3 To review the scheme of delegation.

This forms part of the Corporate Governance Framework of the Trust and is reviewed periodically.

Other

14.4 To review performance indicators relevant to the remit of the Committee.

Through reporting from the auditors, the Audit and Risk Committee remained appraised of the Trust's performance in financial indicators as benchmarked against other mental health foundation trusts and the wider NHS.

14.5 To examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee.

No actions have been referred to the Committee by the Board of Directors during the year.

14.6 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.

Direct oversight of regulatory reviews carried out during the year, such as those undertaken by the CQC, have remained within the remit of the Trust Board itself, with assurance for CQC reporting through the Quality and Safequarding Committee.

14.7 To review the work of all other Trust committees in connection with the Committee's assurance function.

See 9.4 above.

14.8 The Committee may also request specific reports from individual functions within the Trust (for example, clinical audit).

Reports have been requested during the year including on the process for raising and addressing sickness management and salary overpayments, follow up reports have been requested on overpayments due to the initial limited assurance given.

The Committee also received assurance on the overall 2022/23 Clinical Audit programme, its fitness for purpose and its delivery; and provided an initial view of the Clinical Audit Programme for 2023/24.

14.9 The Committee may refer specific issues to the Board, Finance and Performance Committee and other Committees and make recommendations as appropriate.

At the conclusion of every meeting the Committee discussed and agreed any necessary referrals to other Committees. These are noted on the assurance summary of the meeting presented to the Public Board meeting. Referrals are noted on the Committee's actions matrix and archived once evidence and assurance has been received that these are complete.

14.10 The Committee will receive assurance reports on Information Governance arrangements, particularly in respect to compliance with the Information Governance Toolkit and legislative compliance including the Data Protection Act and General Data Protection Regulation (GDPR).

An update on Data Security and Protection including cyber security and compliance with the Data Security and Protection Toolkit was received in April 2023 in line with the revised national reporting timetable. Significant assurance was confirmed. Reporting will continue on bi- annual basis.

14.11 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.

The Committee receives updates on compliance against the Conflicts of Interest Policy twice a year. The revised policy was approved in April 2023. This also includes reporting on gifts, hospitality, sponsorship and secondary employment in line with the Policy.

15. Feedback from Audit Committee Handbook survey

The Director of Corporate Affairs and Trust Secretary and Committee Chair have completed Checklist 1 from the HFMA Audit Committee handbook and this year, Members (and regular attendees) have been invited to complete the Checklist 2 questionnaire individually. This questionnaire covers Committee processes and effectiveness. The significant majority of responses were either 'strongly agree' or 'agree' in terms of positive response.

16. Objectives

These are now embedded in the terms of reference and assessed as part of the year-end effectiveness report which will be prepared for the Committee in April 2024.

The key objectives are:

- **To ensure the internal audit programme is effectively implemented and reports signed off in a timely manner**

Measured by adherence to agreed timelines for internal audit processes as reported through internal audit plan progress reports as standing item at all Committee meetings.

- **To promote best practice across all Board Committees, building upon embedded practice and seeking continuous improvement**

Evaluated through end of year reports and ongoing discussion at Board Committee chairs meetings during the year. Best practice across all Board Committees is a core item of business at the Board Committee Chairs meetings.

- **Ensure continued engagement/governor involvement in external audit and related Committee matters**

The Lead Governor is invited to observe the year end account sign off meeting but unfortunately could not make this in June 2023, the Chair offered a follow up meeting. Presentation of the Annual Report and Accounts and report from the External Auditors is reported to the Council of Governors in September every year.

- **To further embed oversight of risk within the Board Committee structure**

The Committee has led focus on the BAF, including Deep Dives where required, to drive Board and Committee business to focus work towards the successful delivery of the Trust's strategic objectives.

This is measured through the year-end review of Committees (April annually) to confirm embeddedness of established process in this area. Assurance summaries from Committees to the Board operated well during the year to date in their role to provide the Board with assurance on key areas of Committee business and also to escalate risk issues.

- **To ensure that robust governance processes are in place, including oversight of effective implementation of any revised governance structure arising from Trust strategy review.**

Evidenced through implementation of the framework of established activity in internal audit, external audit, assurance reporting on risk management and other internal/external reports which have given assurance to allow sign off of annual report and accounts including the Annual Governance Statement.

The Annual Governance Statement brings together all the detail on systems, controls and processes. A draft will be presented to the Committee in April 2024. The Committee has received staged reporting on the Head of Internal Audit Opinion.

The Committee also oversees the Well Led Review action plan.

- **To identify training needs of Audit and Risk Committee members and deliver appropriate training/support to enable members to be effective in their Committee role**

The Committee Chair has attended networking events relating to their roles during the year and he also attends the JUCD Audit Committee Chairs group. Additional training and support is provided to the newest members of the Committee. The latest HMFA Audit Committee Handbook has been circulated to the Committee. Internal and External Audit circulate regular briefing relevant to the audit environment.

- **To review results from the annual Committee effectiveness report and develop actions (not covered by above) for delivery by the Committee to agreed timeframes.**

See 10 above.

- **To clarify and implement effective reporting and oversight of Data Quality**

The Committee has continued to seek periodic assurance from the IM&T lead that data continues to follow the rules of validation. An update report is presented every 6 months.

- **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.**

Although the Committee has not undertaken a specific review in 2023/24 report authors continue to complete the equality, diversity and inclusion section of the front sheets.

- **To ensure any gaps in assurance identified in the internal audit programme are adequately covered via alternative methods such as self-effectiveness or external review**

  This will be evaluated as part of the response to the 2023/24 Head of Internal Audit Opinion and will be considered as part of approval of the 2024/25 Internal Audit Plan. The External Well Led Review, which includes a self-assessment, has been commissioned and regular updates will be reported through the Audit and Risk Committee.

17. Freedom to Speak Up

The Audit and Risk Committee is committed to the principles of Speaking Up and actively shaping the speaking up culture. To this end the Committee has considered in carrying out this review, that it has robustly challenged itself to improve patient safety, develop a culture of continuous improvement, openness and honesty. This can be specifically evidenced through the update reports on Freedom to Speak Up received by the Committee.

18. Ongoing Assurance – Governance Best Practice

The Committee has embedded the principles of the good governance best practice and continues to follow the process contained in its annual forward planning and review of effectiveness.

19. Minutes and Reporting

19.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

Each meeting is formally recorded and available to all Board members.

19.2 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.

An assurance summary is reported to the public meeting of the Board of Directors after each meeting, which summarises discussions, details assurance and actions required, as well as decisions made and identification of any key risks. Items for escalation to the Board or for referral to other Board Committees are also contained within the assurance summary.

19.3 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 (AGS) 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 if 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; and***
- ***Any pertinent matters in respect of which the Committee has been engaged.***

The Board of Directors receives regular updates on the progress of compiling the AGS as part of the Board Committee Assurance Reports. The Committee has delegated authority from the Board to sign off the Annual Report and Accounts including the AGS Report and the sign off meeting is attended by the Chair and Chief Executive. The Committee Chair presented a summary of the Committee's Annual Report for 2022/23 to the Council of Governors in September 2023. The Trust's Annual Report and Accounts for 2022/23 were presented to the Council of Governors by Mazars, the Trust's External Auditors, in September 2023.

19.4 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.

This report outlines how the Committee has addressed all elements of its Terms of Reference during the year. The work of the Committee is included within the Annual Report. The Board took significant assurance regarding the contents of the Annual Report and Accounts for the year ended 31 March 2023 as overseen by the Committee.

19.5 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

The Committee reflected upon its effectiveness at the end of each meeting, the appropriateness of papers and received suggestions for improvement. Overall, members have been satisfied with the way the Committee operates and have commented on good level of debate, challenge and participation of members and attendees and chairing effectiveness. Papers have continued to improve with well-structured recommendations, contributing to holding Executive Directors to account. The Committee has continued to receive good levels of assurance and has been responsive to demand and priorities.

Board Committee Chairs discussed Committee effectiveness at their meetings held in year and were assured of key elements of governance, consistency and intelligence sharing across Committees.

20. Administrative Support

The Director of Corporate Affairs and Trust Secretary discharged her duties in support of the Audit and Risk Committee throughout the year.

21. Review of Terms of Reference

The Terms of Reference will be reviewed in April 2024 as part of the end of year reporting process and are appended to this report for further review.

22. Conclusion

The Audit and Risk Committee has continued to be a well-functioning effective Board Committee throughout 2023/24 and has provided appropriate assurance to the Board.

Appendix 3

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2024

Trust Seal report

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 7 November 2023.

Executive Summary

The Trust's Standing Financial Instructions (point 8.18) state that 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.

These transactions will apply where the Board has previously approved the business through the Capital Expenditure Plan or the Estates 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 7 November 2023. Since the last report, the Trust Seal was used as follows (where the contract value for these transactions exceeded £500,000 or where the nature of the transaction required a seal, ordinarily property transactions such as deeds or leases):

- DHCFT/105 (16 November 2023) Contract Variation - perinatal
  (1) NHS England
  (2) Derbyshire Healthcare NHS Foundation Trust
- DHCFT/106 (24 November 2023) Contract for provision of adult integration substance misuse treatment service (Drug and Alcohol)
  (1) Derbyshire Healthcare NHS Foundation Trust
  (2) Derbyshire County Council
- DHCFT/107 (8 December 2023) Engineering and Construction contract – refurbishment of Bluebell ward at Walton Hospital
  (1) Derbyshire Healthcare NHS Foundation Trust
  (2) Stepnell Ltd
- DHCFT/108 (14 December 2023) Agreement for lease with tenant's fitting out works at Blue Side, Walton Hospital, Whitecotes Lane, Chesterfield
  (1) Derbyshire Healthcare NHS Foundation Trust
  (2) Derbyshire Community Health Services NHS Foundation Trust
- DHCFT/109 (12 January 2024) Impact MHLP subcontract for the provision of specialised mental health services for use with the NHS standard contract 2022/23
  (1) Nottinghamshire Healthcare NHS Foundation Trust
  (2) Derbyshire Healthcare NHS Foundation Trust
- DHCFT/110 (12 January 2024) East Midlands collaborative perinatal contract – NHSE East Midlands to Derbyshire Foundation Trust as lead provider for perinatal services

- DHCFT/111 (27 February 2024) Chesterfield Royal Hospital NHS FT (CRHFT) contract extension – 1 April 2024–31 March 2025 (from 2018-2020) contract
  (1) Chesterfield Royal Hospital NHS Foundation Trust
  (2) Derbyshire Healthcare NHS Foundation Trust
- DHCFT/112 (27 February 2024) Rent review Memorandum, Landlord – Trillium Property Trading Ltd, Tenant – Derbyshire Healthcare NHS Foundation Trust, Property – St Andrew's House, London Road, Derby
- DHCFT/113 (11 March 2024) Inter-trust contract with University Hospitals of Derby and Burton NHS Foundation Trust as provider of clinical services for use with the NHS standard contract 2023/24
  (1) University Hospitals of Derby and Burton NHS Foundation Trust
  (2) Derbyshire Healthcare NHS Foundation Trust
- DHCFT/114 (11 March 2024) Risk and incentive agreement between:
  (1) Nottinghamshire Healthcare NHS Foundation Trust
  (2) Derbyshire Healthcare NHS Foundation Trust
  (3) Leicestershire Partnership NHS Trust
  (4) Lincolnshire Partnership NHS Trust
  (5) Northamptonshire Healthcare NHS Foundation Trust
  (6) St Andrews Healthcare
- DHCFT/115 (28 March 2024) Contract Variation CV01 – Phoenix, City, financial adjustment, City misuse contract 2023
- DHCFT/116 (5 April 2024) Contract Variation:CV01 Extension of P3 contract
- DHCFT/117 (19 April 2024) IAPT (Improving Access to Psychological Therapies) 2022/23
  (1) Derby and Derbyshire Integrated Care Board
  (2) Derbyshire Healthcare NHS Foundation Trust
- DHCFT/118 (19 April 2024) IAPT 2023/24
  (1) Derby and Derbyshire Integrated Care Board
  (2) Derbyshire Healthcare NHS Foundation Trust
- DHCFT/119 (19 April 2024) ICB Main contract 2023/24
  (1) Derby and Derbyshire Integrated Care Board
  (2) Derbyshire Healthcare NHS Foundation Trust
- DHCFT/120 (29 April 2024) Contract for the provision of adult integrated drug and alcohol treatment and recovery services
  (1) Derbyshire Healthcare NHS Foundation Trust
  (2) Phoenix Futures

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	X
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long-term sustainability.	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 the last report to the Board on 7 November 2023 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: **Jo Bradbury**
Corporate Governance Officer

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board May 2024

Board Assurance Framework (BAF)
Issue 1, 2024/25 – Version 1.3

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the first issue of the BAF for 2024/25.

Executive Summary

Director Leads, Deputy Directors, Directors of Operations, Operational Leads and Trust Senior Managers have reviewed the risks to the Trust's strategic objectives for 2024/25 and provided comprehensive updates for the new issue of the BAF.

All risks included in the final version of the 2023/24 BAF have been carried forward to the 2024/25 version.

Changes to the Board of Directors have been implemented from 01.04.24; these changes impact on risk and actions allocation and are noted on the BAF:

- Lee Doyle and David Tucker are removed as Interim Executive Directors of Operations (DO)
- Vikki Ashton Taylor, previously Director of Strategy, Partnerships and Transformation (DSPT) is now Deputy Chief Executive / Chief Delivery Officer (CDO)
- Justine Fitzjohn, previously Trust Secretary, is now Director of Corporate Affairs and Trust Secretary (DCA)
- Dave Mason, Interim Director of Nursing, Allied Health Professionals (AHP) and Patient Experience: 'AHPs' is an addition
- Rebecca Oakley, Interim Director of People, Organisational Development and Inclusion (DPOI): 'Organisational Development' is an addition.

The main updates to the risks are as follows:

Target dates to fulfil actions to close gaps in control have been updated as year-end where definite completion dates are required. Some actions are on-going so quarterly review dates are set to monitor progress (review dates in brackets).

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 root causes have been reviewed to ensure they are current and relevant for the year 2024/25. In version 1.1, root cause B was stricken through, but the Audit and Risk Committee requested it was reinstated in light of the recent clinical demand pressures in acute areas and the potential risk to patient safety. This was agreed by the Director of Nursing, AHPs and Patient Experience.

A key gap in control relating to the ability to complete physical healthcare checks has been removed as this is no longer relevant.

Risk 1B – 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

One action to close a key gap in controls (relating to the preparation of Audrey House as a decant ward) has been closed as it was no-longer required.

The Trust is on track to open acute wards/high dependency unit in November 2024 and PICU in March 2025.

Risk 1C - 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

Business continuity plans are in place. The revised business continuity policy is expected to be ratified in April 2024.

Risk 1D - There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur

The Trust is on track to open acute wards/high dependency unit in November 2024 and PICU in March 2025.

Risk 2A – There is a risk that we are unable to create the right culture with high levels of staff morale

An action relating to the percentage of leaders attending local, system or national leadership programmes was achieved in 2023/24 so this has been removed.

Risk 2B – There is a risk that we do not have a diverse workforce with the right number of people with the right skills to support and deliver safe high-quality care

The progress notes have been reviewed to leave what is relevant to 2024/25, all previous version/notes are archived.

Risk 3A – There is a risk that the Trust fails to deliver its revenue and capital financial plans

Reference to the VAT abatement issue has been removed as this was resolved.

Contributing factors and actions relating to key gaps in control have been updated to reflect the financial position at the start of 2024/25.

Risk 4A – 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 may impact negatively on the cohesiveness of the Derbyshire health and care system

Assurances on controls have been updated to ensure the external sources are current.

Risk 4B – There is a risk of reputational damage if the Trust is not viewed as a strong partner

Measures of progress relating to improved working with Police partners have been updated to ensure they are relevant for 2024/25.

A further update was added to the first key gap in control, at the request of the Audit and Risk Committee.

Risk MS1 – 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

The progress notes have been reviewed to leave what is relevant to 2024/25, all previous version/notes are archived.

Operational Risks

One high level operational risk has been removed from Risk 1A:

- *Risk of treatment breaks/missed doses due to reauthorisation of repeat templates*

Although the risk remains, improvements have been made in working with community team prescribers and the impact on the Pharmacy team has lessened. The risk has been reduced to moderate and remains on the Trust-wide risk register (reviewed by the Executive Leadership Team (ELT).

BAF Reporting Cycle/Format – all changes/updates to this issue of the BAF, compared with Issue 4 2023/24, are indicated by blue text. All text that has been stricken through will be removed from the next issue (Issue 2 2024/25).

Version 1.1 was reviewed by ELT on 9 April 2024. Version 1.2 was approved by the Audit and Risk Committee on 25 April 2024. A request for Quality and Safeguarding Committee to thoroughly review Risk 1A, the root causes and assurances was made.

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	X
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long-term sustainability.	X

Risks and 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

- Executive Directors
- Deputy Directors
- Directors of Operations
- Operational Leads
- Managing Directors
- General Managers
- Operational Risk Handlers

Formal Reviews

- Executive Leadership Team, Issue 4.1: 9 April 2024
- Audit and Risk Committee, Issue 4.2: 25 April 2024

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 & 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 Trust Board is requested to:

1. Review and approve this first issue of the BAF for 2024/25 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**
Director of Corporate Affairs and Trust Secretary

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

Board Assurance Framework 2024/25 – Issue 1.3 Board May 2024

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

Ref	Risk	Director Lead	Risk Rating	Responsible Committee
Strategic Objective 1 - To Provide GREAT Care in all Our Services				
24-25 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	Executive Director of Nursing, AHPs and Patient Experience (DON) / Medical Director (MD)	**HIGH**	Quality and Safeguarding Committee
24-25 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) – Currently Interim Executive Directors of Operations (DO)~~ Chief Delivery Officer (CDO)	**HIGH**	Finance and Performance Committee
24-25 1C	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	~~Chief Operating Officer (COO) – Currently Interim Executive Directors of Operations (DO)~~ Chief Delivery Officer (CDO)	**MODERATE**	Finance and Performance Committee
24-25 1D	There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur	Executive Director of Nursing, AHPs and Patient Experience (DON) / ~~Chief Operating Officer (COO) – Currently Interim Executive Directors of Operations (DO)~~ Chief Delivery Officer (CDO)	**MODERATE**	Quality and Safeguarding Committee
Strategic objective 2 – To be a GREAT Place to Work				
24-25 2A	There is a risk that we are unable to create the right culture with high levels of staff morale	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee
24-25 2B	There is a risk that we do not have a diverse workforce with the right number of people with the right skills to support and deliver safe high-quality care	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee
Strategic Objective 3 – To Make BEST Use of Our Resources				
24-25 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans	Executive Director of Finance (DOF)	**EXTREME**	Finance and Performance Committee

Strategic Objective 4 – To be a GREAT Partner				
24-25 4A	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 may impact negatively on the cohesiveness of the Derbyshire health and care system	~~Director of Strategy, Partnerships and Transformation (DSPT)~~ Chief Delivery Officer (CDO)	**MODERATE**	Trust Board
24-25 4B	There is a risk of reputational damage if the Trust is not viewed as a strong partner	~~Director of Strategy, Partnerships and Transformation (DSPT)~~ Chief Delivery Officer (CDO)	**MODERATE**	Trust Board

Strategic Objective 1 – To Provide GREAT Care in all Our 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, increasing risks in the clinical and medical workforce
b) Risk of substantial increase in clinical demand in some services
~~c) Changing demographics of population and substantial impacts of inequality within the deprived areas 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, with escalating risks in alcohol consumption~~
g) Lack of compliance with physical healthcare monitoring in primary and secondary care, not at the required level for reductions in mortality
h) Restoration and recovery of access standards in autism and memory assessment services
i) Lack of appropriate environment to support high quality care, i.e. single gender dormitories and PICU leading to out of area (OOA) bed use for PICU
j) 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
k) Due to the move in Electronic Patient Record (EPR) system there is potential that data quality could adversely affect clinical standards
~~l) Violent crime in the community, sexual safety incidents and youth violent crime all increasing~~
m) Health inequalities across Derbyshire. Initial insights show gaps in access to service, case load and worsening patient outcomes for our patients
n) Sustained pressure in the crisis and acute care pathway with bed occupancy over 85% and increased waiting time for patients to access bedded care from the community
~~o) Cost of living crisis with post pandemic surge in June 2023. Sustained increases in referrals since January 2023, (20% addition)~~
p) Gaps in Advocacy for Children who are under 18
q) ~~Learning~~ Capacity to learn from other organisations in their ability to maintain adequate mortality, serious incidents and learning reviews to respond to improve practice and to also comply with the coroner's formal requirements
~~r) Emerging increase in pressure on services, as a result of inappropriate use of technology and social media~~

