PUBLIC BOARD MEETING
TUESDAY 2 JULY 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, apologies and declarations of interest 1.1 Trust Vision and Values 1.2 2024/25 Register of Interests	Selina Ullah
STANDING ITEMS			
2.	9.35	Minutes of the Board of Directors meeting held on 7 May 2024	Selina Ullah
3.		Action Matrix and Matters Arising	
4.		Questions from members of the public	
5.	9.40	Chair's update	Selina Ullah
6.	9.55	Chief Executive's update	Mark Powell
OPERATIONAL PERFORMANCE, STRATEGIC PLANNING AND CORPORATE & QUALITY GOVERNANCE			
7.	10.10	Integrated Performance report to include Finance, People Performance and Quality	Vikki Ashton Taylor/ Dave Mason/Rebecca Oakley/James Sabin
8.	10.50	Fit and Proper Persons Test - Declaration	Selina Ullah
11.00 BREAK			
9.	11.10	Improving the Working Lives of Doctors in Training	Arun Chidambaram
BOARD COMMITTEE ASSURANCE			
10.	11.20	Board Committee Assurance Summaries	Committee Chairs
REPORTS FOR NOTING ON ASSURANCE FROM BOARD COMMITTEES			
11.	11.45	Quality and Safeguarding Committee 11.1 Learning from Deaths/Mortality – Annual Report 11.2 Guardian of Safe Working – Annual Report 11.3 Revalidation of Doctors Compliance Statement - for Approval	Lynn Andrews
CLOSING BUSINESS			
12.	11.55	Identification of issues arising for inclusion or updating in the BAF	Selina Ullah
13.		Meeting effectiveness	
FOR INFORMATION			
Summary of Council of Governors meeting held 7 May 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 3 September 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 Capital and 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).

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 7 May 2024

MEETING HELD IN PUBLIC	
Commenced: 09.30am	Closed: 12:38pm

DRAFT

PRESENT	Selina Ullah	Trust Chair
	Tony Edwards	Deputy Trust Chair
	Ralph Knibbs	Senior Independent Director
	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	Deputy Chief Executive and Chief Delivery Officer
	Dr Arun Chidambaram	Medical Director
	Justine Fitzjohn	Director of Corporate Affairs and Trust Secretary
	Dave Mason	Interim Director of Nursing and Patient Experience
	Rebecca Oakley	Acting Director of People and Inclusion
	James Sabin	Director of Finance
IN ATTENDANCE	Anna Shaw	Associate Director of Communications and Engagement
	Jo Bradbury	Corporate Governance Officer
For DHCFT2024/040	Laura Hawksworth	IPS Peer Support Worker (Guest for Patient Story)
For DHCFT2024/040	Joe Thompson	Assistant Director of Clinical Professional Practice
For DHCFT2024/049	Andy Harrison	Senior Responsible Owner
OBSERVERS	Sandra Austin	Equal Network Advisor
	Fiona Birkbeck	Public Governor, High Peak and Derbyshire Dales
	Hannah Horton	Clinical Lead, North Derbyshire and Bolsover Community Mental Health Teams and Living Well
	Rebecca Mace	Area Service Manager, Adults o Working Age, Community Mental Health Team
	Helen Poyner	Head of Delivery, Living Well

DHCFT/ 2024/038	**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. The Register of Directors' Interest for 2024/25 was noted with no declarations of interest raised with any of today's agenda items.
DHCFT/ 2024/039	**ANNUAL REVIEW OF 2023/24 DECLARATIONS OF INTEREST** The report set out the year-end Register of Directors' interests that will be published in the Annual Report for 2023/24. To ensure openness and transparency during Trust business,