BAF Ref: 24-25 1A	**Director Lead**: Dave Mason (Interim DON) / Dr Arun Chidambaram (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	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; monitoring and effective responses to infection and control guidance, EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits in and out of hours and Board visits
Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints and risk investigation; clinical audit; 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, reviewed model of announced and unannounced visits to service throughout the 24-hour period
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; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment Head of Nursing and Matron compliance visits Board visits and out of hours 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 Trust fully compliant with National Quality Board Learning from Deaths guidance ~~Transitional Monitoring~~ Relationship Meetings with CQC (in planning ~~bi-monthly~~) Patient Safety Incident Response Framework (PSIRF) implementation

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Summary of progress	Action rating
~~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~~	~~31.03.24~~	~~Revised metrics now form part of the quality dashboard and are reported regularly to the Quality and Safeguarding Committee~~ ~~Implementation of coaching and self-report pilot model of care underway to improve compliance and patient empowerment via the Health Protection Unit~~	~~AMBER~~

				~~Targeted actions now in place across all service lines to improve on physical health checks~~ ~~360 Assurance audit completed and actions implemented~~ ~~Quality improvement targeted work in September 2023, which has demonstrated improvement in clinical standards~~	
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	~~31.03.24~~ 31.03.25	Following the CQC inspection of ward 35, the Trust has reviewed its governance structures relating to meeting the fundamental standards Quality Surveillance Dashboard revised (programme of ward visits which are assessed against the CQC's single assessment framework) A CQC/Fundamental Standards Trust Oversight Group has been established, which scrutinises progress of actions arising from regulatory inspections and Mental Health Act visits and provides sign-off of completed actions	AMBER

				DARs have been reviewed and going forward will become Divisional Performance Reviews (DPRs) and the Trust Leadership Team (TLT) group has been reviewed and will provide a combined quality and operational function	
Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment services ~~Waiting time increased over Covid-19 period, exacerbated by underlying demand – ASD diagnostic waiting lists remain high~~	Investment required by ICS to meet assessment and treatment demands [ACTION OWNER~~S~~: CDO~~DO/DSPT~~]	Agreed funding allocation has occurred, recruitment to posts is active	~~(31.03.24)~~ (30.06.24)	Commissioned target of 26 assessments per month now being sustainably exceeded. Discussions underway with ICB commissioners and executives on next steps to bolster ASD investment through contractual changes. Positive engagement session with GPs on their role in future pathways including need to include ADHD	AMBER
Six service areas were assessed as 'Requires Improvement' by CQC in relation to safety	Develop and implement an improvement plan to promote self-assessment and Trust-wide quality surveillance ~~enable all six service areas to reach 'Good' for safety in relation to the CQC standards~~ [ACTION OWNER: DON]	Internal reporting against self-assessment CQC inspection and assessment as a measurement tool	~~31.03.24~~ 31.03.25	Significant improvement in all services ~~Three CQC actions remain open due to intermittent compliance~~ Following the CQC inspection of ward 35, the Trust has reviewed its governance structures relating to meeting the fundamental standards Quality Surveillance Dashboard revised	AMBER

				(programme of ward visits which are assessed against the CQC's single assessment framework). A CQC/Fundamental Standards Trust Oversight Group has been established, which scrutinises progress of actions arising from regulatory inspections and Mental Health Act visits and provides sign-off of completed actions DARs have been reviewed and going forward will become Divisional Performance Reviews (DPRs) and the Trust Operational Oversight Leadership (TLT) group has been reviewed and will provide a combined quality and operational function	
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/CDO]	Improvement in operating standards compliance to be overseen by the Trust's CQC oversight group. To be confirmed by internal assessments against the new self-assessment framework and ultimately via external CQC inspection and assessment ~~of at least 'Good'~~ Accreditation for Inpatient Mental Health Services (AIMS) to be completed by end of Quarter 3 2023/24	~~31.03.24~~ 31.03.25 ~~(31.03.24)~~ (30.06.24)	Increased performance management scrutiny and unannounced site visits undertaken with compliance checks ~~Mock inspections completed in acute services, there is support for the areas requiring improvement~~ Mock inspections and CQC assurance forums continue	AMBER

	Implement Community Mental Health Framework [ACTION OWNER: CDO ~~DSPT~~]	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	~~31.03.24~~ 31.03.25	Work being carried out to become accreditation ready ahead of the implementation of the shift consultation to ensure compliance with European Working Time Directive (required as part of an accreditation application) Policy and Standard Operating Procedure (SOP) for Derbyshire Living Well and Derby Wellbeing Services is published. Internal Trust programme Board in place to strengthen contribution and involvement in system-wide programme and delivery Mobilisation underway in High Peak, ~~and~~ Derby City, ~~Current phase is~~ Chesterfield and North-East Derbyshire ~~(Quarter 3 2023/24)~~. System Programme Team now established following vacancies ~~Next~~ Final stage of mobilisation is underway in Amber Valley, Erewash, South Derbyshire and Derbyshire Dales –	

				Completion at end of March 2024 ~~Planned for Quarter 4 2023/24~~	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times	Develop and implement an improvement plan [ACTION OWNERS: MD/DON/CDO/~~DSPT~~]	Compliance with suite of metrics and reporting schedule	~~(31.03.24)~~ (30.06.24)	~~NICE guideline mapping established, governance work continues~~ ~~Programme of work in place from Performance Summit continues to progress~~ ~~RAP plans in place and regularly reviewed~~ The re-launched Divisional Performance Reviews commence in April. The DON is working on the development of a new clinical quality dashboard	AMBER
Implementation of new quality priorities for: - Sexual safety - Implementing CQUINS and Clinical outcome measures - Recovering services – equally well - New Trust strategy and priorities - Dormitory eradication programme	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	~~31.03.24~~ 31.03.25	The Trust has developed a ~~is developing~~ a sexual safety plan and has ~~agreed to~~ signed up to the sexual safety charter Sexual safety – Improvement work (dashboard, preceptorship training and protocols) commenced. Sexual safety on professional standards video launched with new training Sexual safety checklist for services in design	GREEN

				Dormitory eradication programme in construction Trauma informed practice conference and work programme commenced in May 2023. Trauma lead in post for six months to develop training and strategy Plan for existing dormitory stock and to maintain and improve dignity for active bed stock assessed and presented to the ICB	
~~There is a risk that patients in our care in Derbyshire or commissioned services may receive poor care due to experiencing abuse or professional misconduct.~~ Learning from other independent and national exposures of abuse presents the challenge that we need to have in place to identify poor or concerning behaviour	Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected [ACTION OWNERS: DON/MD]	~~Engagement and mobilisation of the organisation to discuss~~ Communication and effectively responding to learning from recent exposes Mobilise and emphasise expectations of standards of care and Freedom to Speak Up ensuring that staff are aware of how to raise concerns ~~Discuss and activate colleagues to revisit what compassionate care means and actively encourage, inspire, reward – Supervision, reflective practice and asking for help~~ ~~Mobilise and re-emphasise expectations of standards of care and Freedom to Speak Up~~	~~31.03.24~~ (30.06.24)	~~Wide range of~~ Options for ~~colleagues~~ staff to have conversations about care delivery and raise concerns available ~~available,~~ include~~ing~~ Trust-wide and divisional engagements, Freedom to Speak Up, Schwartz Rounds Improvements in engagement of temporary staff identified Increased visibility of senior staff through Board visits and mock CQC inspections and out of hours visits Robust oversight of patient safety incidents,	AMBER

		~~Revisit system and process of governance and using intelligence to take oversight of services~~ ~~Inspire~~ Facilitate conversations on the risks of harm and closed cultures. Reset the culture and the tone of the requirement for professional scrutiny and all employee requirements to prevent harm and report poor care/ abuse Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so colleagues feel empowered to report any concerns Professional leads are in place to ensure that registered professional staff are aware of the requirements to practice in line with their professional codes To work in accordance with the multi-agency policy relating to PIPOT ~~Review reports and allegations in multi-disciplinary manner and include safeguarding and security specialist with effective recording and monitoring~~		concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee External partnership working including Healthwatch, Advocacy services and statutory services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board Trust-wide Learning, Culture and Safety Group launched ~~established~~, providing oversight of teams/services with repeating patterns for improvements to be made	
Clinical improvement in the current use and transformation of Care Programme Approach	Identify the Trust's preferred alternative model to replace CPA	Review of changes to national policy to replace CPA	~~31.03.24~~ 31.03.25	Ongoing oversight of CPA continues with focus on care planning and risk assessment	AMBER

(CPA), to support safe community practice	Establish transition plan which includes communications and training strategy and clear timeline for go live of the new system and detailing when use of CPA will cease Implement an improvement plan to enable all services to provide the highest standard of care [ACTIONS OWNERS: DON/MD]	Safe and effective practice is in place		Planning discussion has taken place in relation to the transition from CPA to the preferred alternative model, Dialogue Plus Fundamentals of Care group oversight of key core aspects of CPA CPA training continues at present until alternative identified	
Clinical improvement in the current practice standards for new mental health in-patient standards released by NHS England	Scrutinise new practice standards and develop a new improvement plan, which establishes the Trust's baseline position against the standards, identifies the gaps in compliance and details specific actions needed to achieve the standard, to enable all services to provide the highest standard of care [ACTION OWNERS: DON/MD]	Review new standards and new reporting requirements with the clinical improvement team	~~31.03.24~~ (30.06.24)	~~Review of new standards underway~~ Commencement of the implementation of the national in patient standards from January 2024. Arrangements in place for the national lead to present to the executive team and operational leads in March 2024 ~~Request for Trust to become pilot site for new standards framework, once formally available~~	AMBER
Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To consider a reset of the Trust clinical strategy	Scrutinise new policy direction and develop new plans Routinely review incidents for learning in suicide prevention including cluster analysis and benchmarking [ACTIONS OWNERS: DON/MD]	Adjust strategy and policy to meet requirements Undertake a cluster analysis of in-patient and acute care pathway deaths	~~31.03.24~~ (30.06.24)	Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities for 2024/25 focusing on prevention and oversight, linked to new strategies	AMBER

				Trust clinical strategy to be reviewed and implemented and to include relevant national strategies	
Review of Patient Carer Race and Equality Framework and develop implementation plan	Revisit new policy direction and develop new plans [ACTION OWNER: MD]	Review framework and develop implementation plan	~~31.03.24~~ (30.06.24)	Patient Experience Strategy event completed Patient Experience Strategy to be renewed, with the voice of patient and carers at the forefront, ensuring race and equality clearly referenced	AMBER

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	20.06.23: There has been no increase in budget but the team now at a full complement of staff after a long period of shortages due recruitment problems and sickness. The team are making changes to pilot alternative assessment processes which should be faster but are admin-heavy. Additional funding has been provided on a one-year basis to employ someone who can complete some research to evaluate the changes that are going to be implemented 09.01.24: Pilot assessment is continuing and waiting list has reduced to 2.5 years. Outstanding risks - Waiting time continues to be above NICE targets. Risks mainly related to continued complaints about waiting times and criticism in national press	01.01.16	01.04.24	HIGH
22790	Corporate Services – Pharmacy	Prescribing Valproate to women of child-bearing potential: Failure to comply with regulations	24.05.23: ePMA now deployed to all services in the Trust which will help with our understanding of valproate use and can be incorporated into planning. Reporting will need to be constructed as part of the optimisation of ePMA 01.03.24: Pharmacy team contributing to system-wide discussion and awaiting Trust medical presence at these meetings. Still highly likely that we are not adherent to national standards, with a risk of pregnancy affected by valproate	28.02.22	01.06.24	HIGH

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
Patient safety and dignity risks associated with dormitory in-patient bedded care
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

BAF Ref: 24-25 1B	**Director Lead**: ~~Lee Doyle/David Tucker (Interim DOs)~~ Vikki Ashton Taylor (CDO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 3	Impact 5	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; Infection, Prevention Control (IPC) 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; IPC policy and procedure

Assurances on controls – Internal	Assurances on controls – External
IPC risk assessments Health and Safety Audits Premises Assurance Model System (PAMS) reporting Estates Strategy	Mental Health Capital Expenditure bidding process External authorised reports for statutory health and safety requirements Estates and Facilities Management internal audit

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Deliver two new adult acute 54-bed units with ~~a~~ single room en-suite with additional staffing and new model of care ~~VAT abatement appeal – Combined capital funding shortfall risk of £14.2m if appeal unsuccessful~~ [ACTION OWNER: CDO]	Delivery of approved business cases	~~31.03.24~~ (30.06.24)	Two new build adult acute unit FBCs nationally approved September 2022, funded by £80m national PDC and £18.6m CDEL. ICS supported and approved revenue funding Delay in national approval and redesign of foundations. Planned to go live November 2024 ~~HMRC appeal on VAT abatement concluded - Abatement agreed for Adult Acute Units~~	AMBER
	Older Adult service relocation to refurbished ward with single room en-suite and gender segregation, with additional staffing and new model of care, by September 2024 to eradicate dormitories in Northern Derbyshire and avoid the 12-bed service being isolated in otherwise vacated wards National PDC capital funding approval [ACTIONS OWNER: CDO]	Delivery of approved business case	~~31.03.24~~ (30.06.24)	Older Adult service relocation FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Scheme re-tendered due to affordability, refurbishment started on site December 2023~~, planned go-live August 2024~~. This aspect of the project is progressing well and on track to open Bluebell Ward in August 2024	GREEN
	~~Audrey House refurbishment as decant ward to enable Radbourne Unit dormitory eradication refurbishment.~~	~~Delivery of approved business case~~	~~(31.03.24)~~	~~National PDC capital funding approved by NHSE~~	~~GREEN~~ BLUE

	~~Dormitories cannot be fully eradicated without use of this decant ward~~ ~~National PDC capital funding approval [ACTIONS OWNER: DO]~~			~~No longer required for decant, completion as enhanced care unit November 2023, go-live November 2024~~ ~~Decant ward no longer required as alternative solution sourced. Audrey House has been refurbished and available to be operational whenever required. Planned opening November 2024~~	
	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire. Service users continue to receive care in non-compliant wards until this refurbishment is completed National PDC capital funding approval [ACTIONS OWNER: CDO]	Delivery of approved business case	~~(31.03.24)~~ (30.06.24)	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE ~~December 2022.~~ Radbourne Ward 32 refurb commenced November 2023 – January 2025 and live March 2025~~. Refurb~~ Ward 35 refurb scheduled January 2025 – March 2026, subject to funding live April 2026 ~~Significant cost pressure being actioned, contracts split, Ward 32 continuing as planned whilst cost pressure resolved for Ward 35~~	RED
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) ~~£3.5m national capital agreed November 2022. Derbyshire CDEL flexibility agreed~~	Agreed programme of work with capital funding to support it	~~(31.03.24)~~ (30.06.24)	FBC approved by ICS ~~in June 2022~~ PICU fully funded by national and Trust capital ~~November 2022. HMRC appeal on VAT abatement sufficient for~~	AMBER

	~~for Trust to fund £10.9m remaining capital from cash reserves 2022/23 and 2023/24. VAT abatement risk~~ National PDC capital funding approval [ACTIONS OWNER: CDO]			~~PICU. Practical~~ On track and expected to be operational March 2025 ~~completion expected November 2024, live March 2025. Audrey House Enhanced care Unit national PDC capital funding approved by NHSE December 2022 – Goes live November 2024~~	

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 1 – To Provide GREAT Care in all Our 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

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 and~~ flu vaccination, health risk assessments

BAF Ref: 24-25 1C	**Director Lead**: ~~Lee Doyle/David Tucker (Interim DOs)~~ Vikki Ashton Taylor (CDO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	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. Security and Protection Policies and Procedures. Business continuity ~~plan~~ policy and procedure

Assurances on controls – Internal	Assurances on controls – External
IM&T Strategy delivery update to F&P – Annual Embedded programme of software and hardware upgrades Live testing of business continuity plans	Templar Cyber Organisational Readiness Report (CORS) Annual external cyber review by Dynac (vulnerability scan) Data Security and Protection (DSP) annual review by Internal Audit Compliance with DSP Toolkit; high levels of training compliance

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
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: CDO]	Reporting to the Divisional ~~Achievement~~ Performance Reviews (~~DARs~~DPRs)	~~(31.03.24)~~ (30.06.24)	~~The majority of Business Impact Analyses have been received and are subject to quality spot checks. Business Continuity Plans to be developed by mid-January – Drafts received from some divisions~~ ~~EPRR Steering Group to monitor and updated TLT in November 2023. Overdue plans have been followed up, with revised trajectory for completion in line with core standards feedback in Quarter 4~~ Business impact assessments collected. Business continuity training for Trust leads starts March 2024. Revised business continuity policy - Ratification expected April 2024. Wider business continuity work (e.g. Audit) will take place in Quarter 2 as part of the EPRR Core Standards Recovery Action Plan	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 1 - To Provide GREAT Care in all Our Services

There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur

Impact: May adversely impact on regulatory requirements to provide safe and quality care. Patients' dignity and privacy may be impacted. Enforcement regulatory notices may issued against the Trust that may impact on Trust reputation and restrictions to capital could be applied.

Root causes:

a) There was commitment across mental health services to eradicate dormitories by 2022 – Although the Trust has active plans for Making Room for Dignity with a fully funded programme, with the building and infrastructure commencing, the Trust has not delivered in the set timeframes
b) Infrastructure does not comply with current standards
c) Outdated approach of delivering mental health care in dormitories does not comply with current guidance
d) Dormitories compromise patient privacy and dignity due to the dormitory layout
e) Dormitories do not comply with Infection, Prevention and Control (IPC) guidance
f) Dormitories could compromise Health and Safety regulations and increase risks, e.g. fire safety
g) Dormitories are not therapeutic spaces to provide mental health care in

BAF Ref: 24-25 1D	**Director Lead**: Dave Mason (Interim DON) / ~~Lee Doyle/David Tucker (Interim DOs)~~ Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Initial risk rating			Current risk rating			Target risk rating			Risk appetite		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Moderate 3	High 4	Accepted	Tolerated	Not Accepted

Preventative – Screening of each admission considering safety, care and infection control needs supported by the infection control team, health and safety audits; risk assessments; physical health care screening and monitoring; Maintaining environments and cleaning, Director and senior leader visits. Board visits. Quality governance structures, teams and processes to identify quality related issues. EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Mock inspections
Detective – Quality dashboard reporting; Board visits 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, reviewed model of announced and unannounced visits to service throughout the 24 hour period, cleaning schedules and maintenance logs. Compliance to Delivering Same Sex Accommodation requirements
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; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee, Making Room for Dignity programme

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards Bed Management processes Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits Infection Control Board Assurance Framework reported to NHSE Positive and Safe self-assessment Head of Nursing/Matron compliance visits Cleaning and maintenance schedules IPC training Level 1 and 2 Trust targets of 85% compliance	Delivery of Same Sex Accommodation Guidance 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 Estates and Facilities Management internal audit Transitional Monitoring Meetings with CQC (bimonthly) Patient Safety Incident Response Framework (PSIRF) implementation Monitoring of IPC standards compliance and reporting – ICS IPC Team

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Inpatients care is delivered in wards with dormitories, that compromise on patient dignity, privacy and effective IPC practice	Implement bed management process that ensure that admissions are screened to comply to gender, safety and IPC requirements Ensure that the environments are routinely check by clinicians, estates, and domestic staff Infection Prevention and Control monitoring, and training compliance Effective monitoring of the clinical environments by clinical, estates and domestic staff [ACTIONS OWNERS: DON/CDO]	Monitor and report breaches of same sex admission breaches Monitoring of maintenance and cleaning schedules Head of Nursing and Matron environmental walk abouts Infection and Prevention and Control reports and monitoring of infections Individual screening of admissions to appropriate ward environments to ensure gender needs, safety needs and IPC needs are met Provision of other rooms for privacy and confidentiality	31.03.25	Head of Nursing and Matron reviews routinely conducted Level 1 and level 2 IPC training are above compliance target Fully funded programme of work in place: 'Making Room for Dignity'. Construction started in Chesterfield and Derby. Designs have been co-produced with construction experts, clinicians, carers, patients and people with lived experience~~. The new environments will require more staff – Recruitment is underway~~ Launch of amended gatekeeping and purposeful admission process expected in April 2024. This will further develop robust bed management processes	AMBER

				Ward Health Check forums relaunched to monitor range of metrics including training compliance	

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 are unable to create the right culture with high levels of staff morale

Impact: This could impact on the wellbeing and motivation of our people as well as the quality and effectiveness of the services we provide. This could also impact on our ability to recruit as well as maintain staff, with a potential negative impact on the broader reputation of Derbyshire Healthcare

Root causes:

a) The changes being made to national terms and conditions and pensions in the current economic climate, create additional pressures for people
b) The staffing and work challenges lead to unhealthy working practices and hours of work
c) The levels and pace of change and transformation are unprecedented
d) The growth of, increasing complexity and sometimes unconnected national and regional ask in the People and Inclusion directorate
e) The level of change and turnover in the Board and senior leadership
f) The cost-of-living crisis is not matched by compensatory solutions in national terms and conditions
g) The capacity of leaders to focus on supporting, engaging and developing people
h) Lack of consistency and expectations of people leaders
i) Lack of strategic development pathway for leaders
j) The volatile work environments where staff can be exposed to harm and trauma
k) The delivery of wellbeing, leadership, occupational health and engagement is led at arms-length with delivery through joint arrangements with DCHS and UHDB
l) Legacy team issues exist in areas across the Trust
m) The need to develop cultural competence and confidence that is needed to value and create a sense of belonging for people of all backgrounds, ethnicities and with lived experience
n) The long-term lack of investment in Organisational Development and Equality Diversity and Inclusion (EDI) teams, practices and solutions
o) Historical dual approach to bank staff which leads to differential treatment
p) The potential erosion of benefits and differentiation enjoyed by Trust staff, for example car parking
q) Limited representation of staff within networks and no clear and consistent operating framework

BAF Ref: 24-25 2A	**Director Lead**: Rebecca Oakley (Interim DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

Initial risk rating			Current risk rating			Target risk rating			Risk appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	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
Detective – Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams
Directive – Joined Up Care Derbyshire (JUCD) People Strategy, National People Plan; People building blocks and priorities; Strategic people priorities, Communications Strategy, ICS People 5x7 plan

Assurances on controls – Internal	Assurances on controls – External
National staff survey and reporting into board, ELT and divisions Quarterly pulse check and action planning process Exit interview analysis and reporting	Benchmarking in mental health Trusts and at system level Staff survey analysis and reporting

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of planned leadership development growth, stretch programmes and opportunities including coaching and mentoring	Strategy developed to align to organisational leadership needs ~~Review of system level leadership offer and impact~~ Review and development of Trust leadership offer and impact Re-establish leadership forum Development of coaching access at local, system and national [ACTIONS OWNER: DPOI]	Percentage of leaders with development plan as part of objectives ~~Percentage of leaders attending local, system or national leadership programmes~~	~~(31.03.24)~~ (30.06.24) ~~Complete~~	~~Deputy Director of People is part of system leadership workstream to review current offer and develop 12 month plan on leadership offer – Draft proposal to be finalised~~ ~~New leadership programme (aimed at band 8B staff) completed~~ ~~Leadership forum revised and first forum took place December 2022 with monthly forums now planned throughout 2023. First face to face forum took place June 2023~~ Third cohort of Aspiring-2-Be leadership course launched	RED

				~~Second leadership conference October 2023 on Just and Restorative Culture for Leaders~~ Development of Leadership Development strategy has commenced to be ready ~~January~~ April 2024, being revised	
Fully embedded person-centred culture of leadership and management	Review of policies and processes to support a person-centred approach to leadership and management Introduce just and restorative culture approach Review of leadership development offer Re-establish line manager development sessions Scrutiny of people data at divisional level [ACTIONS OWNER: DPOI]	Reduced number of formal staff relations issues/cases reported in monthly people assurance report to ELT Staff survey results Reporting to TLT	~~(31.03.24)~~ (30.06.24)	Review of cases and case management reported to ELT bi-monthly with reasons for delays identified ~~Deep dive on employment review cases and processes took place at PCC in February 2023~~ ~~Respect policy published~~ ~~System funding secured for Just and Restorative Culture training programme and materials~~	AMBER
No operating framework through which to maximise the impact of staff networks	Collaboratively develop and Implement Staff Network Framework to provide consistency across the networks with clear framework, clarity of roles and objectives to increase engagement with under-represented staff Support to Bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager [ACTIONS OWNER: DPOI]	Engagement and buy-in by network Chairs Sign up to the framework by network Chairs and Executive Directors Annual updates by network Chairs of engagement undertaken to be included in annual reports	~~(31.03.24)~~ (30.06.24)	New executive model implemented in December 2022. Draft framework developed and engagement with key stakeholders commenced New EDI steering group established; meetings commenced Network chair meetings operating and attended by DPI and Head of EDI	AMBER

				~~Staff network conference held May 2023~~ Collaborative staff network actions agreed and regular meetings with chairs and vice chairs taking place to align power of staff networks on	
The current capacity and structure of the People and Inclusion directorate is not able to meet the Trust, system, regional and national demands alongside challenges from outsourcing key services via People Services in DCHS and UHDB	Review of current People and Inclusion structure to align to needs and priorities of Trust, identify gaps and develop plan to mitigate Review of gaps in services delivered by People Services or UHDB and develop accountability framework Formalise existing governance meetings to ensure clear processes in place for People and Inclusion Services contract and UHDB key service contracts Review of current communications and engagement and people priorities across the Trust and system [ACTIONS OWNER: DPOI]	A People and Inclusion structure that can support the Trust to deliver against the people priorities Accountability dashboard presented to ELT quarterly Terms of reference in place and regular meetings A People and Inclusion structure that can support system-wide priorities People and Inclusion staff survey results	~~(31.03.24)~~ (30.06.24)	Contract review meetings established for Occupational Health and Payroll Services (UHDB) New governance structure to be developed to manage the Joint Venture – Discussions commenced Monthly payroll contract meetings in place - Improvement Manager appointed by UHDB for six months to support contract, data and system standardisation	RED
Lack of maturity of EDI framework	Produce and implement EDI framework with clear legislative, and mandated NHS national regional and local deliverables required for the EDI function and structure to deliver [ACTIONS OWNER: DPOI]	Agree framework and capacity requirements to deliver Regular wider engagement with EDI Delivery Group, and divisional leads taking place Final presentation to PCC Roll out of framework Delivery against the People Performance Dashboard	~~(31.03.24)~~ (30.06.24)	Trust Reducing Health Inequalities Board now established, meeting with Trust-wide and system stakeholders to direct our response to reducing health inequalities Draft framework outlines measures	AMBER

We have not engaged with our Bank staff to develop a strong sense of belonging, engagement and psychological contract with the Trust	Regular monthly engagement sessions Staff survey participation Clinical supervision and appraisal participation Alignment to Agenda for Change for pay and conditions [ACTIONS OWNER: DPOI]	~~Staff survey participation response rates~~ Staff survey engagement scores Attendance at engagement sessions	~~Complete~~ ~~(31.03.24)~~ (30.06.24) ~~(31.03.24)~~ (30.06.24)	~~Engagement sessions held October 2022 to January 2023~~ ~~Partaking in first national bank staff survey~~ Aligned all bank staff bands 2, 3, 4 and 7 to Agenda for Change pay scales Band 5/6 bank pay approved for alignment to Agenda for Change Review of bands 2 and 3 roles on bank versus substantive roles and agreement on transition into band 3 with training - Complete Review of training competences for bank and agency commenced	AMBER
Lack of visible and differential staff benefits and responsive support for staff that reflects current working conditions, e.g., cost of living crisis	Review of gaps in benefits to realign to staff needs Review of current reward and recognition framework Develop range of staff benefits that align to Trust values and 'people first' approach Develop the salary sacrifice offer to support colleagues with cost of living crisis [ACTIONS OWNER: DPOI]	Staff survey engagement score Staff turnover Pulse check scores	~~(31.03.24)~~ (30.06.24)	Delivering Excellence Every Day awards (DEEDs) revised and re-launched System-wide discussions commenced regarding a benefits package ~~Mileage rates adjusted to reflect cost of living crisis~~ Review of lease cars with view to offer a more attractive rate as a retention tool completed Learning shared from UHDB survey on what matters most to colleagues when at work	AMBER

				Flexible working engagement programme planned for launch	
Inconsistency in application of an inclusive approach impacting on developing and sustaining a sense of belonging	Embed an inclusive approach, promoting equality and ensuring diversity at all levels through learning and development, Schwartz Rounds, personal development reviews, mid-year reviews, rewards and awards, objective settings [ACTION OWNER: DPOI]	Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks Data drawn from all engagement activities to identify impacts on staff experience and any inequalities that need to be closed	~~(31.03.24)~~ (30.06.24)	Work commenced - Divisional level EDI staff survey data shared with divisions. Divisional People Leads are leading discussions on actions on improvements and achievements	AMBER
Systematic planning and attendance of training	Training to be embedded in e-roster and designed to support safe staffing by minimising face to face sessions needed Progress the breaks and shift pattern change process [ACTIONS OWNER: DPOI]	Full compliance with safer staffing levels in line with NHSI Workforce Safeguards Training compliance in line with CQC requirements Staff survey health and wellbeing scores Comprehensive system and trust level health and wellbeing offer Compliance with NHSI workforce safeguards requirements Staff are able to take breaks and access the right health and wellbeing support E-roster team appropriately resourced and supported	~~(31.03.24)~~ (30.06.24)	New reporting processes in for TLT, PCC and Board – Now embedded with triangulation on staffing/agency/bank to be included at PCC Shift and break consultation being planned to commence ~~2023~~2024 Training lead meeting regularly with all service managers to review staff training plans Meetings scheduled with neighbouring mental health Trusts to compare training offers and delivery modes	AMBER

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 have a diverse workforce with the right number of people with the right skills to support and deliver safe high-quality care

Impact: May lead to reduced staffing levels and skill gaps which impact on safe staffing levels and addressing health inequalities in patient facing services and the ability of our supporting and corporate teams to support front line services

Root causes:

a. There are occupational shortages nationally which mean that the supply of staff is limited
b. There is fierce competition for professions between NHS providers for a limited number of people
c. People want to work more flexibly and a different approach to employment in 'generation z'
d. There is no embedded workforce planning across the NHS informing the supply chain
e. There is no connection between people and finance systems impacting on the ability to do real time effective planning
f. The long-term pandemic response and recovery and resultant pressures for staff has impacted on the attractiveness of careers in the NHS
g. The delivery of people services is led at arms-length through the joint venture with DCHS, with limited direct ability to manage demand
h. The transformation plans require the largest scaling of services and therefore workforce growth
i. Workforce models are not in place across the organisation
j. Lack of certainty of the final workforce requirements of Making Room for Dignity
k. A large proportion of the workforce is within 10 years of possible retirement
l. The demand and usage of bank staff has doubled in the last two years
m. Pressures on workforce development and Continued Professional Development (CPD) funding may risk ability to develop skills and expertise
n. Funding pressures not aligned with workforce demand
o. Inherent bias in processes, policy and approach which have led to disparity in the workforce
p. Historic challenges in attracting, retaining and progressing people from diverse backgrounds, with lived experiences and with disabilities into the NHS

BAF Ref: 24-25 2B	**Director Lead**: Rebecca Oakley (Interim DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

Initial risk rating			Current risk rating			Target risk rating			Risk appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Alliance, system and national Human Resources forums for sharing best practice and risk mitigation, website, workforce plan
Detective – People Performance Report in TLT, ELT and PCC; Bank Improvement Group; Combined Delivery Group with multi-disciplinary team (MDT) input; Medical Staffing Group, Sustainability Meeting; FTSU culture; exit interview process stay interview process
Directive – People building blocks; strategic priorities; 5x7 System People Priorities; JUCD Careers Team; JUCD and People and Inclusion meeting; recruitment policy and procedure; TRAC recruitment system; safe staffing plans

Board Assurance Framework 2024/25 – Issue 1.3 Board May 2024

Assurances on controls – Internal	Assurances on controls – External
People Performance Report in TLT, ELT and PCC People Dashboard in PCC PCC forward plan and deep dive plan Workforce plan Embedded recruitment and retention scheme	Healthcare Support Workers (HCSW) submissions System operational planning process Safe staffing report

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data Establish a workforce transformation group to develop workforce development plans and ownership at divisional level [ACTIONS OWNER: DPOI]	Vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs	~~(31.03.24)~~ (30.06.24)	~~Workforce transformation group commenced 2022 - Divisional workforce plans being developed to support 2023/24 workforce plan~~ ~~System workforce conference took place February 2023 with key speakers from DHCFT~~ ~~Workforce summit held August 2023 to review new roles and implementation. Divisional workforce plans and associated actions were reviewed~~ ~~2023/24 Trust workforce plan developed and presented at PCC~~ Work commenced to map apprenticeship plan and resources required Agency reduction plan in place	AMBER

We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts [ACTIONS OWNER: DPOI]	Career conversations taking place Internal appointments/promotions Turnover rate Key staff survey measures	~~(31.03.24)~~ (30.06.24)	Talent Strategy finalised Pilot launched for senior leaders in January 2023 – Phase one meetings with each executive taking place Deputy DPOI is system lead on talent management System appraisal developed to support system movements and talent management	RED
Lack of capacity, experience and plans for recruiting overseas	Develop International Recruitment (IR) plan and programme Appoint IR team to lead programme Engage with national IR support Access national IR funding Support Trust teams to prepare for IR arrivals [ACTIONS OWNER: DPOI]	Number of IR appointments Retention rate of IR	~~(31.03.24)~~ (30.06.24)	~~Funding secured for four IRs~~ Regular meetings established with midlands IR lead System AHP IR bid successful IR pastoral support officer appointed Clinical Educator of IR appointed Recruitment and Retention Lead appointed	RED
Onboarding and Retention process and planning needs to be embedded	Understand the key retention issues for posts/teams/professions with the highest turnover Ensure 'stay conversations' form part of regular 1:1s Develop NHS retention framework for nursing [ACTIONS OWNER: DPOI]	Improvements to turnover Staff survey engagement scores	~~(31.03.24)~~ (30.06.24)	~~'Stay' survey piloted with Allied Health Professionals and 1-2 year starters~~ ~~New starter survey completed with all started in six months and learning shared at Trust and divisional level~~ Nursing retention framework self-assessment completed	AMBER

				System retention lead appointed to support Trust level and system work Recruitment and Retention Lead appointed	
Medical staffing team and role not sufficiently developed Workforce plan for medical staff not in place	Review existing medical staffing team and workforce support and identify gaps Develop new model to support and maximise the medical workforce Develop medical agency model to ensure efficient usage Develop a medical staff workforce plan [ACTIONS OWNER: DPOI]	Engagement of medical workforce Reduction in agency spend	Complete ~~(31.03.24)~~ (30.06.24)	~~Terms of reference agreed by MD and DO for review of existing medical staffing team and creation of a medical workforce plan. Resources identified and funding agreed for the review by ELT~~ ~~First medical staffing workshop completed March 2023~~ Further discussions held as part of the agency summit – Agreed action to support agency reduction	AMBER
Lack of culturally competent recruitment processes	Completion and implementation of recommendations of the Above Difference recruitment and retention system pilot Wider engagement with recruiting managers, staff networks, clinical leads and operational leads Quartile monitoring of utilisation of Above Difference recruitment and retention tools Continuous improvement approach to implementing learning [ACTIONS OWNER: DPOI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	~~(31.03.24)~~ (30.06.24)	Recruitment leads across the system all trained through Above Difference programme ~~Pilot nearing completion with six workstreams completing key learning to be shared at future system human resources meeting to agree actions and programme management to move forward at pace~~ ~~Examples of innovation already being trialled such as one page job description being piloted by two teams~~	AMBER

Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPOI]	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	~~(31.03.24)~~ (30.06.24)	~~KPI review commenced~~ ~~Indeed piloted for hard to fill posts in acute~~ ~~Cohort recruitment successfully piloted for Health Care Assistants and Human Resources apprenticeships~~ ~~System recruitment post approved with funding to pilot a cohort recruitment approach including writing inclusive adverts and job descriptions~~ Trust Strategic Recruitment and Retention Lead appointed	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 3 – To Make BEST use of Our Resources

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) 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. System financial position resulting in required additional financial savings to support the System position from Mental Health funds
b) Non-delivery of expected financial benefits from transformational activities
c) Non-delivery of required levels of efficiency improvement
d) Lack of sufficient cash and working capital
e) Loss due to material fraud or criminal activity
f) 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
g) Costs to deliver services exceed the Trust financial resources available
h) Lack of cultural shift/behaviours to return to financial cost control regime
i) Inability to reduce temporary staffing expenditure

BAF Ref: 24-25 3A	**Director Lead**: James Sabin (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Appetite		
Moderate	Likelihood 2	Impact 5	Extreme	Likelihood 4	Impact 5	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

Preventative – Integrated Care System (ICS) signed off and fully support the dormitory eradication programme. Devoted and adequate team for Programme delivery. High quality business cases. Regular meetings with NHSE 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; Treasury management procedures, 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

Assurances on controls – Internal	Assurances on controls – External
Dormitory eradication and PICU Programme monitoring and reporting 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 including HFMA checklist, 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	NHSE feedback throughout progress of dormitory eradication Programme and business cases in programme Systems Finance and Estates Committee/System Project Management Office/system DOF meetings 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 Programme Director, Senior Responsible Officer completed NHS Better Business Case Training

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Trust cash and capital risks related to national funded acute capital programme: - Inflation cost risk - Risk-share - Cashflow timings and variability ~~- VAT abatement appeal unsuccessful~~ - Guaranteed Maximum Price exceeds national funding envelope (due to	Risk share arrangements with PSCP Programme approach and engagement with all stakeholders. Close involvement with NHSE ~~VAT abatement appeal~~ [ACTIONS OWNER: DOF]	Cash and capital reporting and forecasting evidence of plan delivery and/or indicates areas of required management action	~~31.03.24~~ 31.03.25	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations Hyper-inflation cost risk remains – Due to world events and economy but this is reducing ~~is very high due to world events and economy~~ National PDC capital funding approved by NHSE for two new builds and three refurbishment schemes, plus PICU year 1	AMBER

hyperinflation and other factors)				Hyperinflation still affecting sub-contractor costs with significant cost pressures on Radbourne Unit Refurb and Older Adults ward refurb requiring ongoing action HMRC appeal on VAT abatement claim concluded and VAT abatement was agreed ~~for Adult Acute Units but not PICU~~	
System capital programme funding shortfall for self-funded Trust capital programme: System Capital Departmental Expenditure Limit (CDEL) inadequacy for system capital requirements	System capital draft planning assumes the final year of the self-funded element of the PICU build through system CDEL / Trust cash reserves ~~VAT abatement appeal in progress~~ Access any new national funding streams in year to maximise system capital plan in order to redirect CDEL capital for other schemes [ACTIONS OWNER: DOF]	Ongoing reporting will ascertain how and when the shortfall can be bridged by additional capital sources	~~31.03.24~~ 31.03.25	System capital plan has been submitted as part of planning process ~~and will be limited to high priority schemes and includes two new builds and year 2 of PICU from system CDEL~~	AMBER
Additional revenue related to new builds, refurbishments and PICU not fully funded by system	Close partnership working with ICB and system partners. National funding for PDC revenue costs included in allocations for 2023/24 plan Early recruitment to staffing built into revenue plan of the Trust and funded by the system (both income and expenditure in the plan) [ACTIONS OWNER: DOF]	Monitoring and reporting of income allocations and expenditure in year	~~31.03.24~~ 31.03.25	Funding for PDC revenue from NHSE included in financial plan submission. Guidance change has removed £2.5m of income Funding for early recruitment costs from ICB allocations included in the financial plan submission MHLDA DB agreed to oversee revenue delivery contained within programme spend	RED
Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight [ACTION OWNER: DPOI/DOF]	Enhanced bank and agency costs reported as part of wider financial and workforce reporting	~~31.03.24~~ 31.03.25	Reports to ELT and F&P outlining current areas of pressure and required actions to be taken as part of the financial planning decision making process	RED