	the Register is updated with each new interest declared/removed and included at the next meeting in the papers that are considered by the Board of Directors at each meeting. **RESOLVED: The Board of Directors approved 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.**
DHCFT/ 2024/040	**<u>PATIENT STORY</u>** Dave Mason, Interim Director of Nursing and Patient Experience, introduced Laura for the patient story. Laura explained that she is autistic and is awaiting assessment for attention deficit hyperactivity disorder (ADHD) and shared that she also suffers with depression, anxiety, obsessive compulsive disorder (OCD), and borderline personality disorder (BPD), which is now known as Emotionally Unstable Personality Disorder (EUPH). It was noted that Laura's motivation for sharing her story is to highlight that people with BPD can enter a phase of recovery and hold down a job when supported and in the right environment. Laura wants to challenge negative attitudes towards this condition and encourage a more recovery-focussed point of view. Laura explained that two and a half years ago, she was a patient with the Trust's Community Mental Health Team and had access to both an Occupational Therapist and a Psychiatrist. Her long-term goal was to get back into employment, so when her Occupational Therapist suggested a referral to the Individual Placement and Support (IPS) employment team, she agreed. Laura was delighted to meet with an Employment Specialist who discussed work preferences. Laura had previously enjoyed working as a voluntary Peer Support Worker and she was advised by the Employment Specialist that there was a current opportunity within that team. She was so encouraging and kind that Laura submitted an application. Subsequently, she was invited to an interview. As this was to be conducted virtually, Laura was able to focus on the preparation. Research for the interview focussed on challenges within the NHS around budgeting, staff shortages and increased demand for mental health services and how these impact on IPS principles. During the interview, Laura spoke from the heart about her experiences and how it had been a long-term passion to support people with mental health issues as she has experience of being in a dark place mentally, feeling alone and hopeless with no support. When Laura was offered the job straight after the interview, she compared the feeling to receiving the 'golden buzzer' on tv's 'Britain's Got Talent' and she reflected that this was a real turning point in her life and her mental health recovery. Laura's favourite part of the job is meeting new people and empowering them to realise their own potential. She explained the IPS process, which is bespoke to individual needs, from referral through to securing employment, the main points being : • Consider and agree the preferred type of work, hours and required support • Referral to a Peer Support Worker if needed • Investigation of the barriers to employment • Help with confidence building, anxiety and mental health improvement • Application and interview guidance. It was noted that promoting the service can be challenging, and the team has leaflets and posters in waiting areas, attends multi-disciplinary meetings, spends time in the community and attends at job centres and job fairs. Laura stressed the importance of inclusivity and

DRAFT

	addressing the barriers to reaching more ethnically diverse groups, such as language or cultural differences and general attitudes towards mental health. Arun Chidambaram, Medical Director, thanked Laura for addressing the stigma around mental health within society and healthcare and recognised the benefit of the interview being conducted via MS Teams, helping relieve anxiety. Dave was interested in the main factors that have influenced Laura's outlook and her next goal. Laura confirmed that IPS has made a huge difference, as she is able to be honest about her mental health and ask for help, her next goal is to enjoy undertaking the Peer Support Worker role. Mark Powell, Chief Executive, added that he had found Laura's story very inspiring. He commented that she should be proud of herself and is a great advocate for the Trust's services. He asked if she had any suggestions for improvement. Laura was concerned that the service is not able to reach sufficient ethnic-diverse groups and requires increased promotion and referred to a suggestion from Joe Thompson, Assistant Director of Clinical and Professional Practice, to print the information leaflets in several languages. Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, asked about the first few weeks of starting in the role and what improvements could be made. Laura explained that she found the NHS culture very different, as she had been used to being told what to do and given set tasks, compared to using her own initiative in this post. She suggested a 'buddy' scheme might be helpful, however, the team has been so positive and welcoming, she has been able to reach out as needed. Lynn Andrews, Non-Executive Director, was encouraged that Laura has been supported by an excellent manager and team, which must have made a positive difference, and Laura agreed, recognising John Flaherty, IPS Team Leader and Samantha Parr, IPS Manager, in particular. Selina asked Rebecca Oakley, Acting Director of People and Inclusion, what the Trust can do to generate referrals and to ensure that managers have the skills to ensure people feel fully supported and able to bring their whole selves to work. Rebecca advised that as part of Joined Up Care Derbyshire, leaders receive training on Quality Conversations and Inclusive Leadership. **Action, People and Culture Committee to investigate the triangulation of enabling the workforce through psychological safety and inclusive leadership.** **RESOLVED: The Board of Directors was greatly inspired by Laura's story and keen to improve IPS referral generation and to ensure leadership training is fully inclusive, compassionate and embraces the importance of psychological safety.**
DHCFT 2024/041	**MINUTES OF THE PREVIOUS BOARD OF DIRECTORS MEETING** The draft minutes of the previous meeting held on 5 March 2024 were accepted as a correct record.
DHCFT 2024/042	**ACTION MATRIX** Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary explained that the overdue action, DHCFT/2023/101, triangulation of the Board Assurance Framework (BAF) and Board Committee scheduling is being addressed imminently with the support of James Sabin, Director of Finance. In relation to the action DHCFT/2024/025, Vikki updated that readmission data is now included as part of the Integrated Performance Report (IPR) today and that the national measure is the rate of mental health readmissions within 28 days of discharge. It was noted