				~~Agency summits have taken place with agreed actions for medical and non-medical agency workstreams.~~ Funding contribution agreed with Eating Disorder Provider Collaborative for exceptional agency costs, further costs are being recharged but are in dispute	
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 2023/24 plan including recurrent long term cost reductions to return to breakeven Planning for 2024/25 has led to a recent ask for directorates to develop plans of 4% cost improvement in addition to various transformation schemes ~~2023/24 assumes 3% recurrent delivery and 1% non-recurrent delivery~~ [ACTIONS OWNER: DOF]	Efficiency and QI reporting to Execs and F&P	~~31.03.24~~ 31.03.25	Limited schemes identified at time of draft plan submissions. ~~Schemes initially identified to deliver £8.7m in full~~ Current target for cost improvement is £10.4m, which still results in a deficit of circa £11.7m ~~There remains a gap to deliver the full programme.~~ The main risk is in relation to the recurrent delivery~~. Weekly Transformation Delivery Group taking place, with executive leads attending monthly~~ Executive vacancy panel established in December 2023 Further reviews on all roles on the Trak recruitment system are underway to reassess need	RED
Financial cost pressures created both internally and by system first decisions leading to the requirement for mitigations to close both the internal gap and the system financial gap	Additional 'stretch' management action required to reduce other cost and mitigate impact to achieve overall financial position [ACTION OWNER: DOF]	Achievement is incorporated into most likely case forecast reported to ELT, F&P, and system reporting Business cases to go through ELT before any financial commitments are made, ensuring good governance process are followed	~~31.03.24~~ 31.03.25	The financial position for Derbyshire is a risk to the statutory duties for DHCFT to manage its financial position Financial plan for 2024/25 is at the first stage of draft planning but the national process has now been delayed and planning will be extended into May ~~2023/24 finalised. Plan assumes a level of~~	RED

				~~inflationary cost uplift in line with national guidance~~ ~~Financial sustainability plan developed~~ All new investments to follow governance processes with business cases to ELT ~~All emerging costs that are deemed 'out of our control' such as industrial action, pay award funding shortfall, excess inflation and PDC funding withdrawal are all being reported separately across the system and reported to regulators as risks to delivery of the breakeven plan~~ ~~Announcement of £200m additional funding for the NHS for winter resilience, more details are awaited on impact to systems~~	

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
23067	Corporate - Finance	The Trust fails to deliver its revenue and capital plans	Financial detriment resulting from: - Large capital development programme - Commissioning decisions, including tender processes or wider system first decisions - Non-delivery of transformational and efficiency schemes - Loss of income and required service developments - Costs to deliver services exceed income Efficiency and transformation programme monitoring and escalation process in place. Cost pressures are currently being managed in the overall position 20.12.23: Capital funding remains in place for the new builds and refurbs, and risks are being regularly reported and managed, discussions to continue with regional and national colleagues. Plans in place to reduce agency over remaining months. Executive vacancy control panel established System has submitted a deficit figure of £47m to NHSE/I, of which DHCFT is £5.0m 21.03.24: Position remains stable. (The modest £0.2m deterioration in forecast is driven by national change in approach to treatment re PFI contract and IFRS 16). We are on track to deliver our deficit forecast and risk of deteriorating further is reducing. We continue to meet with the ICB and wider NHSE region to discuss the capital pressure which remains a risk for 2024/25 - This relates to a large CIP requirement of 4%. Work is ongoing to develop plans from all directorates by the end of March 2024	21.06.23	21.04.24	EXTREME

Strategic Objective 4 - To be a GREAT Partner

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 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, for example Provider Collaborative Leadership Board, may impact on provider Foundation Trust governance arrangements and decision-making processes
d) ~~ICB s~~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: 24-25 4A	**Director Lead**: Vikki Ashton Taylor (CDO) ~~(DSPT)~~	**Responsible Committee**: Trust Board

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	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, mental health and learning disability teams at a regional and national level. Assumed NHSE -led appointment process to new ICS Board positions
Detective – 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

Board Assurance Framework 2024/25 – Issue 1.3 Board May 2024

Assurances on controls – Internal	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 and ICB ~~teams with DHCFT represented by DSPT~~ ~~Appointments/assurance of new ICS Board (ICB) through NHSE/I processes~~ Gateway process run by NHSE prior to agreement to establish a Trust as lead-provider in regional collaboratives Representation on system-wide governance groups

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Increased decision-making at a system and/or provider alliance level may create conflicting accountabilities with the Trust-level governance structures which could result in an increased governance burden	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements [ACTION OWNERS: CEO/DCA ~~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	~~(31.03.24)~~ (30.06.24)	Ongoing review of Trust governance to ensure operational performance delivery of MHLDA constitutional standards that DHCFT is a lead or main provider of the performance Trust CEO is a member of ICB Board Derbyshire Provider Collaborative Leadership Board have an agreed work programme as approved by ICB The Trust is an active member of and provides regular assurance to system-wide governance groups, for example their quality and safety group	AMBER

Internal ICB capacity changes to achieve revised expenditure requirements in 20023/24 and 2024/25 may impact on capacity and capability to deliver key deliverables such as system planning, and programmes of transformation	Keep changes to staffing levels and work programmes under regular review. This may lead to system wide agreement on priorities [ACTION OWNER: CDO ~~DSPT~~]	Impact monitored through system wide MHLDA Delivery Board, Provider Collaborative Leadership Board and ICB Board, of which the CEO is a member	~~(31.03.24)~~ (30.06.24)	Escalation of risk and impact internally to ELT and Board as appropriate and to ICB ~~The Trust has the opportunity to comment on the emerging ICB organisational structures~~ Review DHCFT staffing to identify succession planning opportunities and/or cover arrangements	RED

Related operational high/extreme risks on the Corporate Risk Register: None

Strategic Objective 4 – To be a GREAT partner

There is a risk of reputational damage if the Trust is not viewed as a strong partner

Impact:
May lead to poor experience and care for people accessing services within Place and communities. Possible organisational ability to influence developments within the ICS

Root causes:
a) Organisation historically too internally focused – Provider responsibilities impacting on executive and operational capacity
b) Not actively engaging enough as part of a broader multi-agency partnership at Place and community level
c) Increasing national expectations in provider collaboration and multi-disciplinary delivery model at Place level

BAF Ref: 24-25 4B	**Director Lead**: Vikki Ashton Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

Initial risk rating			**Current risk rating**			**Target risk rating**			**Risk appetite**		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Active membership in each Local Place Alliance; Active participation in Integrated Place Executive; ~~Regular meetings with NHSE on programme progress;~~ Meaningful stakeholder engagement (internal and external); Multi-disciplinary and cross organisational development and implementation of services
Detective – Quality Improvement (QI) delivery; Contract performance; Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives
Directive – Integrated Care Strategy; Joint Forward Plan (JFP); Trust Strategy

Assurances on controls – Internal	**Assurances on controls – External**
Appointment to Managing Director roles Regular TLT and ELT updates and discussions NED Board members on JUCD committees	Monthly Mental Health and Learning Disability assurance meetings with NHSE Monthly reporting by County and City Places to JUCD Place Executive Patient surveys conducted by Healthwatch CEO on ICB Board and Integrated Care Partnership (ICP)

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
System partners report that some of its core constitutional targets were not being met and was failing to make progress, at pace and scale	New internal performance improvement group and clarity to Trust Board on which DHCFT constitutional standards are not being met and whether the DHCFT contribution is the lead or material and how performance will improve Recovery action plans for areas where constitutional standards are not being met [ACTIONS OWNERS: CDO ~~DO/DSPT~~]	Improvement in performance in constitutional standards Recovery action plans in place in all required areas	~~(31.03.24)~~ (30.06.24)	Integrated performance report allows insight on key areas of improvement, with actions and narrative around next steps. Progress with recovery action plans: Performance improvement in dementia diagnosis and perinatal access has resulted in DHCFT now delivering the core constitutional targets in this area and others Ongoing work to reduce inappropriate Out of Area Placements, underpinned by a Recovery Action Plan continues including a Multi-Agency Discharge Event and planned opening of local PICU, however inappropriate Out of Area placements remain above trajectory ~~CQUIN, and Real World Health insights have been added to track on a monthly basis to ensure we improve performance and patient outcomes~~ ~~Prototype dashboard to measure compliance with constitutional standards has been presented to the Productivity Board and will be~~	RED

				~~monthly going forward until ready to go to TLT~~	
System partners report that DHCFT is inward looking and does not fully support PLACE developments	Managing Directors to design a communication and improvement plan, with 360 feedback that PLACE partners feel DHCFT support, data is provided and their support named Managing Director is accessible [ACTION OWNER: CDO]	PLACE / PCN and GP Directors provide direct feedback to Managing Directors on their relationship, knowledge and impact of the additional leadership support. This includes examples of collaboration and the impact of this support Confirmation of frequency of contact, joint action / achievement log of issues raised and achieved Managing Directors reports to TLT with summary of impact to ELT	~~(31.03.24)~~ (30.06.24)	Managing Directors (MDs) actively engaging with Primary Care Networks (PCNs) MDs are now members of Derby City PLACE Board and PLACE County Partnership Board Executive Directors are members of Integrated Place Executive. Senior management representation named for all PLACE Alliance groups. City and County Partnership Board currently developing purpose, MDs are actively involved in. MDs are also linking in with local GP forums within the City and County CEO meeting with GP network monthly Appointment of a Lead GP – Mental Health specifically for Derby City Place to support relations, pathways and opportunities between the Trust and primary care. GP support only in place until May 2024; case for the GP support to be presented to the MHLDA Board in April	GREEN

Social care partners have reported that the lack of progress on autism diagnostic reductions is difficult and would like to see increased pace of improvements	Improvement plan for joint autism service [ACTION OWNER: CDO]	Feedback from social care on awareness of the Autism Strategy and autism waiting times reduce across the interagency investment plan	~~(31.03.24)~~ (30.06.24)	November 2023 Derbyshire System Delivery Board: Agreement to recognise that the current commissioning landscape and output from investment still has major gaps, with a subsequent impact on other local services. Support for the development of fuller proposal for re-use of resource allocated for an improved offer, recognising this may require reallocation of current spend Autism waiting times continue to be achieved for the 26 contracted assessments per month, and sustained for year to date	AMBER
Police partners report they do not always feel supported by mental health services and are under pressure to respond to mental health crisis	Police education and support, communication and improved partnership working ~~improvement plan with MH Delivery Board and Trust Directors~~ [ACTION OWNER: CDO ~~DSPT~~]	~~Inter-agency meeting and review of a joint way forward in 2023 including~~ Training sessions offered to Police partners: • Police mental health awareness training sessions • Suicide prevention work • Joint working with Trust safeguarding teams ~~co-produced outcomes~~ • Collaborative response to Right care Right Person (RCRP) ~~Agreed outcomes are monitored and reported through the MHLDA~~	~~(31.03.24)~~ (30.06.24)	Police are a formal member of the MHLDA DB and attending and contributing ~~New national guidance in draft and collaborative approaches including staffing of 136 suites included in programme level investment~~ Street triage pilot was established between Police and Trust. ~~but this~~ This ceases on 31.03.24 and will be replaced by ~~Right Care Right Place (~~RCRP~~)~~ Mental Health Response Vehicle (MHRV) to be implemented ~~from April~~ during 2024, to reduce pressure on	AMBER

		~~DB with liaison with DHCFT Police Liaison group~~		Police to respond to mental ill health calls Crisis café ~~has~~ have opened in Buxton, Ripley and Swadlincote ~~planned to open~~ Trust ~~chairing~~ is a member of the RCRP implementation executive group ~~across~~ covering the Derbyshire system with Police stakeholders and system colleagues	
Patient and carers groups report that they would like to see more progress in service user and carer involvement and moving from engagement to decision making	Peer support strategy and objectives for EQUAL and the Mental Health Engagement Group [ACTION OWNERS: DON/MD]	Peer support strategy Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	~~31.03.24~~ (30.06.24)	EQUAL group established to support service user and carer engagement. EQUAL has created several sub committees and informs future service improvements across the East Midlands Perinatal Mental Health Provider Collaborative	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Board Assurance Framework 2024/25 – Issue 1.3 Board May 2024

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:

a) The community Intensive Support Team and Learning Disability models have non-standardised operating models and require more capacity
b) Currently the delivery and commissioning partnership in Derbyshire have not met national standards or local ambitions for more robust community-based offers, working across the geography and in an integrated way with partners including social care and the voluntary sector
c) 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
d) Inpatient bedded facilities do not meet safer staffing levels due to vacancies
e) 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
f) The current LD bedded care facilities do not meet the national specifications for the Royal College of Psychiatrists Learning Disability recommended standards and are not in line with future clinical model for the LD&A pathway for Derbyshire
g) Derbyshire bedded care facilities for LD services had not had a full CQC inspection since 2016 as a core service
h) Health inequalities across our Derbyshire footprint – Initial insights show gaps in access to service, case load and worsening patient outcomes

BAF Ref: 24-25 MS1	**Director Lead**: ~~Lee Doyle/David Tucker (Interim DOs)~~ Vikki Ashton Taylor (CDO)	**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

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	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; Board visits 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; Trust Policy Dashboard

Assurances on controls – Internal		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			
Key gaps in control	**Actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion or (review)**	**Summary of progress on action**	**Action rating**
The community Intensive Support Team and Learning Disability models require improved models of support	Review all models of support offered by the Intensive Support Team (IST) [ACTION OWNERS: CDO/DON/MD]	Outcome of review – Improved models of support	~~(31.03.24)~~ (30.06.24)	Review outcome: Services brought together across the North and South under a single manager and now have single clinical pathways ICB have presented work to both providers ~~on future vision of the pathway,~~ which looks at how to ensure community offers like IST are enhanced further through the review of ~~other~~ pathway offers where resource is disproportionately allocated ~~DCHS launched a new operational structure in November 2023, which has initiated further discussion on integrated working going forward, to be discussed over Quarter 4~~ Next steps are to commit more resources to community pathways including IST is	AMBER

				interdependent on the future bedded model which is being explored by the ICB	
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	Continue to work on developed delivery improvement plan, owned by system partners, to improve position. This includes new cohort stratification approach that has been developed – key action to implement and fully embed approach to ensure focussed system action on existing inpatients who are place inappropriately and out of area [ACTION OWNER: CDO]	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients working across partner systems Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission and market stimulation and development, including improvement in the use of Dynamic Support Registers as a means of admission avoidance Make significant impacts on the number of stranded patients who have delayed discharges in units across the country resulting in the NHSE escalations	~~(31.03.24)~~ (30.06.24)	Derbyshire has been stepped up of national escalation regarding performance with inpatient services after demonstrating significant progress and improvement against plans and clear grip. New Dynamic Support Pathway (DSP) launched following cross-agency redesign work ~~Full c~~Cross-system delivery plan continues to be monitored through Neurodevelopmental Delivery group Board – Includes action plan in response to inflow, flow and outflow as discussed with NHSE and ICB leaders ~~Refining use of platform criteria to ensure best application for autistic patients on mental health wards supported at November Clinical Quality Reference Group, with ratification at System Quality Group in December 2023~~	AMBER

				~~Focussed ICB-led session on care and accommodation work scheduled for December 2023. NHS England assurance sessions reduced to quarterly in recognition of progress~~	
Current substantial staff vacancies are negatively impacting on safer staffing levels in a non-DHCFT Derbyshire bedded care facility	Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements [ACTIONS OWNERS: CDO/DON]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	~~(31.03.24)~~ (30.06.24)	Reviews of safer staffing and stabilisation in non-DHCFT Derbyshire bedded LD facility - New period of ~~Some~~ service stabilisation underway with a focus on expediting discharge of current inpatients, and not accepting further admissions ~~achieved, further work under new structures required~~ Workforce issues including recruitment and retention, staff wellbeing and mitigations against use of agency staff being addressed with rapidly mobilised short-term leadership from DHCFT into the unit ~~considered. Ongoing commitment to working in an alliance with DCHS to support a resolution for future bedded care for LD&A~~ Improved engagement with universities and final year student nurses	AMBER

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: CDO/DON]	Full compliance with required care standards External review of Long-Term Segregation and review to end restrictive practices	~~(31.03.24)~~ (30.06.24)	Joint paper from Trusts to ICB regarding overall bedded offer and inpatient review discussed with ICB executives March 2024 ~~is with ICB for feedback and due for joint discussion in January 2024~~ Overall quality plan for improvement for LD&A inpatients in place following review by ICB - This includes trying to reduce the level of out of area care	AMBER
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: CDO/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	~~(31.03.24)~~ (30.06.24)	~~Work to provide facilities that meet national standards to be completed~~ Partnership working with DCHS and ICB to agree future plans and direction of travel for bedded offer for Derbyshire patients continues. Executive level discussions are underway for the long term goal, whilst providers work together to stabilise position in current unit and expedite discharges Broad expectations on model of care (bed 'type') agreed across partners, including offering community-house step up/step down options	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Board Assurance Framework 2024/25 – Issue 1.3 Board May 2024

Risk Rating
The full Risk Matrix is included in the Trust's Risk Management Strategy

Risk Assessment Matrix					
Risk Score = Consequence Rating X Likelihood Rating					
	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 RATING	RISK APPETITE
Very Low	Accepted
Low	
Moderate	Tolerated
High	Not Accepted
Extreme	

Actions Against Gaps in Key Controls - Expected completion dates to be included or next review dates to be shown in brackets	Action 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	Director of Finance	DON	Director of Nursing, AHPs and Patient Experience – Interim
MD	Medical Director	DPOI	Director of People, Organisational Development and Inclusion – Interim
CDO	Deputy Chief Executive / Chief Delivery Officer	DCA	Director of Corporate Affairs and Trust Secretary
~~DSPT~~	~~Director of Strategy, Partnerships and Transformation~~	~~COO~~	~~Chief Operating Officer – Currently Interim Executive Directors of Operations (DO~~

Definitions

Preventative	A control that limits the possibility of an undesirable outcome	Directive	A control designed to cause or encourage a desirable event to occur
Detective	A control that identifies errors after the event		

Board Committee Assurance Summary Reports to Trust Board – 7 May 2024

The following summaries cover key items discussed at the meetings that have been held since the last public Board meeting held on 16 January 2024 and are received for information.

- Quality and Safeguarding Committee - 12 March 2024 and 18 April 2024
- Mental Health Act Committee – 15 March 2024
- Finance and Performance Committee – 19 March 2024
- People and Culture Committee – 26 March 2024
- Audit and Risk Committee – 25 April 2024

Key:

	Full Assurance received during the meeting with the accompanying report
	Significant assurance received during the meeting with the accompanying report
	Limited assurance received during the meeting with the accompanying report
	No Assurance received during the meeting with the accompanying report
	items shared **for information** to advise the committee on progress and next steps

Quality and Safeguarding Committee – key assurance levels for items – 12 March 2024	
	Regulation Compliance (Care Quality Commission (CQC), Mental Health Act, Ward 35) The Committee noted the closure of actions arising from the previous CQC inspections in 2019/20. Progress of these and other CQC MHA inspections are now monitored through regular oversight meetings with assurance being provided through to Quality and Safeguarding Committee. Progress around the new self-assessment process was shared, along with detail of a pilot of the process, which includes a site visit, set questions, self-assessment by the team and review by a confirm and challenge panel. **Limited assurance** was accepted on the strengthened governance of CQC related actions and on the progress of actions from the CQC's inspection.
	Risk Report The Risk Report for Quality and Safeguarding Committee has been developed over the year to focus on clinical and safety risks. The report provided **limited assurance** on the status of current extreme/high level Trust-wide operational risks. It was requested that a trend of the risks over the last two to three years be presented to the Committee, along with deep dives on Adult Care Acute (risk to shift cover and supervision due to Mental Health Nurse staffing levels) and on Children's Services (risk to achieving Paediatric Referral to Treatment (RTT) compliance).

	Patient and Carer Experience Strategy – 2024-2027 It was reported that the strategy has been co-produced and carers and service users from across all Trust services have been invited to take part with oversight via the Patient and Carer Experience Committee meeting (PEC). It was noted that agreed clear measurable timescales are to be included along with action plans and utilise live cases for feedback/evidence of progress with a collaborative emphasis. The Committee endorsed the approach and ratified the strategy so a workplan can be developed, while sustaining the work already underway.
	Patient Experience, Compliments and Complaints The report provided an overview of the themes and changes made to Trust services, resulting from feedback on incidents and complaints received for Quarter 3. Due to recurring themes, the Committee accepted **limited assurance** and agreed that tangible plans to improve patient feedback around staff behaviour is to be included with the future reporting.
	Regulation 28 Notice – Risk Analysis Report The Committee received an update on the Regulation 28 Notice served upon the Trust and on the actions undertaken, which include improvement of audit compliance with the reporting requirements was presented. It was noted that scrutiny has moved to daily and weekly reviews and that data for the period shows county compliance is 92% and city is 96%, moving more recently to 100%. **Significant assurance** was accepted on the establishment of a revised protocol and the generally sound system of control.
	Guardian of Safe Working Report It was noted that one exception report had been submitted, resulting in time off in lieu and payment to the doctor. A plan to roll out live rotas within MS Teams to improve shift co-ordination and challenges around utilisation of study leave and potential resolution, were discussed. The Committee accepted **significant assurance** that the duties and requirements as set out in the 2016 Junior Doctor terms and conditions of service are being met.
	Commissioning for Quality and Innovation (CQUIN) Update It was reported that whilst there is a good level of compliance within Perinatal services, there is a gap in other areas. On this basis the Committee received **limited assurance** that any of the CQUIN targets will be achieved at the year end, and whilst there is no longer a financial penalty, the goal is to enhance patient experience.
	Sexual Safety and Trauma (Sexual Safety Charter) It was noted the Trust has become a signatory of the Charter, committing to a zero-tolerance approach to any unwanted, inappropriate and/or harmful behaviours towards the work force. It was agreed that the Committee will receive a State of Readiness Action Plan in May, detailing how the Charter's 10 core principles are to be embedded by July 2024.
	Clinical Audit – Effectiveness and Clinical Audit Plan Update The Committee noted progress made in 2023/24 and considered the evidence provided on the effectiveness of the 2023/24 Clinical Audit Programme. **Limited assurance** was accepted on the basis of the timing of the report, as effectiveness would be better evaluated next year as currently the quality improvement approaches were not yet fully embedded.

	Impact of Industrial Action The Committee received an analysis of the industrial action taken by Junior Doctors between December 2023 and February 2024. It was noted that the data does not reveal any significant change or rise in safety incidents, due to successful mitigation by consultants taking this role additionally out of hours.
	Getting it Right First Time (GIRFT) The Committee received an update on progress since the GIRFT report on community-based support for adult rehabilitation services in February 2023. It was agreed that tangible outcomes would not be realised for at least a year and further updates would be received in six monthly intervals.
	Board Assurance Framework (BAF) – key risks identified: the Committee discussed the impact of today's discussions on certain risks, including the ongoing waiting list for ASD assessments and implementation of CQUINs and it was agreed that relevant escalations to the Board can be referenced within the Board Assurance Summaries.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: None **Next scheduled meeting:** 18 April 2024
Committee Chair: Lynn Andrews	**Executive Lead: Dave Mason, Interim Director of Nursing and Patient Experience**

Quality and Safeguarding Committee – key assurance levels for items – 18 April 2024	
	Fundamental Standards Report The Committee received an update on progress of Care Quality Commission (CQC) actions and preparedness, assurance on progress of actions and information on Mental Health Act (MHA) visits. The Committee was made aware of the unannounced inspection of Acute services and noted the immediate feedback which had been responded to and subsequently, this Committee will see the action plans to provide assurances. **Limited assurance** was accepted on the completion of CQC actions and the Committee agreed to hold regular updates its meetings to monitor progress.
	Significant assurance was accepted that the recent MHA action plan has been developed and submitted appropriately. **Significant assurance** was accepted on the development of the new mock inspection process which is being piloted in April with a three-part process of site visit, data collection and 'confirm and challenge' panel prior to ratings being agreed.
	Draft Quality Account The draft Quality Account for 2023/24 was received for review. It was agreed that the public document needs to reflect the current position, link back to the new Trust Strategy and also include the positive areas of celebration. The final draft will be received for sign off at the May meeting.

	Safer Staffing The report provided a formal opinion on the required skill mix and provided assurance on the work being undertaken to monitor and develop the skill mix of staff across the Trust to ensure safe services. It was noted that the majority of trusts use the Mental Health Optimal Staffing Tool (MHOST) as an adjunct to the e-rostering system and the Trust is due to implement this as part of a new establishment review. It was noted that this is expected to reduce use of temporary staffing and agency within inpatient services and improve compliance with safer staffing targets. The report indicated safe services, however, the evidence-based tool will enhance planning, in addition to crucial professional judgement. Following the recent CQC inspection, the implementation is to be fast-tracked as a matter of priority and on this basis the Committee received **significant assurance**.
	Regulation 28 Notice The Committee received an update on the Regulation 28 Notice serviced upon the Trust and on the actions undertaken. A response had been submitted to the coroner and to the CQC.
	East Midlands Perinatal Mental Health Provider Collaborative The Committee received the report which provided assurance regarding the oversight of inpatient perinatal services within the East Midlands at Quarter 3 2024/25. It was noted that the paper is prepared by the Commissioning Collaborative on the Trust's behalf and due to the limited quality data, it was agreed that future reporting will include additional information, including risks and compliments.
	Quality Dashboard Discussions focussed on incidents, concerns and falls, along with the ambiguity of some of the language, targets and common cause variations detailed in the report. It was agreed that the dashboard will be re-evaluated. The Committee noted that every fall triggers an immediate review and an amended care plan, and the team is confident in the mitigations. **Significant assurance** was on progress towards clinical performance targets.
	Industrial Action An analysis of the impact of the most recent episode of industrial action by Junior Doctors, which took place from 24-28 February 2024 was presented to the Committee. It was noted that all key data points had been analysed and fall within common cause variation, excluding the longer term, softer impacts, which are hard to measure.
	Care Planning/Person-Centred Care The Committee noted progress in the overall care plan compliance which has increased to 83%. The target of 85% compliance for Community Mental Health services was discussed and it was noted that this was a legacy target, introduced as a realistic goal, to address previously extreme non-compliance. It was agreed that it would be more appropriate to measure against a target of 100% with an explanation of any gaps. The Committee accepted **significant assurance** that there is a generally sound system of control.

	Board Visits – Themes and Findings Following the move from Quality visits to Board visits, the Committee received an update on progress so far. It was highlighted that ambition is to engage with staff, recognise and appreciate their efforts and feed-back on the challenges being faced. The Committee received **significant assurance** on the process working overall, however, more fine-tuning is required, along with a definitive method to capture feedback.
	Annual 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 2023/24. The report demonstrated the extensive matters covered and evidenced that the Committee had worked effectively. Following significant review, the updated Terms of Reference were agreed.
	Board Assurance Framework (BAF) – key risks identified: the BAF has been given a thorough appraisal to improve focus and reflect the current position.
	Escalations to Board or other Committees: None **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** 14 May 2024
Committee Chair: Lynn Andrews	**Executive Lead: Dave Mason, Interim Director of Nursing and Patient Experience**

Mental Health Act Committee – key assurance levels for items – 15 March 2024	
	Mental Health Act (MHA) Manager's Quarterly Report The Committee received an analysis of the MHA office activity for a 12-month rolling period with a particular focus on 1 October 2023–31 December 2023. The Committee received **significant assurance** that the reading of rights, both inpatient and CTO, has improved since the Committee (and the MHA Office) began to monitor more actively, but **limited assurance** on other aspects of the report in terms of under performance against targets.
	Community Treatment Order (CTO) Review The Committee received an update on the case of Derbyshire Healthcare NHS FT v Secretary of State for Health and Social Care, including the corrective actions taken by the Trust and the legal ramifications of the Judgement. The Committee received **significant assurance** that the Trust has closed the risk of further instances which would infringe case law.
	Section 12 Doctor Assurance Report The Committee noted the improvements to the process for ensuring Approved Clinician and Section 12 status. The Committee noted the Trust is moving to a digitalisation of the Section 12 process and accepted **limited assurance** until this is in place.

	Training Report The report provided an overview of current Mental Capacity Act training within the Safeguarding Adults Level 3 class. It was noted that work is being done to allow more spaces for people to undertake training and online access is being made available to improve compliance. The Committee received **limited assurance** based on the compliance levels.
	Restrictive Practice Quality Report The Committee was updated on progress made regarding implementation of the Positive and Safe strategy in specific aspects that connect with the Mental Health Act Committee, oversight of the Code of Practice or concerns highlighted within Mental Health Act reports. Although the report is received twice-yearly by the Quality and Safeguarding Committee, which takes primacy on the practice issues, matters are highlighted to the Mental Health Act Committee to give assurance that the Trust is discharging its responsibilities under the Code of Practice, in line with the Reducing Restrictive Practice Policy. The report identified areas that require further improvement including observations and absconsions and areas that have improved, including physical restraints and seclusions which have reduced significantly. The Committee received **limited assurance** based on the areas that still required improvement.
	Use of Section 136 Suites 135/136 The report showed a recent consistent level of activity with Section 136 Suite, noting the numbers had fluctuated over the last four years. Following the street triage pilot ending in March 2024, it was noted that nationally there is a lot of evidence this is a definite benefit for the system, however, there is no direct replacement starting in April and the Committee was hopeful that NHS England would support. The Committee received **significant assurance** that the persons brought to the custody suite appeared to be appropriate admissions given the outcome of assessments.
	Update from Associate Hospital Managers Associate Hospital Managers gave a verbal update on their activities. It was noted that there are currently eight people on the hospital managers team, who are busy with contested and uncontested hearings and that uncontested renewal hearings are up to date.
	Year-End Effectiveness Report and Review of Terms of Reference (ToR) The Committee agreed **significant assurance** that its activity had been compliant against its Terms of Reference during 2023/24. The ToR were agreed following some minor amendments to the membership and a title change.
	POLICY DASHBOARD In relation to two externally held policies, overdue policies, an escalation is to be raised with Joined Up Care Derbyshire.
	Board Assurance Framework (BAF) – key risks identified: None.

	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** 14 June 2024
Committee Chair: Ashiedu Joel	**Executive Lead: Arun Chidambaram, Medical Director**

Finance and Performance Committee – key assurance levels for items – 19 March 2024	
	Assurance on Estate Strategy – specifically Making Room for Dignity Programme (MRfD) Received the update on progress made. Some members more familiar as involved in the MRfD group. Progressing well and risks reducing. Still working through the £7.5m cost pressure. Submitted ask to NHSE via the Integrated Care Board (ICB) and awaiting outcome. Some minor issues being resolved as part of progressing developments linked to inaccurate plans, etc. Costs being managed within funding contingencies. Overall, no major concerns to escalate to the Finance and Performance Committee or Board at present. Received for noting. Questions raised around focus moving from contracts, building and funding focus, towards implementation and mobilisation. Separate meetings have progressed this issue and it's been agreed the recruitment, staffing, culture, and service transformation aspects will link into People and Culture Committee going forward. **Limited assurance** was received on the progress of the programme and the risks associated with it.
	Delivery of Information, Management and Technology (IM&T) Strategy, incorporating wider Digital and Clinical Digital Strategy Questions were raised around the understanding of the digital architecture and the nature to which it's planned, examples being, national funding or offers of nationally supported initially free systems, which send you down a certain path, rather than following a strategic or well-developed plan. Core architecture v short term assessment and then cut loose. Links to clarity of priorities, eg Management and Supervision Tool (MAST). Recognition that the next iteration of the digital strategy will look very different. Revisiting priorities and being clear around where we should potentially lead and perhaps follow. The Committee was happy with the assurance on progress. It is considered a good news story and demonstrates progress. However, it is less clear regarding if delivered on time, on budget or meeting the needs of the organisation. A change of focus in the reporting to be more forward looking is requested. Noted as partial assurance. **Limited assurance** was received on the progress of the programme with an ask for future development in reporting.

	Financial Performance, Month 11, incorporating Cost Improvement Programme (CIP) Position Finance report received with confirmation the forecast has deteriorated slightly linked to a change in approach of NHSE in relation to the treatment of International Financial Reporting Standards (IFRS) 16 on Private Finance Initiative (PFI) contracts. Now forecast to end the year, with a c£4.6m deficit. This also has led to the system deteriorating to c£52m. The finance drivers of the position are stable and well known. Although it is well recognised, there needs to be a shift in delivery from non-recurrent to recurrent CIPs, and work is underway it was noted that some good work has progressed the continued reduction in agency usage. The Trust remains on track to deliver the capital position and has no major concerns over cash, debt or Better Payment Practice Code (BPPC) compliance. Out of Area bed usage remains higher than anticipated (21 at the end of February but has since improved down to 19 by meeting date). This was discussed further under the Integrated Performance Report (IPR) item. The item was noted. The Committee gained **limited assurance** on delivery of the financial plan due to the level of risks that are being managed and the non-recurrent reliance of CIP plans.
	Review and Approval of Treasury Management Policy and Procedures This was considered low risk given minimal changes to the policy and the dormant nature of the opportunity to invest commercially under current rules. The policy was ratified/approved. The Committee received **significant** assurance on the policy being fit for purpose.
	Contracts Update Routine item. No major risks or concerns flagged. Noted for assurance purposes. The Committee received **significant** assurance.
	Continuous Quality Improvement Update <u>Improvement and Transformation Report</u> Comprehensive report at the last Board meeting on progress. Proposal for Non-Executive Directors to go through the Quality Improvement (QI) training. Noted for assurance purposes. The Committee received **significant** assurance on the progress and ongoing training plans.
	Operational Performance Routine item. No major risks or concerns flagged. Noted for assurance purposes. The Committee gained **limited assurance** on delivery of the performance metrics recognising there are still a number of areas off trajectory and not aligned to agreed contract and performance targets.

	Operational Plan Update, including Financial Planning The paper shared was acknowledged as a financial planning position statement rather than a robust financial plan. This was understandable given the drawn-out planning process and lack of national guidance. The Trust and collective Integrated Care Board (ICB) system positions have both improved since the initial submission on 27 February through to 13 March submission. The national discussion on 14 March highlighted the pressure and need to go further as a collective NHS. Strong messages of expecting no workforce growth. There has also been a helpful national message and a clear direction that Mental Health Investment Standard (MHIS) and Service Development Fund (SDF) funding can be used to manage ongoing and existing pressures within Mental Health providers struggling to achieve finance balance. Due to the weekly planning brief meetings for Finance and Performance Committee Non-Executive Director members, they felt well informed and were appreciative. The current and latest position was a £9.8m deficit based on a 5% CIP delivery. Focus remains on progressing CIPs with an emphasis on a shift to recurrent plans. Reviewing all planned recruitment and pausing where possible. Outline capital plan but the Dormitory cost pressure to resolve and manage as a system. Outcome - Noted the planned 21 March Submission, £9.8m deficit. Recognising the ongoing work to make further progress. A clear ask remains to continue to explore the difficult questions and bring this back to the Board Development session planned for April. <u>Planning update</u> (additional from a non-finance perspective) Still awaiting planning guidance Operational requirements and targets – working on the assumption that they don't change significantly and will be required to deliver. Expectation to reduce workforce. Minimal growth outside of Dormitory investment. **Limited assurance** was accepted.
	System Updates, ICB Finance Committee/System Directors of Finance (DoF)s Committee members are sighted on the organisation and system challenge in line with the initial submission. Progress has been seen over the previous few weeks and is continuing. Still fluid and progressing with no clear guidance. On track to submit in line with requirements and continuing to work on reducing the planned deficit.
	Emergency Preparedness Resilience and Response (EPRR) Making significant progress but still rated as non-compliant by NHSE mainly due to partial compliance. Recovery Action Plan (RAP) put in place, but this has been impacted on by reduction in staff capacity. Focus on key elements to be able to improve the position, these are the ones that are most relevant to staff and patients and day to day running of the Trust. The Committee gave thanks to the clarity provided in the report. The Committee wanted to understand what the consequences of being non-compliant are. Even though the Trust has been non-compliant with the standards when the Trust has faced some significant events with flood, fire, power outage and bouts of industrial actions, these incidents have all been managed safely and all incidents have been fed back to the Board.

	Year-End Effectiveness Review of Finance and Performance Committee Paper summarises activity, assurances and feedback the Committee has undertaken during the year. Need to ensure papers give the levels of assurance going forward. Good coverage on MRfD programme and the financial position. Digital integration activity needs more focus going forward. Driving transparency on the financial plan.
	Review of Committee Terms of Reference (ToR) It was agreed to include the Clinical Operational Managing Director leads as full members for the next six months and then review as may need to use resources differently going forward. Following a review, agreed to amend the Interim Director of People, Organisational Development and Inclusion to attendee from member. Subject to minor changes agreed for onward ratification at Board as part of the annual assurance process.
	Collaborations and Other Alliances <u>Perinatal – Lead Provider Collaborative</u> It was noted that this service is not moving to a hybrid model of cost and volume, plus top up after six months, delayed for further six months. Not detrimental in not moving to the new funding model, still looking at opportunities through clinical refence group. Contract in place for next six months and discussions with NHSE regarding contracts going forward. <u>IMPACT – Adult Secure Provider Collaborative</u> Board formally approved risk and gain share agreement. Brought to Committee for completeness but out of synchronisation with normal scheduling due to required timescales. Covered at Board so less to discussion here. <u>Other updates – Eating Disorders and Child and Adolescent Mental Health Services (CAMHS)</u> No further updates other than the ongoing dialogue related to the patient with a complex eating disorder and pursuing a more appropriate setting and funding. This was referenced in various aspects of the Finance and IPR reports.
	Board Assurance Framework, 2023/24 Risks Overview Nothing further to update on apart from MRfD risks turning into operational risks.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: Nothing further to update. **Next scheduled meeting:** 21 May 2024.
Committee Chair: Tony Edwards	**Executive Leads: James Sabin, Executive Director of Finance**

People and Culture Committee – key assurance levels agreed – 26 March 2024	
	People and Inclusion Assurance Dashboard The Committee scrutinised the areas of decreased compliance for certain training modules, Clinical and Management Supervision and Appraisals. The Committee received **limited assurance** on the progress shown in the dashboard information and noted the ongoing actions to address the gaps.
	Modern Slavery Statement The Committee had **significant assurance** that the Modern Slavery Statement for 2023/24 had been effectively reviewed by the Trust's Procurement, Safeguarding, Recruitment and Equality and Diversity leads and recommended that the statement could be submitted to the Board on 7 May.
	Update on System Developments The Committee noted the verbal briefing, which included an update on the continued scrutiny on finance, minimisation of workforce growth and a drive to reduce agency usage. The ambition for trusts to develop and grow their apprenticeship model over the next few years was noted.
	Year-end Effectiveness Report and Review of Terms of Reference (ToR) Having reviewed the business carried out during 2023/24 the Committee agreed **significant assurance** around the effective performance of the Committee in the past year. Meetings had been well chaired and performed under clear and structured agendas that were supported with well-informed reports. Suggested revisions to the TORs were discussed and agreed.
	Future Workforce – Children's Services – 0-19 Years The Committee noted the difficulty faced in attracting, recruiting and retaining School Nurses and Health Visitors due to the national shortage and the actions taken to address this, which included investment in Band 5 General Nurse roles with a view to transition onto the specialist Health Visitor course. It was reported that this universal pathway, along with a review of the recruitment retention proposal is showing improvements and the availability of peer support has been enhanced by relocation of the teams to one base.
	2023/24 Flu Campaign The report focused on access to vaccination, following feedback from the 2022/23 campaign. It was noted that there had been an increase of 15% in Trust delivered vaccinations to colleagues due to the effective approach and the quality improvement journey the Trust had undertaken.