DRAFT

	that previously, the target threshold was set at 10%, however, this data is no longer routinely monitored by NHS Digital.
DHCFT 2024/043	**<u>QUESTIONS FROM MEMBERS OF THE PUBLIC</u>** No questions had been received.
DHCFT 2024/044	**<u>CHAIR'S UPDATE</u>** Selina provided the Board with her reflections on activity since the previous Board meeting on 5 March 2024 and drew attention to the below points: Selina had been impressed with the individual services she had visited, which included the Allied Health Professionals Hub and the Physiotherapy team, who had explained how they managed to address an increase of more than 130% in referrals following the pandemic, using Quality Improvement (QI) and maintaining a focus on staff wellbeing. The team tracks data to ensure resources are moved appropriately. Selina suggested it would be beneficial to scale up this learning across the organisation to empower and encourage others to liaise with the QI team, to ensure all staff have a voice. As an example, Selina referred to discussions with Paul Beckworth, Catering Manager, which had emphasised the team's desire to provide a good service for patients, along with aspirations to be cost effective and environmentally aware. The Board noted that the e-Roster team had made saving suggestions, the Estates and Facilities team had showcased an appetite for further developments and improvements and the Patient Experience team had demonstrated the importance of patient voices and the need to respond quickly and compassionately to issues raised. Following a meeting with staff-side representatives, Selina has invited them to observe at Board meetings and to consider how working relationships can be further improved. Unfortunately, Selina was unable to attend the Medical Senate. However, Arun reported the forum had discussed how to empower people to make changes and he would distribute a summary to the Board. Arun commended Selina for raising the mental health profile at the recent NHS Provider Board meeting and Selina emphasised that mental healthcare must be recognised equally with physical healthcare, and she will continue to advocate this. The Board noted there has been much engagement with the Council of Governors and the Chairs of the East Midlands Alliance, and Selina had been part of the stakeholder panel for the recruitment of the University Hospitals of Derby and Burton (UHDB) NHS Foundation Trust's Chair. Prem Singh has been appointed and Selina is looking forward to working with him. The importance of providing opportunities for teams to come forward with suggestions was discussed and the Board recognised that continuous improvement is the main focus of the new strategy and needs to be embedded as business as usual. Mark added that all feedback received is taken back to the Executive Directors who are often assigned things to address. Selina acknowledged the passing of Linda Langley, the Trust's previous Lead Governor. Selina commented on Linda's compassionate nature, valued engagement and interaction and extended condolences to her husband, Steve and family. **RESOLVED: The Board of Directors considered the content of the Chair's update.**
DHCFT 2024/045	**<u>CHIEF EXECUTIVE'S REPORT</u>** The report covered current local issues and national policy developments and also reflected a wider view of the Trust's operating environment.