	Equality, Diversity and Inclusion (EDI) Report, including Gender Pay-Gap Report The report took the Committee through the Trust's EDI Framework, which is based on five action areas: • Leadership • Addressing bullying, harassment, discrimination. and abuse • Inclusive recruitment and retention • Progression and promotion • Create a culture of inclusion and belonging. It was noted that there are three projects in review which will help to embed understanding of EDI within the workforce and that there are plans to launch an advertising toolkit to assist managers improve the diversity of attracted candidates. The Committee received **significant assurance** around the EDI Framework itself and agreed, in principle, for the EDI Steering Group be structured to have operational oversight.
	Deep Dive Recruitment The Committee noted the range of activities that are underway to expand the workforce, including a more pro-active approach to recruitment, developing Trust-wide campaigns, enhancement of the fast-track student offer, international recruitment pipelines and the creation of enhanced paid campaigns to attract experienced Band 6 Nurses. It was reported that resourcing is the main challenge, and the Trust is looking at the use of additional media to raise its profile, including platforms such as Indeed and the British Medical Journal (BMJ) publication, along with co-ordination of joint campaigns. The Committee noted the improvements but agreed **limited assurance** based on the shortfall areas.
	Staff Survey It was noted that the 2023 results are compared against 51 organisations within the same benchmarking group and are divided into the People Promise themes. The results were positive in many areas and the return rate had been the best yet at the Trust. The Committee discussed the needs for managers to accept responsibility for communicating and supporting identified actions and it was agreed that the Trust is building on the foundations year on year to progress. **Significant assurance** was agreed on the processes and improvements.
	Review of People and Culture Committee Board Assurance Framework Risks The Committee agreed that Risk 2A, "the level of change and turnover in the Board and senior leadership", was a legacy statement and should be removed.
	Board Assurance Framework (BAF) – key risks identified: None.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** 28 May 2024
Committee Chair: Ralph Knibbs	**Executive Lead: Rebecca Oakley, Acting Director of People and Inclusion**

Audit and Risk Committee - key assurance levels for items - 25 April 2024	
	Board Assurance Framework (BAF) It was noted that the Quality and Safeguarding Committee closely monitors Risk 1A, and it was suggested that consideration be given to re-instate Risk 1A (b) as this remains a concern. The Committee approved Issue 1 (version 1.2) of the BAF for 2024/25, subject to the amendments discussed and agreed **significant assurance** 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.
	Operational Risk Management It was noted that many assessments had been completed but not yet recorded and that plans are in place for all current high and extreme risks. The Committee accepted **significant assurance** on the risk management process and the efforts made by the Risk and Assurance Manager to drive the process.
	Annual Governance Statement Review The 2023/24 Annual Governance Statement was presented to the Committee, and it was agreed that suggested amendments will be fed within two weeks. The Committee agreed to accept a final (clean) version of the Annual Governance Statement in May 2024, when it will be included in the master Annual Report.
	Going Concern Assessment The Committee approved the going concern assessment for inclusion in the 2023/24 Annual Report.
	Annual Report and Accounts – Review of First Draft The Committee received the first draft of the Annual Report. The changes between versions would be logged for the Committee to see what will be incorporated into the final document for sign off at the June meeting, following the audit. The draft Annual Accounts were also presented, and it was agreed that suggested amendments to the documents would be provided within two weeks.
	Six Month Update on the Implementation of the Freedom to Speak Up (FTSU) Policy Framework The FTSU Guardian highlighted the inclusion of the improvement and action planning tool, and it was noted that 52% of the workforce has completed the mandatory Speak Up training module within the first three weeks. The paper provided **significant assurance** to the Committee that the Trust has adequate arrangements in place for speaking up and summarises the work that is being carried out under the FTSU policy framework within the Trust for the period July to December 2023.
	Audit and Risk Committee Year-End Effectiveness and Review of Terms of Reference (ToR) The Committee considered the year-end report on its activity and effectiveness for 2023/24. Members supported the view that the Committee's objectives had been achieved and noted the **significant assurance** provided regarding the discharging of its remit as outlined in the Committee's ToR. The Committee approved minor revisions to its ToR.

	Board Committees' Year-End Effectiveness Reports and Review of their Terms of Reference (ToR) The Committee agreed **full assurance** on the year-end effectiveness reports from the Board Committees concerning their activity and effectiveness for 2023/24, comparing the work of the Committees to their ToRs. Some standard terms were proposed for all Committees**.** A summary of the year-end reporting will be presented to the Trust Board in May.
	Well Led Action Plan The report gave an update on the Well Led Review (WLR) action plan. It was noted that there has been good progress on the initial six-month recommendations (deadline 31 March 2024) and there is a plan in place to review and progress the longer term 12-month recommendations (deadline 30 September 2024). It was agreed to rag-rate the outstanding actions to reflect the current status and to report back in July. **Limited Assurance** was agreed on the basis that some actions remain outstanding.
	Conflicts of Interest and Declarations of Interest Update The Trust's returns for Decision Making Staff had seen a marginal increase on the level of responses from the previous year and as such the Trust will initially adopt a three-pronged approach to achieve a high return for the forthcoming year, requesting returns in May, July and October. **Limited assurance** was agreed on the basis that more work needed to be done to approve the return rates. In relation to the declarations arose from the Estates team. analysis showed that these were from existing, rather than prospective contractors and there was no influence to purchasing intentions of the Trust or its employees. It was agreed to include a caveat that declarations are to be made ahead of accepting gifts or hospitality.
	Internal Audit Plan The Committee approved the 2023/24 Internal Audit Plan, subject to the re-phasing of audits to give a greater spread over the year.
	Internal Audit Progress It was reported that Safeguarding and Supervision of Staff reviews are in the draft stage and will be completed in time for the Head of Audit Opinion. The Committee noted that the Trust has achieved 100% implementation of actions for 2023/24.
	Interim Head of Audit Opinion Internal Auditor, 360 Assurance, reported that the final opinion cannot be given until all reports have been completed. However, based on current information, a significant assurance opinion is expected.
	Counter Fraud Progress The Committee received an update on activity undertaken in accordance with the Counter Fraud Plan and included the current position in relation to continued compliance with the Government Functional Standard and submission of the Trust's Counter Fraud Functional Standard Return.. It was noted that a suite of training modules has been provided to emphasise the responsibility of all staff to bring fraud concerns to the team's attention.
	Counter Fraud Plan The Committee approved the Counter Fraud Work Plan 2024/25.

	External Audit - Audit Strategy Memorandum The report summarised Mazars' audit approach, significant audit risks and areas of key judgements. It was noted that there are no changes in terms of risks identified and overall progress was on track with no issues to be reported.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** 23 May 2024
Committee Chair: Geoff Lewins	**Executive Lead: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2024

Guardian of Safe Working (GOSW) Quarterly Report (March 2024)

Purpose of Report

This quarterly report from the DHcFT 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.

Executive Summary

The Committee is requested to note:

1) One exception report was submitted in this period (an ST4 doctor on the north psychiatry rota breaching non-resident on call rest requirements). Immediate time off in lieu (TOIL) and payment were given to the doctor, and a fine levied against the Trust.
2) The GOSWH has recently been elected as the Local Negotiating Committee (LNC) Chair. There are synergies between the GOSWH and LNC, which should optimise discharging the duties of the GOSWH.
3) The GOSWH has worked with colleagues in the region to re-invigorate the regional GOSWH network and is currently the chair of this group. One meeting has occurred thus far, and they are set to be quarterly.
4) Through discussion with the Director of Medical Education (DME) and consultation through the Trust Medical Training Committee (TMTC), personalised work schedules have now been disseminated to both doctors and supervisors. The wording of the email communication highlights its utility, both from a training and supervisory perspective. It also forms a more objective basis on which exception reporting can be done. The email was accompanied by a blank template, a hypothetical example, and a live version of a doctor that is using it (with their permission).
5) Following discussion at the January Junior Doctor Forum (JDF), a doctor and a member of the Medical Education team are looking to roll out 'live rotas' embedded within MS Teams channels. This should allow for clear version control to assist both switchboard colleagues as well as the doctors on the rota. This approach has the blessing of Medical Staffing and the Medical Director. The GOSWH will look to support the Medical Education team and the doctor driving this forward.
6) Following discussion at the January JDF, a meeting is planned (date to be confirmed) to scope and define a rota coordinator role. This will need a business case, and the current financial climate means it is unlikely to be immediately granted. That being said, there was clear consensus that such a role would be beneficial and thus groundwork now could capitalise on when such funding becomes available.

7) Meetings have been set up to discuss the medical workforce implications of the new build inpatient units in both the north and the south of the Trust. People involved include the GOSWH, Medical Staffing, Clinical Directors and operational managers.

8) A discussion is set in April to look to procurement for junior doctor study leave expenses. Currently the doctor would pay and claim back, with money coming from the Deanery via the employer. Courses and conferences can be expensive, and this there is a worry on accessibility. Direct procurement would prevent doctors going out of pocket, but also set the Trust apart from other placements in the region.

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	X
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long-term sustainability.	X

Risks and Assurances

This report from the DHcFT Guardian of Safe Working 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.

Consultation

- The GOSW has shared the previous report to this Committee with the Joint Local Negotiating Committee, the Trust Medical Training Committee, the Junior Doctor Forum and its constituent junior doctors. Following presentation to this Committee, this report will be shared with the next Junior Doctor Forum and its constituent junior doctors.
- This report provided the Quality and Safeguarding Committee with significant assurance on 12 March 2024 that the Trust is discharging its statutory duties in employing Junior Doctors on the 2016 contract.

Governance or Legal Issues

None.

Public Sector Equality Duty & 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:

None.

Recommendations

The Board of Directors is requested to:

1. Note the contents of this report
2. Be assured that that the duties and requirements as set out in the 2016 Junior Doctor terms and conditions of service are being met.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Dr Kaanthan Jawahar**
Guardian of Safe Working Hours

GUARDIAN OF SAFE WORKING QUARTERLY REPORT
(December 2023)

1. Trainee data

Extended information supplied from 5 December 2023 to 4 March 2024.

Numbers in post for doctors in training

Numbers of doctors in post WTE	North	South
FY1	3	5
FY2	2	4
GP ST	3.6 (headcount 4)	6.4 (headcount 7)
CT	10.6 (headcount 11)	11.8 (headcount 12)
HSTs	3	7.2 (headcount 8)
Paediatrics ST	0	1.8 (headcount 3)

Key
CT = Core trainee years 1-3
FY1/FY2 = Foundation year trainee (years 1 and 2)
HST = Specialty trainee (ST) years 4-7
GP ST = General practice specialty trainee
Paediatrics ST = Paediatrics specialty trainee (year 4+)

2. Exception Reports

Covering the period 5 December 2023 to 4 March 2024.
Total number of exception reports = 1 (all working hours related)

Location	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	1	1	0
South	0	0	0
Total	1	1	0

Grade	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	0	0	0
ST4-7	1	1	0
GP	0	0	0
Foundation	0	0	0
Total	2	2	0

Action taken:

Location	Payment	TOIL	Not agreed	No action required
North	1	1	0	0
South	0	0	0	0
Total	1	1	0	0

Response time:

Grade	48 hours	7 days	Longer than 7 days	Open
CT1-3	0	0	0	0
Foundation	0	0	0	0
ST4-7	0	1	0	0
GP	0	0	0	0

- The exception report in this period was on the north psychiatry on non-resident on call rota. The ST4 doctor breached their minimum rest requirements (8 hours per 24 hours, of which 5 hours must be continuous between 10pm and 7am), resulting in compensatory rest, payment to the doctor and a fine levied against the trust.

3. Work schedule reviews

No formal work schedule reviews during this period.

4. Fines

- The current total of fines available for the JDF to spend is £886.28 through cost code G62762.
- Fines recently spent on crockery and a lamp for junior doctor common areas. Further items are also being purchased for the rest areas.

5. Locum/Bank Shifts covered (5 December 2023 to 4 March 2024)

	North	Cost	South	Cost
Locum/bank shifts covered	29	£16,320	36	£21,410
Agency locum shifts covered	0	0	0	0

6. Agency Locum

Nil.

7. Vacancies (5 December 2023 to 4 March 2024)

	North	South
CT1-CT3	0.4	0.2
ST4-7	3	0
GP Trainees	0.4	0.6
Foundation	0	0

8. Qualitative information

- The GOSWH has recently been elected as the LNC Chair. There are synergies between the GOSWH and LNC, which should optimise discharging the duties of the GOSWH.
- Through discussion with the DME and consultation through the TMTC, personalised work schedules have now been disseminated to both doctors and supervisors. The wording of the email communication highlights its utility, both from a training and supervisory perspective. It also forms a more objective basis on which exception reporting can be done. The email was accompanied by a blank template, a hypothetical example, and a live version of a doctor that is using it (with their permission).
- The GOSWH has worked with colleagues in the region to re-invigorate the regional GOSWH network and is currently the chair of this group. One meeting has occurred thus far, and they are set to be quarterly.
- Following discussion at the January JDF, a doctor and a member of the Medical Education team are looking to roll out 'live rotas' embedded within MS Teams channels. This should allow for clear version control to assist both switchboard colleagues as well as the doctors on the rota. This approach has the blessing of Medical Staffing and the Medical Director. The GOSWH will look to support the Medical Education team and the doctor driving this forward.
- Following discussion at the January JDF, a meeting is planned (date to be confirmed) to scope and define a rota coordinator role. This will need a business case, and the current financial climate means it is unlikely to be immediately granted. That being said there was clear consensus that such a role would be beneficial and thus groundwork now could capitalise on when such funding becomes available.
- Meetings have been set up to discuss the medical workforce implications of the new build inpatient units in both the north and the south of the Trust. People involved include the GOSWH, Medical Staffing, Clinical Directors and operational managers.
- A discussion is set in April to look to procurement for junior doctor study leave expenses. Currently the doctor would pay and claim back, with money coming from the Deanery via the employer. Courses and conferences can be expensive, and this there is a worry on accessibility. Direct procurement would prevent doctors going out of pocket, but also set the Trust apart from other placements in the region.

9. Compliance of rotas

Current work schedules are compliant with the 2016 junior doctor contract.

10. Other concerns raised with the Guardian of Safe Working (GoSW)

None that are not already covered in section 8.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2024

Sexual Safety Charter

Purpose of Report

To provide assurance. The Trust has signed up to the sexual safety in healthcare making clear its intention and commitment to provide a safe environment for staff, patients, carers and visitors which is free of unwanted sexualised behaviour.

Executive Summary

Those who work, train, and learn within the healthcare system have the right to be safe and feel supported at work.

Organisations across the healthcare system need to work together and individually to tackle unwanted, inappropriate and/or harmful sexual behaviour in the workplace. We all have a responsibility to ourselves and our colleagues and must act if we witness these behaviours.

NHS England has established a national charter for sexual safety in healthcare which is based upon 10 core principles.

Derbyshire Healthcare has become a signatory of the charter. In order to meet our organisational obligations as signatories, we are committed to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce, which we will achieve through establishing a clear plan demonstrating the actions we will take to embed the charter's 10 principles.

Therefore, the report includes the Trust's high-level plan, which sets out how this will be achieved.

Where the actions to establish these principles are not currently in place, the Trust will work towards ensuring these are in place by July 2024.

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3)	The Trust is a **great partner** and actively embraces collaboration as our way of working.	
4)	We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long-term sustainability.	

Risks and Assurances

- Provides assurance in respect of the organisation's stated commitment to uphold the principles of the charter and the articulation of actions to ensure compliance with these.

Consultation

- Deputy Director of Nursing and Patient Experience
- Quality and Safeguarding Committee 12 March 2024.

Governance or Legal Issues

- Alignment with national charter on sexual safety for healthcare organisations

Public Sector Equality Duty & 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:

There are no impacts on specific groups, however compliance with the Charter's principles will afford greater protections from unwanted sexualised behaviours.

Recommendations

The Board of Directors is requested to understand that the organisation is a signatory to the NHS England charter on sexual safety and to support the approach outlined in terms of actions to meet the ten charter principles.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Nikki Roome**
Assistant Director Safeguarding Adults

Introduction

Those who work, train and learn within the healthcare system have the right to be safe and feel supported at work.

Organisations across the healthcare system need to work together and individually to tackle unwanted, inappropriate and/or harmful sexual behaviour in the workplace.

We all have a responsibility to ourselves and our colleagues and must act if we witness these behaviours.

As signatories to this charter, we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the following principles and actions to achieve this:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently.

These commitments will apply to everyone in our organisation equally. Where any of the above is not currently in place, we commit to work towards ensuring it is in place by July 2024.

Next Steps

Steve Russell, Chief Delivery Officer for NHS England, wrote to all Chief Executives, Chief Nurses, and HR Directors to outline the launch of the first NHS Sexual Safety Charter. This letter seeks the support of all NHS organisations to take a systematic zero-tolerance approach to sexual misconduct and violence, keeping our patients and colleagues safe, recognising that sexual misconduct can happen to anyone anywhere. Those who work, train and learn within the healthcare system have the right to be safe and feel supported at work.

The need for this hugely important work has been emphasised by research published in the British Journal of Surgery *(Sexual harassment, sexual assault and rape by colleagues in the surgical workforce, and how women and men are living different realities: observational study using NHS population-derived weights | British Journal of Surgery | Oxford Academic (oup.com)*.

This study focused on the national surgical workforce, concludes that sexual misconduct has been experienced widely in this group, with women affected disproportionately.

Whilst we have already started work in this area, we are in the process of assessing our current practice against the ten core principles and will be reviewing our policies, procedures, training, and cultural interventions.

The Sexual Safety Policy has been completed and this week we have received comments from our forums to ensure it clearly reflects our commitment to keeping staff and patients safe and ensuring staff know how to report concerns.

The Assistant Director of Safeguarding Adults and the Safeguarding Trainer attend the community of practice for sexual safety, which allows the sharing of good practice. Furthermore, a sexual safety survey has been sent out, initially, to our inpatient ward staff.

Aim?

The aim of this survey is to generate baseline data to understand staff's levels of confidence and skills in managing, reporting and supporting each other and service users in relation to sexual safety. A further second aim is to understand any areas of excellence as an opportunity to share and build on.

Who?

This survey is aimed at staff who work in an inpatient ward setting.

Distribution?

Initially, to the Radbourne and Hartington units, with a plan to send out to other teams by 31 March 2024. The survey has now been sent to Tissington ward to initially focus work on here and Ward 33. The responses continue to come in from other areas.

How?

The survey can be completed online, by following a QR code or a link and on paper, through printing. If printed, the survey owner will need to upload the responses manually to MS forms so that the responses are collated.

What will we do with the results?

We will use the results to generate baseline data for our improvement. The suggestions that colleagues give in the survey will support developing change ideas, which we hope will support an improvement in confidence and skills.

Analysing and understanding the responses will be completed by 30 April 2024. This will be shared and will inform our approach for further work to support our colleagues and prevent unacceptable behaviours in our workforce.

The Icare programme delivers training for support staff around sexual safety and boundaries. It has been well received and we will continue to be a part of this programme.

Our commitment to this charter and a sexual safety charter is to be discussed on 7 April 2024 with an emphasis on how we reach all of our staff and the delivery of a training package that is sustainable. A sexual safety action plan has been developed. Further meetings held to continue this work.

The community of practice continue to meet on a monthly basis, work is progressing around an easy read sexual safety charter poster that is owned by all 6 areas involved in the Community of Practice for in-patient areas.

Wards have been asked to include the sexual safety booklet, which was developed some time ago, in their admission pack. Further assurance will be sought by the assistant Director will be done to ensure this is happening.

Further implementation and assurance around the strategy will be shared following this meeting.

Gender, Race & Disability Pay-Gaps Report

Purpose of Report

To analyse the difference in average pay between males and females; black, Asian, and minority ethnic (BME), and white employees; and between disabled and non-disabled employees. The pay gaps report makes recommendations for actions to increase equality in the pay bands of colleagues with different protected characteristics.

Executive Summary

Gender pay-gap reporting is a mandatory requirement for organisations in England with over 250 employees (Equality Act 2010). The NHS EDI Improvement Plan 2023 requires NHS organisations to extend pay gap reporting to cover race and disability. These figures are made available in the attached report. The pay-gap is different to equal pay (the same hourly rate for the same job) as it highlights the difference in the *average* hourly rate. The pay gap reflects the position of different people in the organisation. For example, the pay gap is larger if males occupy more of the senior positions relative to the overall percentage of males in the workforce.

Two measures are used for pay-gap reporting: the mean and the median. These are both measures of "central tendency". The mean is commonly referred to as the average: the number of hourly rates added together and divided by the total number. The median is the midway point, if all the hourly rates were set out from lowest to highest. The mean can be affected by uncommonly high or low hourly rates known as outliers. This can explain some of the large differences between the two figures.

The national median pay gap for gender in 2023 for full-time employees was 7.7%. In Derbyshire Healthcare, the median figure in 2023 for all employees is 11.53%. The mean and median figures for the Trust have increased slightly since 2021, although not dramatically, and represent a lack of progress towards equality between male and female pay.

Race and disability pay gap reporting is not mandatory and is relatively new to the NHS. This means there are fewer points of comparison between years, and it should be investigated whether the standard pay gap reporting framework works as well for these groups. The overall race pay gap shows a mean pay gap of -9.44% meaning that BME colleagues earn more on average, although this figure reverses with the median pay gap with white colleagues earning 3.3% more. Notably, when medical grade colleagues are removed from the figures, the mean pay gap is 7.7%, meaning white colleagues earn more. The figures here are likely to reflect the higher proportion of BME medics in the workforce. The overall disability pay gap is 0% median and 2.36% mean in favour of non-disabled employees, which indicates parity.

The relatively new reporting of race and disability pay gaps are one measure of equality within the Trust but should be seen in conjunction with our Race and Disability Equality Standard reports which continue to highlight areas of inequality within the organisation.

The production of these figures will enable year-on-year comparisons and provide a basis for improvements where needed.

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3)	The Trust is a **great partner** and actively embraces collaboration as our way of working.	
4)	We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long-term sustainability.	

Risks and Assurances

- Assurance to the Board will come through the EDI Steering Group and People & Culture Committee
- Challenges in lack of progress towards equality for gender pay gap and framework for collecting new data through race and disability pay gap reporting.

Consultation

- Strategic Recruitment Lead, Staff Networks
- People and Culture Committee 26 March 2024.

Governance or Legal Issues

- Mandatory reporting in line with Equality Act 2020. Requirement to publish on Trust website.

Public Sector Equality Duty & 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 report demonstrates pay gap inequality where it exists in the organisation in three protected characteristic areas. The NHS EDI Improvement Plan recommends an extension of this to other protected characteristics in subsequent years.

Recommendations

The Board of Directors is requested to note the information contained in the Gender Pay Gap Reports.

Report presented by: **Ralph Knibbs**
Chair, People and Culture Committee

Report prepared by: **Amany Rashwan**
Organisation Development and Inclusion Practitioner

Derbyshire Healthcare
NHS Foundation Trust

Gender, Race and Disability Pay Gaps Report

2023/24 (data extract as of 31 March 2023)

Table of Contents

Background

The gender pay gap reflects inequalities and discrimination in the labour market that mostly affect women. Women earn significantly less than men over their entire careers for complex, often interrelated reasons. These include but not limited to:

- differences in caring responsibilities
- more women in low skilled and low paid work
- outright discrimination[1]

NHS organisations are covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on 31 March 2017. These regulations underpin the Public Sector Equality Duty and require Employers with 250 employees and over need to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work.

This will include those under Agenda for Change terms and conditions, medical staff and very senior managers. All calculations are made relating to the pay period in which the snapshot day falls.

What is the gender pay gap?

- The gender pay gap is the difference between the average earnings of men and women, expressed relative to men's earnings.
- The mean pay gap is the difference between average hourly earnings of men and women.
- The median pay gap is the difference between the midpoints in the ranges of hourly earnings for men and women.

[1] Close the gender pay gap | The Fawcett Society

Reporting requirements

There are six calculations an organisation is required to publish, which are listed in the table below:

Table 1: Gender Pay Gap reporting requirements.	
Mean gender pay gap	The difference between the average of men's and women's hourly pay.
Median gender pay gap	The difference between the midpoints in the ranges of men's and women's pay. All salaries in the sample are lined up separately for men and women in order from lowest to highest, and the middle salary is used. The figure is the difference of these two middle points.
Mean bonus gender pay gap	The difference between the mean bonus payments made to relevant male employees and that paid to relevant female employees. For DHCFT this refers to local and national clinical excellence awards.
Median bonus gender pay gap	The difference between the median bonus payments made to relevant male employees and that paid to relevant female employees. For DHCFT this refers to local and national clinical excellence awards.
Proportion of males and females receiving a bonus.	The proportions of relevant male and female employees who were paid a bonus payment. For DHCFT this refers to local and national clinical excellence awards.
Proportion of males and females in each quartile band.	The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay bands.

What employers need to publish:

- The information outlined above will need to be published within one year of the date for the 2023 snapshot (publishing deadline of 30 March 2024 for data as of 31 March 2023).
- The information must be published on a website that is accessible to employees and the public free of charge.
- The information should remain on the website for a period of at least three years beginning with the date of publication.
- In addition, employers have the option to provide narrative that will help people to understand why a gender pay gap is present and what the organisation intends to do to close it.

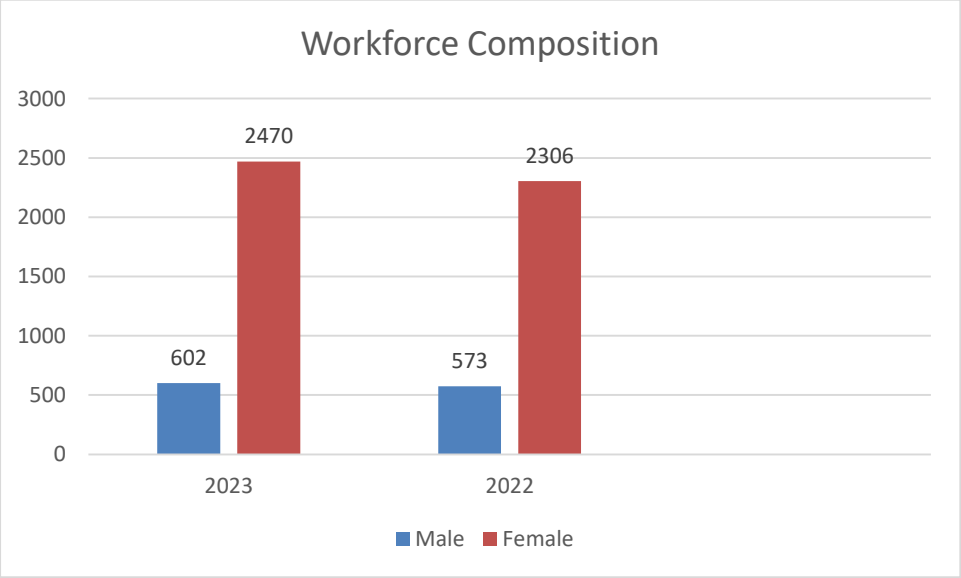
Gender Pay Gap

Our Workforce

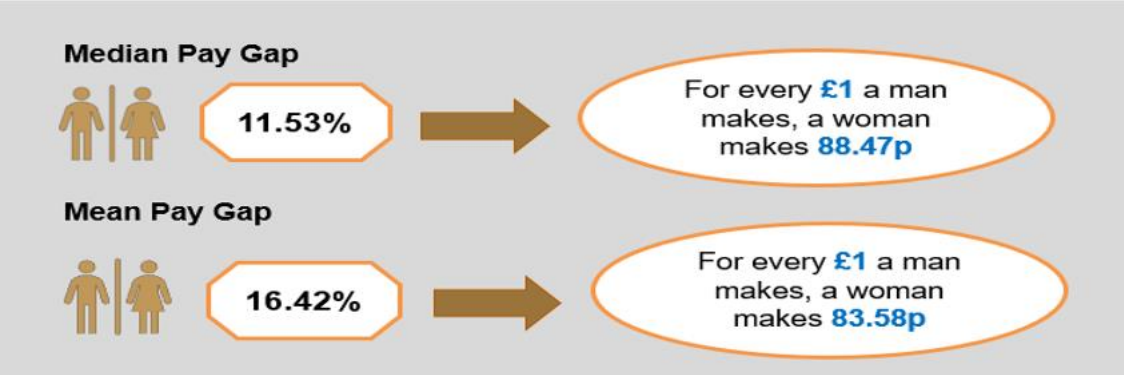
We collected our data on 31st March 2023, when our workforce consisted of 3072 employees 2470 (80.40%) women and 602 (19.60%) men. This has seen an increase of 193 people since 31 March 2022. The percentage of Women has remained relatively consistent over the past 12 months increasing slightly from 80.1% in 2022 to 80.4% in 2023.

Whilst the percentage of women has stayed the same in previous years due to the increase in employees in the total workforce the number of females has increased across all quartiles.

In common with the whole NHS, our Trust is predominantly female however we are committed to continue to encourage both men and women to apply for our roles where there is an under representation.



Gender Pay Gap



Gender	Average Hourly Rate	Median Hourly Rate
Male	£21.94	£19.48
Female	£18.34	£17.24
Difference	£3.60	£2.25

The median pay gap increased from last year to 11.53% from 10.39% in 2022 and the mean pay gap has reduced from very slightly from 16.51% in 2022 to 16.42%. Both of these figures are higher than the mean of 15.41% and median of 9.96% in 2021. There is a £3.60 mean pay gap between men and women and a £2.25 median pay gap which shows the importance of trying ensure proportionate representation of gender across the Trust.

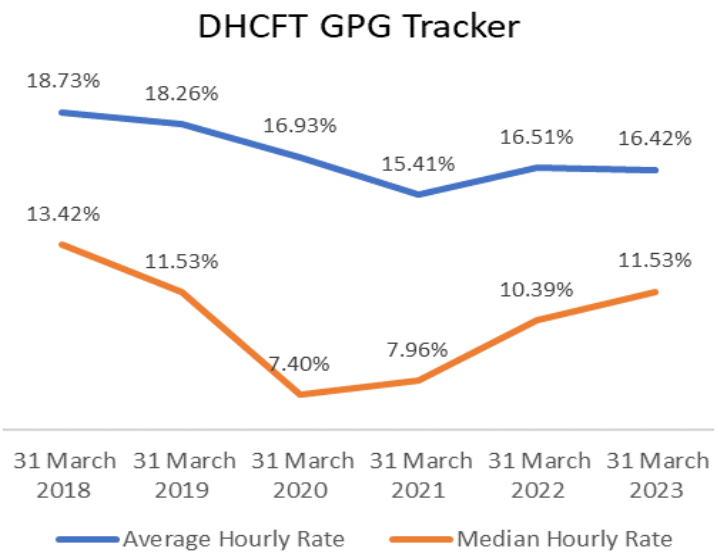
It is disappointing that the gap median pay gap has increased for the second year in a row however this can be due to the distribution of women across the pay bands.

The reason why the mean pay gap has not significantly improved could be linked to a reduction in the proportion of women in the top quartile and an increase in the proportion in the lower quartile.

We will continue to understand the reasons for this and look to address these in the coming years.

Gender Pay Gap

	31 March 2022		31 March 2023		Variation	
Gender	Average Mean Hourly Rate	Median Hourly Rate	Average Mean Hourly Rate	Median Hourly Rate	Average Mean Hourly Rate	Median Hourly Rate
Male	£21.02	£18.44	£21.94	£19.48	£0.92	£1.05
Female	£17.55	£16.52	£18.34	£17.24	£0.79	£0.72
Difference	£3.47	£1.92	£3.60	£2.25	£0.13	£0.33
Pay Gap %	16.51%	10.39%	16.42%	11.53%	-0.09%	1.14%



Quartiles

The table below highlights the proportion of women across the organisation and this distribution has a direct impact on the gender pay gap. By creating a more equal distribution this is likely to reduce the gender pay gap.

Since 2022 the number of males and females has increased across all quartiles however the proportion of women has increased by 1.36% in the lower quartile since 2022. The increase in the median pay gap since 2021 could be a result of the proportion of women in lower bands. The proportion of women in the lower quartile has increased from 83.75% in 2021 to 85.71% in 2023. In order to improve the gap more work must be done to ensure women progress through the pay bands but also attract males into roles where they are underrepresented in the lower quartile.

In addition to this there has been a significant reduction of 0.92% of women in the upper quartile from 2022 to 2023 which is trend which started in 2021 which will have a direct impact on the pay gap.

31 March 2022

Quartile	Female	Male	Female %	Male %
1	636	118	84.35	15.65
2	580	146	79.89	20.11
3	650	144	81.86	18.14
4	546	213	71.94	28.06

31 March 2023

Quartile	Female	Male	Female %	Male %
1	684	114	85.71	14.29
2	599	156	79.34	20.66
3	698	157	81.64	18.36
4	571	233	71.02	28.98

Variation

Female %	Male %
1.36	-1.36
-0.55	0.55
-0.23	0.23
-0.92	0.92

Proportion of females and males in each quartile over a period of 3 year						
	Women			Men		
Quartile	2021	2022	2023	2021	2022	2023
Q 1 (Lowest)	83.75 % 608	84.35% 636	85.71% 684	16.25% 118	15.65% 118	14.29% 114
Q2 (lower Middle quartile)	80.84 % 557	79.89% 580	79.34% 599	19.16% 132	20.11% 146	20.66% 156
Q3 (upper Middle quartile)	79.54 % 618	81.86% 650	81.64% 698	20.46% 159	18.14% 144	18.36% 157
Q 4 (Highest)	71.21 % 522	71.94% 546	71.02% 571	28.79% 211	28.06% 213	28.98% 233

Table 2 below shows DHCFT's overall mean and median gender pay gap and bonus gap based on hourly rates of pay over a period of 3 years.

According to the Office for National Statistics (ONS), median hourly pay for full-time employees nationally was 7.7% less for women than for men in April 2023 (figures exclude overtime pay), the Trust's current median hourly pay gap is 3.83% higher than the national figure.[2]

(If the mean gap is larger than the median gap it indicates the presence of a small number of top end outlier payment values favouring men, in relation to average hourly or bonus pay).

Bonus Gap

There are currently two types of bonus payments at Derbyshire health the clinical excellence and long service awards. The variation of the bonus pay gaps can depend on who is eligible for each award and is not linked to previous years payments. 43 males received a bonus compared to 88 females.

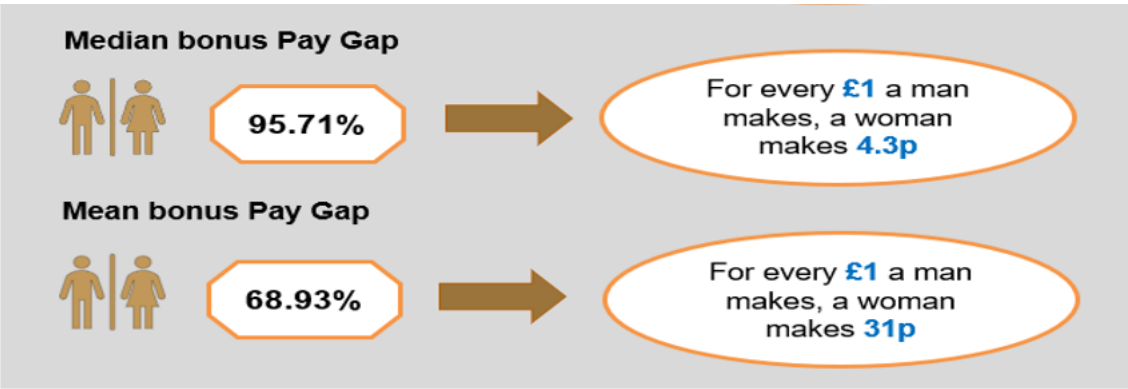
The bonus pay gap was mainly due to the clinical excellence awards and this can be associated with some large outlier payments to males based on honouring historic entitlements which increase this gap. Without the top 6 payments who are all males the mean pay gap would significantly reduce. During Covid in 2020, the **Clinical Excellence Awards** started being divided equally between eligible consultants at

[2] The gender pay gap - House of Commons Library (parliament.uk)

DHCFT, the existing gap is mainly due to a number of consultants receiving the award based on the historical process.

The bonus gap for long service awards is 1.43% and there is no median gap so this indicates that the scheme is administered consistently.

We will continue to monitor bonus payments and how these are paid to ensure fairness particularly in our clinical excellence Awards which tends to cause the bigger gap.



DHCFT Overall mean and median gender pay gap and bonus gap based on hourly rates of pay			
	DHCFT 2021	DHCFT 2022	DHCFT 2023
Mean bonus gender pay gap	89.54%	87.62%	68.93%
Median bonus gender pay gap.	88.93%	50.00%	95.71%
NB bonuses paid relate to clinical excellence awards which are for applicable consultants only rather than all employees (even though the calculation includes all staff)			

Q1 = Lowest, Q4 = Highest

Clinical excellence and long service awards

Doctors' clinical distinction/excellence awards is regarded as bonus pay, as well as any other payments above the level of ordinary for performance or expertise such as performance related pay for very senior managers, long service awards and others. The relevant period means the period of 12 months ending with the snapshot date. To gain a clearer understanding, bonuses have then broken down to illustrate the difference in Doctors' clinical excellence awards and long service awards.

The table relates exclusively to the **Clinical Excellence Awards (CEAs)** available to medical consultants. CEA is a national programme to recognise and reward medical consultants who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role, with a commitment to the continuous improvement of the NHS. They are determined locally, following a nationally agreed criterion.

Clinical Excellence Awards

Gender	Avgerage Bonus Pay	Median Bonus Pay
Male	£11,816.59	£6,996.75
Female	£7,876.27	£6,996.75
Difference	£3,940.32	£0.00
Pay Gap %	**33.35%**	**0.00%**

Long Service Awards

There are currently two schemes in operation within Derbyshire Healthcare NHS Foundation Trust. One is an 'in-service' award scheme which is only available to staff who transferred in from North-eastern Derbyshire PCT in 2004. The other is a scheme whereby individual employees receive a long service award on retirement if they have had 20 years or more continuous NHS service. The employee receives this automatically as part of the retirement process.

Long Service Awards

Gender	Avgerage Bonus Pay	Median Bonus Pay
Male	£246.15	£200.00
Female	£242.62	£200.00
Difference	£3.53	£0.00
Pay Gap %	**1.43%**	**0.00%**

The Long Service Award Scheme recognises employees' continuous service within the NHS.

The table below shows a comparison from 2022 to 2023

Clinical Excellence Awards

31 March 2022		
Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£14,588.71	£9,048.00
Female	£4,775.33	£3,619.20
Difference	£9,813.38	£5,428.80
Pay Gap %	67.27%	60.00%

31 March 2023		
Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£11,816.59	£6,996.75
Female	£7,876.27	£6,996.75
Difference	£3,940.32	£0.00
Pay Gap %	33.35%	0.00%

Variation	
Average Mean Bonus Pay	Median Bonus Pay
-£2,772.12	-£2,051.25
£3,100.94	£3,377.55
-£5,873.06	-£5,428.80
-33.92%	-60.00%

Long Service Awards

31 March 2022		
Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£250.00	£200.00
Female	£236.00	£200.00
Difference	£14.00	£0.00
Pay Gap %	5.60%	0.00%

31 March 2023		
Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£246.15	£200.00
Female	£242.62	£200.00
Difference	£3.53	£0.00
Pay Gap %	1.43%	0.00%

Variation	
Average Mean Bonus Pay	Median Bonus Pay
-£3.85	£0.00
£6.62	£0.00
-£10.47	£0.00
-4.17%	0.00%

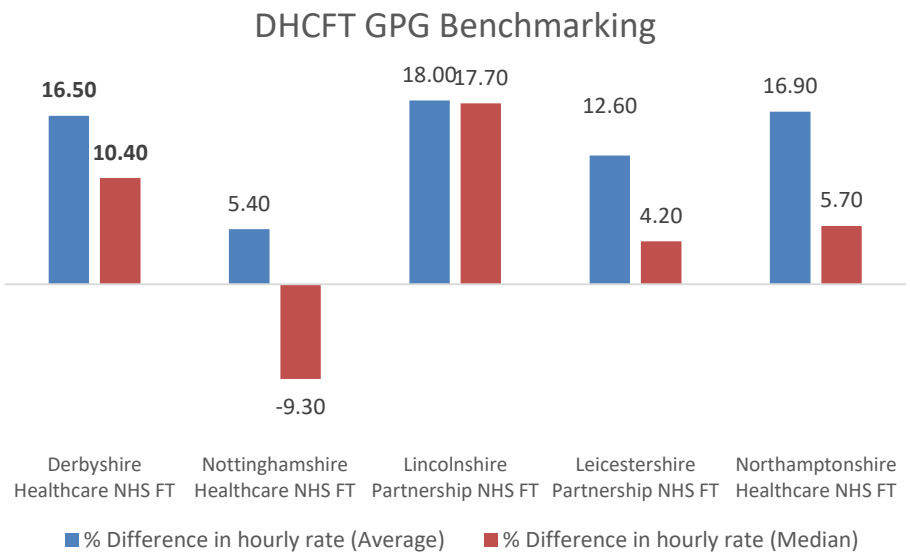
The tables below represent a comparison of 2022 versus 2023 Gender Pay Gap results for Derbyshire Healthcare NHS FT:

Competitor Benchmarking

The table below shows the Trust compares compared to similar NHS provider Trusts from data published in 2021.

Employer	% Difference in hourly rate (Average)	% Difference in hourly rate (Median)	% Women in lower pay quartile	% Women in lower middle pay quartile	% Women in upper middle pay quartile	% Women in top pay quartile	% Who received bonus pay (Women)	% Who received bonus pay (Men)	% Difference in bonus pay (Mean)	% Difference in bonus pay (Median)
Derbyshire Healthcare NHS FT	**16.50**	**10.40**	84.30	79.90	81.90	71.90	3.40	5.30	87.60	50.00
Nottinghamshire Healthcare NHS FT	**5.40**	**-9.30**	76.50	66.70	76.40	78.90	28.40	32.50	14.40	33.30
Lincolnshire Partnership NHS FT	**18.00**	**17.70**	14.00	19.00	18.00	28.00	0.20	2.80	18.00	17.70
Leicestershire Partnership NHS FT	**12.60**	**4.20**	84.70	82.20	85.20	75.40	0.90	3.80	53.80	0.00
Northamptonshire Healthcare NHS FT	**16.90**	**5.70**	89.30	83.10	87.30	77.10	25.40	34.80	42.90	39.40

Source: *GOV.UK*


DHCFT GPG Benchmarking
16.50
10.40
5.40
-9.30
18.00
17.70
12.60
4.20
16.90
5.70
Derbyshire Healthcare NHS FT
Nottinghamshire Healthcare NHS FT
Lincolnshire Partnership NHS FT
Leicestershire Partnership NHS FT
Northamptonshire Healthcare NHS FT
% Difference in hourly rate (Average)
% Difference in hourly rate (Median)

Ethnicity & Disability Pay Gap Reporting

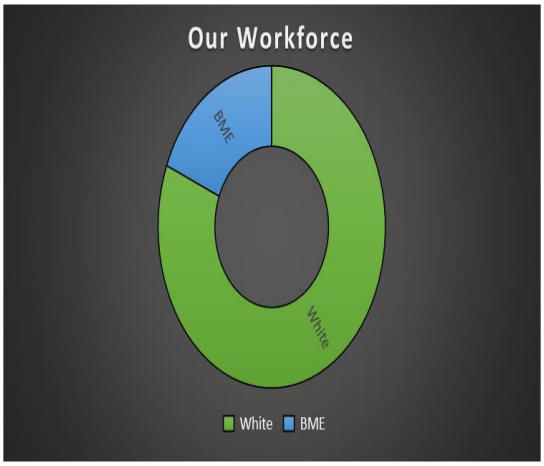
In line with the aspirations of the NHS nationally[3], the Trust has compiled the below ethnicity & disability pay gap reporting for the second year, as part of the organisation's approach to improve inclusion and tackle inequality in the workplace.