DRAFT

	Mark highlighted the many discussions that have taken place in relation to the 2024/25 operational and financial plan, which was submitted to the Integrated Care Board (ICB) on 2 May. The 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 the financial plan for 2024/25, which shows a deficit position. It was noted that this will be a significant challenge during the year in order to manage demand for services and meet national priorities, whilst seeking to develop and deliver a longer-term financial strategy that moves the Trust towards financial balance. In relation to Joined-Up Care Derbyshire (JUCD), it was noted there is a deficit of £75m and that financial planning is a challenge nationally. Mark referred to the recent, unannounced inspection of the acute service line by the Care Quality Commission (CQC), which has identified several improvement areas. The Trust's immediate commitment to put the necessary requirements in place was noted, along with the positive feedback received around the caring and sensitive interactions between staff and patients. The full report is expected in June. Mark reflected on today's patient story and the annual cost of mental health to the nation, and he emphasised the importance of ensuring individuals are in valuable employment with the support of effective partnerships. Mark advised that NHS Providers has published a new guide for Board members to support the reduction of health inequalities. The guide recommends the use of a self-assessment tool to determine the current position, along with a list of suggested objectives. It was noted that the reduction of health inequalities is a key part of the new Trust Strategy and part of the Clinical Strategy also. It was agreed that the self-assessment tool will be used at a Board Development Session to challenge where the Trust is positioned currently. **Action, Arun.** In support of the Trust's commitment to evidence-based digital transformation, the Board noted a report has been published by the NHS Confederation's Mental Health Network which outlines the challenges, benefits and opportunities. Arun advised that the Trust is already in the process of optimising its current digital technology and also looking to the future. Mark was keen to recognise the achievements of Trust staff. In particular, Dr Rais Ahmed has been appointed as Associate Registrar for Leadership and Management, for a five-year term with the Royal College of Psychiatrists' Leadership and Management Committee as well as being part of the College Council. Rais will promote the importance of good clinical leadership and medical management to effective mental health services. In addition, Professor Subodh Dave, who is also Dean of the Royal College of Psychiatrists, is planning to complete a monthly marathon and long distance run every month for 12 months to raise money for Doctors in Distress. Tony Edwards, Deputy Trust Chair, wanted to reflect on what the financial plan means in terms of the £6.4m deficit. He explained that the Trust is given a set amount of money, agreement is reached on what services it wants to provide and effectively, the deficit represents the cost of providing those services is more than has been allocated. As the Trust isn't breaking even financially, ways to achieve this are continually explored. Tony stressed that the Trust needs more funding than has been allocated and a great deal of improvement needs to be delivered to ensure sustainability over the next three to five years. Mark echoed this view and reported that planning for 2025/26 will be undertaken over the next two to three months to map out the plans for sustainability.

DRAFT

	RESOLVED: The Board of Directors scrutinised the report, noting the risks and actions being taken.
DHCFT/ 2024/046	**INTEGRATED PERFORMANCE REPORT (IPR)** The IPR provided an update on key finance, performance and workforce measures at the end of March 2024. **Operations** In relation to inappropriate out of area placements, Geoff Lewins, Non-Executive Director, asked if the Trust has conducted a root cause analysis and Vikki referred to the recent multi-agency discharge event (MADE) which highlighted a key requirement to improve connectivity and communication between community and inpatient services. Arun stated the importance of strengthened gatekeeping and challenging interventions via better use of data. It was recognised that one of the biggest strategic challenges is to confirm assurance on inpatient flow plans, including the reduction of length of stay, bed occupancy and inappropriate out of area placements. **Action, Finance and Performance Committee to receive assurance reports on the recovery action plan for inpatient flow as part of the performance report, from 23 July onwards.** Tony highlighted the waiting lists for Memory Assessment Services (MAS), Vikki reported on the significant continuous improvement work that has been led by the teams themselves, supported by the Transformation team. It was noted that demand for dementia diagnosis is increasing and will increase further over the next 10 years, and it is necessary to look at improved pathways. Mark reflected on the progress made over the last 12-14 months and it was noted that CAMHS waiting times have been halved and today's patient story evidenced the positive development of IPS over the last two to three years. In addition, there have been continuous improvements in access to Perinatal and Living Well services. The Board was encouraged by the evidenced successes. **Finance** Due to the focus on the financial position over the last couple of months, the Board did not have any additional questions. However, it was acknowledged that James has dealt with the challenges effectively in the short time since joining the Trust and this is to be applauded. James appreciated the feedback and recognised the achievements are the work of the whole team. **People** Geoff was pleased to see that the overall 85% compliance target for compulsory training has been achieved for the last 24 months. However, he asked if there are mechanisms in place to address the areas of non-compliance. Rebecca advised that compliance for Resuscitation and Positive and Safe training is being monitored through Supervision and monthly governance meetings and the Training and Education Group oversee this. The under-performance for Appraisals and Supervision compliance was noted for Corporate Services and Rebecca confirmed there is a specific action plan in place to address this. Geoff challenged that Supervision compliance remains low and queried if the 95% target is realistic. Rebecca advised that 360 Assurance have completed an audit of