With more year-on-year data, the trust will be in a better position to explore the ethnicity and disability pay gap trends and subsequently address it through impactful interventions.

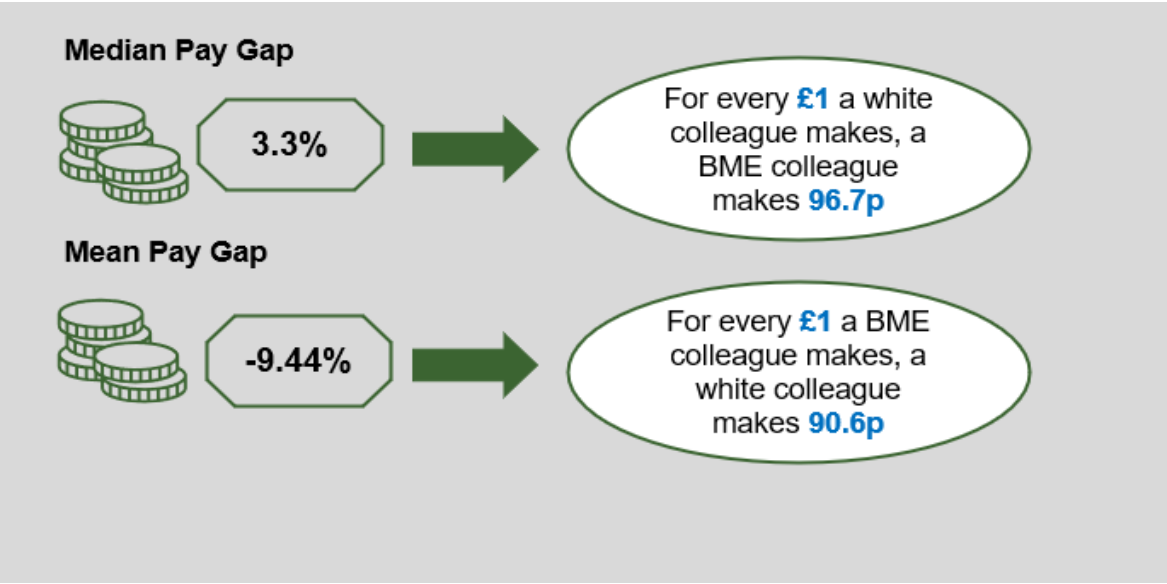
Ethnicity Pay Gap

Our data at a glance

The Trust workforce consists of 79.95% from White background, and 18.5% from BME background. Subsequently, all our quartiles are predominantly White colleagues, however, the highest concentration of colleagues from BME background is in the lower middle quartile.



The overall pay gap



The overall picture indicates that BME staff across the Trust on average earn more than white colleagues as the mean pay gap is 9.44% in favour of BME staff.

[3] NHS England » NHS equality, diversity, and inclusion improvement plan

However further analysis of this indicates that the medical workforce contributes to this where rates of pay are higher than other roles. When removing the medical workforce the ethnicity pay gap is 7.4% in favour of white employees.

Table 3 below shows DHCFT's overall mean and median ethnicity pay gap and bonus gap based on hourly rates of pay over a period of 2 years.

Table 3: DHCFT Overall mean and median ethnicity pay gap based on hourly rates of pay over a 2-year period				
	DHCFT 2022		**DHCFT 2023**	
Mean hourly rate pay gap	-10.94%		-9.44%	
Median hourly rate pay gap	6.53%		**3.30%**	
NB bonuses paid relate to clinical excellence awards which are for applicable consultants only rather than all employees (even though the calculation includes all staff)				
Proportion of white and BME colleagues in each quartile over a period of 2 years				
	BME		**White**	
Quartile	**2022**	**2023**	**2022**	**2023**
Q 1 (Lowest)	17.49% 128	18.77% 143	82.51% 604	81.23% 619
Q2 (lower Middle quartile)	27.20% 192	29.42% 213	72.80% 514	70.58% 511
Q3 (upper Middle quartile)	12.16% 94	14.15% 116	87.84% 679	85.85% 704
Q 4 (Highest)	20.95% 154	22.12% 175	79.05% 581	77.88% 616

Disability Pay Gap results

This is the first year DHCFT is reporting on the Disability pay gap in line with the NHS national aspiration. As per our Workforce Disability Equality Standards report, the trust employs 273 members of staff with a disability which equates to **8.9%** of the overall workforce.

It is crucial to note that this figure might not be representative of the actual number of colleagues who have a disability since it depends on the declaration rates which improved by 2.2% from 2022 to 2023.

As per the below data, the trust does not have a median hourly rate gap between staff who declared a disability and those who stated they do not have a disability. However, the mean hourly rate shows a gap of 2.36% in pay between colleagues who declared a disability and those who did not.

Disability Pay Gap results as at 31 March 2023:

The table below shows the gap in the mean and the median hourly rate between colleagues who stated that they have a disability and those who started that they do not.

Disability	Average Hourly Rate	Median Hourly Rate
No	£18.99	£17.24
Yes	£18.55	£17.24
Difference	£0.44	£0.00
Pay Gap %	2.36%	0.00%

The table below shows distribution of colleagues who stated that they have a disability and those who started that they do not across the four quartiles.

Quartile	No	Yes	No %	Yes %
1	143	619	89.72%	10.28%
2	213	511	90.12%	9.88%
3	116	704	88.17%	11.83%
4	175	616	90.87%	9.13%

Q1 = Lowest, Q4 = Highest

Actions to address the pay gap:

The gender pay gap exists due to a number of factors, some of which are driven by societal and cultural structures that puts women at a disadvantage. These can create bias in organisational structures and systems.

DHCFT's action plan is to adopt evidence-based recommendations to addressing the gap over the next 4 years,

Some of the measures the trust is committing to:

- Review the employee lifecycle to identify any existing barriers to recruitment, progression and retention of women,
- Create clear and transparent routes for progression,
- Review and improve career progression for part-time employees,
- Encourage flexible working for all staff. The flexible working policy is undergoing a review at the moment with the view to improve it and make it inclusive and comprehensive,
- Encourage men to take-up parental leave,
- Support the women's network to maximize the potential of the group and increase their impact,
- Support carers responsibilities,
- Tackle workplace sexual harassment.

Through the new Equality, Diversity, and Inclusion Steering Group will set specific goals for Gender Pay Gap and monitor these with the Workforce Race/Disability Equality Standards to apply fairness of opportunity and parity.

We know that sustained improvements will take time but have confidence in the targeted actions being applied.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2024

Modern Slavery Statement

Purpose of Report
To present the Trust's Annual Modern Slavery Statement for 2023/24 for approval.

Executive Summary
The Trust's Annual Modern Slavery Statement for 2023/24 is attached. This statement was considered and supported by the People and Culture Committee on 26 March to assess whether the Trust has met the criteria for the preceding financial year. The statement has been reviewed by the Head of Strategic Procurement and Tendering, the Assistant Director, Safeguarding Adults, the Strategic Recruitment Lead and the Head of Equality, Diversity and Inclusion. The Board is requested to approve the Statement, and this will be uploaded to the Trust's website, replacing the previous version.

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 creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long-term sustainability.	

Risks and Assurances
The Board receives assurance that the Trust is discharging its statutory duties regarding the modern slavery statement through the statement which it approves on an annual basis.

Consultation
• People and Culture Committee 26 March 2024 • Board of Directors.

Governance or Legal Issues

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.

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 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.

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.

Recommendations

The Board of Directors is requested to approve the revised Modern Slavery Statement for 2023/24 for publishing on the Trust's website, replacing the previous version.

Report presented by: **Ralph Knibbs**
Senior Independent Director

Report prepared by: **Justine Fitzjohn**
Director of Corporate Affairs and Trust Secretary

MODERN SLAVERY STATEMENT – 2023/24

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.

If required, the information may also be provided in other languages.

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 Disclosure Barring Service criminal records check for roles that meet the requirements. 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 PCR 2015 (Public Contract Regulations) procurements tendered in compliance with UK 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.

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

Mark Powell
Chief Executive

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 7 May 2024

Report from the Council of Governors meeting

The Council of Governors has met once since the last report, on 5 March 2024, and the meeting was conducted as a hybrid meeting.

Chief Executive's update

The update was presented by the Trust's Director of Strategy, Partnerships and Transformation in the Chief Executive's absence. It focused on:

- The impact of the Consultants and Junior Doctors ongoing industrial actions
- Annual planning
- Development of the new Trust Strategy
- Service delivery, particularly in relation to out of area placements.

Living Well Derbyshire Programme Update

The Trust's Director of Strategy, Partnerships and Transformation, along with the Deputy Director of Practice, and Transformation and Communications and Engagement Manager presented an update of the Living Well Derbyshire programme. The update included:

- An overview of the Living Well Derbyshire programme
- Key benefits for patients, carers and colleagues
- Feedback
- An outline of phase two
- E-learning package for staff
- Timescale for launching services across Derbyshire in 2023/24
- Getting involved.

Development of Annual Plan: Consult on Annual Planning Process

The Director of Strategy, Partnerships and Transformation and Director of Finance gave a presentation on the NHS planning round. The presentation set out a number of performance targets the Trust is required to deliver and the financial and workforce summaries and what that means in terms of activity.

The planning processes have changed over the last few years, but the statutory position is that the Trust must have due regard to the views of the governors on the:

Update on Trust Strategy Development

The Director of Strategy, Partnerships and Transformation gave an update on the progress of the new three-year Trust Strategy which included:

- An outline of the engagement process which focuses on culture, the Trust's vision and values, and the Trust's approach to health inequalities
- A summary of initial conversations/surveys/meetings which have taken place with staff
- Consultative session with governors has been arranged for 16 April 2024
- Engagement will begin with external stakeholders after Easter
- The new Trust Strategy will be launched in September 2024.

Report From Governors Nominations and Remuneration Committee, held on 13 February 2024

The Trust Chair presented an overview of the matters discussed at the last Governors Nominations and Remuneration Committee which focused on an outline of the appraisal process for the Trust Chair and Non-Executive Directors (NEDs).

Non-Executive Directors Report

Two of the NEDs presented their overview reports on their role and activities at the Trust and within the Joined-Up Care Derbyshire system

Escalation Item to The Council of Governors from the Governance Committee

Governors received a response to a holding to account question to the NEDs around the role of Occupational Therapists, and safe staffing requirements. Governors were assured by the responses given.

Non-Executive Directors' Verbal Summary on the 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.

Review of Governors' Membership Engagement Action Plan

The Membership and Involvement Manager provided an update on the Governors' Membership Engagement Action Plan (the Action Plan). Governors were reminded that they 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. The Action Plan was last reviewed by the Governance Committee on 7 February 2024. The Action Plan is aligned to the key objectives for members' engagement in the Membership Strategy 2021-2024.

Governance Committee Report

The Co-Chair of the Governance Committee presented a report of the meetings held on 7 December 2023 and 7 February 2024.

Governor Training and Development Schedule

The Membership Involvement Manager outlined training and development sessions that governors have received, and sessions that will be taking place during the year. Governors were also made aware of training delivered by external organisations that are available to them.

Election Update

A summary report on the 2023/24 elections was given. Inductions have been completed for the new governors. There is still one vacancy for the seat in Erewash.

RECOMMENDATION

The Trust Board is asked to note the summary report from the Council of Governors meeting held on 5 March 2024.

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
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
ATR	Alcohol Treatment Requirement
ATU	Acute Treatment Unit
B	
BAF	Board Assurance Framework
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BME	Black and Minority Ethnic group
BoD	Board of Directors
BPPC	Better Payment Practice Code
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCT	Community Care Team
CDEL	Capital Departmental Expenditure Limit
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CGA	Comprehensive Geriatric Assessment
CHPPD	Care Hours Per Patient Day
CIN	Children in Need
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
CP	Child Protection
CPA	Care Programme Approach

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQUIN	Commissioning for Quality and Innovation
CRD	Clinically Ready for Discharge
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis Resolution and Home Treatment
CROMS	Clinician Reported Outcome Measures
CRR	Case Record Reviews
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSF	Commissioner Sustainability Fund
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAR	Divisional Assurance Review
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
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
DME	Director of Medical Education
DNA	Did Not Attend
DoC	Duty of Candour
DOF	Director of Finance
DoH	Department of Health
DOL	Deprivation of Liberty
DoLS	Deprivation of Liberty Safeguards
DON	Director of Nursing
DPA	Data Protection Act
DPI	Director of People and Inclusion
DPS	Date Protection and Security
DRR	Drug Rehabilitation Requirement
DRRT	Dementia Rapid Response Team
DSAB	Derby and Derbyshire Safeguarding Adult Board
DSCB	Derby and Derbyshire Safeguarding children Board
DSPT	Director of Strategy, Partnerships and Transformation
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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 and Reprocessing Therapy
EMR	Electronic Medical Record
EPMA	Electronic Prescribing and Medicine Administration
ePMO	Electronic Programme Management Office
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
GMP	Guaranteed Maximum Price
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
HCP	Healthy Child Programme
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
Icare	Increase Confidence, Attract, Retain, Educate
ICB	Integrated Care Board
ICM	Insertable Cardiac Monitor
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IFRS	International Financial Reporting Standards
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IMT	Incident Management Team
IM&T	Information Management and Technology
IRHTT	In-reach Home Treatment Team
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPT	Interpersonal Psychotherapy
IRT	Incident Review Tool
J	
JDF	Junior Doctor Forum
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LAC	Looked After Children
LCFS	Local Counter Fraud Specialist
LA – CYPD	Local Authority – Children and Young People Divisions
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LeDeR	Learning Disabilities Mortality Review
LHP	Local Health Plan
LHWB	Local Health and Wellbeing Board
LNC	Local Negotiating Committee
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LTP	Long Term Plan
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
	Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
MASH	Multi-Agency Safeguarding Hub
MAST	Management and Supervision Tool
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
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLT	Mental Health Liaison Team
MHOST	Mental Health Optimal Staffing Tool
MHRT	Mental Health Review Tribunal
MMC	Medicines Management Committee
MoU	Memorandum of Understanding
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSU	Medium Secure Unit
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NETS	National Educational Training Survey
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
NPS	National Probation Service
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OOA	Outside of Area
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
PCC	People and Culture Committee

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
PCN	Primary Care Networks
PDSA	Plan, Do, Study, Act
PFI	Private Finance Initiative
PFF	Probation Feedback Form
PHC	Public Health Commissioners
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	People in Positions of Trust
PLACE	Patient-Led Assessments of the Care Environment
PLIC	Patient Level Information Costs
PMF	Performance Management Framework
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 Measures
PSF	Provider Sustainability Fund
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Review Framework
Q	
QAG	Quality Assurance Group
Q&SC	Quality and Safeguarding Committee
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
R	
RAID	Rapid Assessment, Interface and Discharge
RAP	Recovery Action Plan
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
ReQoL	Recovering Quality of Life
ROM	Reported Outcome Measure
RRP	Recruitment Retention Proposal
RTT	Referral to Treatment
S	
SAAF	Safeguarding Adults Assurance Framework
SAS Doctor	Specialist, Associate Specialist and Specialty Doctor
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLR	Service Line Reporting
SMI	Severe Mental Illness
SNOMED CT	Systemised Nomenclature of Medicine – Clinical Terms

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
STOMP/STAMP	Stopping The Over-Medication of children and young People with a learning disability, autism or both / Supporting Treatment and Appropriate Medication in Paediatrics
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SW	Social Worker
SystmOne	Electronic patient record system
T	
TAV	Team Around the Family
TARN	Trauma Audit and Research Network
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TLT	Trust Leadership Team
TMAC	Trust Medical Advisory Committee (now Medical Senate)
TMT	Trust Management Team
TMTC	Trust Medical Training Committee
TOIL	Time Off In Lieu
TOOL	Trust Operational Oversight Leadership
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
U	
UDBH	University Hospitals of Derby and Burton
UEC	Urgent and Emergency Care
V	
VARM)	Vulnerable Adult Risk Management
VO	Vertical Observatory
VTE	Venous Thromboembolism
W	
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

(updated April 2024)

FORWARD PLAN - BOARD - 2024/25		07-May-2024	02-Jul-2024	03-Sep-2024	05-Nov-2024	14-Jan-2024	04-Mar-2025
	Deadline for Approved Papers	**25-Apr-2024**	**20-Jun-2024**	**22-Aug-2024**	**24-Oct-2024**	**02-Jan-2025**	**20-Feb-2024**
DOCA/TS	Declarations of Interest	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
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DCEO/CDO	Trust Strategy Progress update (approval Sep, launch thereafter)	X		X		X	X
DPODI	Staff Survey Results (following assurance at People and Culture Committee)						X
DPODI	Annual Gender Pay Gap Report for approval (following assurance at People and Culture Committee)	X					
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for Board delegated authority for People and Culture Committee meeting on 24 September to approve the October submissions			X			
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications/retrospective sign off after PCC on 24 September				X		
DPODI	Workforce Plan for 2024/25		X				
DPODI	Annual Approval of Modern Slavery Statement (following assurance at People and Culture Committee - to be published on Trust website on approval)	X					
DPODI	2024/25 Flu Campaign	Summary of 2023/24 campaign		X			
DOCA/TS	Corporate Governance Report	X					
DOCA/TS	Year-end Governance Reporting from Board Committees and Approval of ToRs (within Corp Gov report)	X					
DOCA/TS	Trust Sealings (six monthly - for information - also within May Corp Gov report)	X			X		
DOCA/TS	Annual Review of Register of Interests	X					
DOCA/TS	Board Assurance Framework Update	X		X	X		X
DOCA/TS	Freedom to Speak Up Guardian Report (six monthly)			X			X
DOCA/TS	Board Effectiveness Report				X		
CHAIR	Fit and Proper Person Declaration		X				
DOF/DCEO/CDO/ DPODI	Planning Update	X (Finances)	X (Ops)				
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
OPERATIONAL PERFORMANCE							
DCEO/CDO/DON/ DOF/DPODI	Integrated Performance and Activity Report to include Finance, People performance and Quality	X	X	X	X	X	X
DCEO/CDO	ICB Joint Forward Plan (included in CEO Update)		X				
DCEO/CDO/DOF	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
Prog Director	Making Room for Dignity progress	X			X		
DON/DPODI	Workforce Standards/Safer Staffing Formal Submission (prior to publishing on website, following assurance at PCC (Workforce Planning) and QSC (Safer Staffing))		X				
QUALITY GOVERNANCE							
EXEC	Update on CQC Domains followoing review of Quality Position Statements		X				
MD	Learning from Deaths Mortality Report on Assurance from Quality and Safeguarding Committee		AR		X	X	X
MD	Guardian of Safe Working Report on assurance from Quality and Safeguarding Committee		AR		X	X	
DON	Receipt of Annual Reports on assurance from Quality and Safeguarding Committee: - Annual Looked After Children - Annual Safeguarding Children and Adults at Risk - Annual Special Educational Needs and Disabilities (SEND)				X		
DCEP/CDO	Continuous Quality Improvement: A Stocktake						X
DON	Infection Prevention and Control Annual Report and BAF				AR		
MD	Re-validation of Doctors Compliance Statement		X				
DON	Outcome of Patient Stories - every two years - due March 2026						
POLICY REVIEW							
DOF/DOCA/TS	Standing Finance Instructions Policy and Procedures (Jul 2024)		X				