DRAFT

	Supervision processes and the outcome is likely to recommend further actions to improve the position. It was agreed that additional oversight is required. **Action, People and Culture Committee to oversee the Training and Education Group.** Mark informed the Board that he is to share his appraisal objectives and those of the Executive Team with the wider organisation in the hope that this will encourage improved conversations. **Quality** Dave highlighted the following points: • reduction in the number of complaints received, attributable to the modified focus on early resolution • over 100 teams signed up to the electronic patient survey and there have been 599 patient feedback responses since September 2023 • whilst the number of Care Plan reviews is not on target, there is an improving trajectory. Mark drew attention to the high number of patients clinically ready for discharge (CRFD) and asked how this is escalated. Dave advised that the MADE event focussed on adult acute beds and discharges for that group and there has been significant improvement, with scrutiny via the Fundamentals of Care Group and improved governance and oversight. It was agreed that a clear escalation route for non-compliance of CPA (Care Planning Approach) will be overseen via the Divisional Performance Reviews. **Action.** Lynn asked if there are any early insights of how falls can be reduced, referring to the potential relationship between falls and delayed discharges and Dave confirmed that each fall triggers an immediate review of the Care Plan and there is a robust process in place. It was agreed that increased assurance of the outcomes will be presented to the Quality and Safeguarding Committee. **Action.** **RESOLVED: The Board of Directors:** **1. Obtained limited assurance on current performance across the areas presented and suggested where further assurance is required** **2. Formally agreed 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.**
DHCFT/ 2024/047	**<u>FINANCIAL PLAN UPDATE</u>** The update formally reported the submission of a final deficit plan of £6.4m, following agreement on 25 April 2024 at the Extraordinary Confidential Board meeting. **RESOLVED: The Board of Directors noted the previously 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.**
DHCFT/ 2024/048	**<u>TRUST STRATEGY PROGRESS UPDATE</u>** The Board received an update on progress in delivering the priority actions identified in the Trust strategy, as at Quarter 4. It was noted that work is underway to reduce the average length of stay to less than 32 days by March 2025, and progress from the launch of the Gatekeeping Framework and Purposeful Admission has resulted in a reduction to 48 days.

DRAFT

	Vikki highlighted that delivery of the required financial efficiencies is expected by September 2024, along with the launch of the new Trust Strategy. Selina observed that there were four actions due for completion in September and Vikki advised that the clear plans to deliver each are set out in the included road map. **RESOLVED: The Board of Directors noted the 2023/24 Quarter 4 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.**
DHCFT/ 2024/049	**MAKING ROOM FOR DIGNITY PROGRESS (MRfD)** Andy Harrison, Senior Responsible Owner, presented the Board with an update on progress of the MRfD programme. It was noted that Stepnell Construction will complete the refurbishment of Bluebell Ward at Walton Hospital, Chesterfield in July and the unit will go-live on 2 September 2024, completing the eradication of mixed-age group wards. Tony commended how Stepnell Construction has embraced the programme, with their positive attitude towards social responsibility and overcoming obstacles and he asked about the current position regarding the gap in funding. James advised that presently, the Trust has to self-fund via the Capital Departmental Expenditure Limit (CDEL) allocation. Mark commented that the challenge was for the Trust and the wider system and once planning is completed, it is hoped the deficit can be further compounded by system CDEL. It was agreed that there will be increased scrutiny of the £5m capital shortfall via the Finance and Performance Committee. **Action.** Lynn queried the staffing pathways and Andy advised that the Adult Acute units will be resourced from existing staff and new recruits will be inducted into teams already established with the new model of care. Vikki added that the model of care work commenced 2021/22 with workforce engagement to agree what the service is to look like and momentum to develop this has continued. The Board discussed contingency planning should recruitment targets not be met. It was noted that recruitment is currently focussed on appointing to leadership posts. Andy informed the Board that despite national workforce shortages, the team has been incredibly successful in attracting Band 5 candidates and there are additional initiatives to attract a wider pool. It was noted that whilst there is a contingency plan to address attracting sufficient numbers, there is no plan if the workforce is not in place at the go live dates and this is something that needs to be generated. **Action, Rebecca and Andy.** Selina reminded the Board of the recruitment event taking place in Chesterfield on 8 June and encouraged their attendance to represent the Trust. In relation to social responsibility, Andy reported that expectation levels for sourcing materials and workforce locally were set at inception and all contractors have met and often surpassed these. It was noted that at go-live, Andy will report on social enterprise. **RESOLVED: The Board of Directors noted the progress to date and assurance on delivery of the MRfD Programme.**
DHCFT/ 2024/050	**CORPORATE GOVERNANCE REPORT** The Board confirmed assurance on the Board Committee year end reporting process and was asked to approve the revised suite of Terms of Reference (ToR) for Board Committees and to receive the Trust sealings report.

DRAFT

	The year-end report for the Audit and Risk Committee was 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. **RESOLVED: The Board of Directors:** **1. Approved the suite of Terms of Reference for Board Committees** **2. Noted 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 received the year-end report of the Audit and Risk Committee.** **3. Noted the Trust seal report.**
DHCFT/ 2024/051	**<u>BOARD ASSURANCE FRAMEWORK (BAF) UPDATE</u>** The Board received the first issue of the BAF for 2024/25, which had undergone a high level of review. The Board noted the key changes to job titles and the reinstatement of Risk 1A, root cause (b), attributable to recent clinical demand pressures in acute areas. Four key gaps/actions had been closed/removed and one high level operational risk had been reduced to moderate. Justine reported that Risk 1A root causes and assurances will be thoroughly scrutinised by the Quality and Safeguarding Committee. Given that the eradication of dormitories will be ongoing through to 2026, Mark suggested this be specified under Risks 1B and 1D. **Action, Dave and Andy.** In addition, Mark asked for a review of the finance risks in context of the deficit. **Action, James.** **RESOLVED: The Board of Directors:** **1. Reviewed and approved this first issue of the BAF for 2024/25 and agreed that the paper provided 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** **2. Agreed to continue to receive updates in line with the forward plan for the Trust Board.**
DHCFT/ 2024/052	**<u>BOARD COMMITTEE ASSURANCE SUMMARIES</u>** 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: **Quality and Safeguarding Committee:** Lynn Andrews, Committee Chair, highlighted that the Patient and Carer Experience Strategy has been revised and co-produced in consultation with carers and service users. It was noted that the Perinatal collaboration has a good level of compliance and that there has been healthy debate around the development of the new Board visits. Mark pointed out that the Patient and Carer Strategy is now part of the wider Trust Strategy and Dave confirmed the importance of linking the two had been emphasised within the Quality and Safeguarding Committee meetings. It was noted that there should be one combined plan, initially assured at Quality and Safeguarding before approval at Board. **Action, Vikki and Dave.**

DRAFT

	Mental Health Act Committee: Ashiedu Joel, Committee Chair, drew attention to the process for ensuring Approved Clinician and Section 12 status. Limited assurance has been accepted until digitalisation of the process is in place. Ashiedu highlighted the challenges around training compliance within the Safeguarding Adults Level 3 class and a review is underway to increase capacity, including facilitation of online access. Finally, the Board noted that further improvement is required for observations and absconsions, in line with the Positive and Safe Strategy. Mark emphasised that the Section 12 report will continue to be scrutinised by the Mental Health Act Committee. **Finance and Performance Committee:** due to the earlier scrutiny around the financial position and Making Room for Dignity programme, Tony Edwards, Committee Chair, had nothing further to highlight. However, he pointed out that the Trust lacks a definitive Digital Strategy. Selina advised that this is one of Mark's 2024/25 objectives and Arun suggested that whilst focus has been to address the current challenges, the Trust should endeavour to be pioneers of future opportunities. **People and Culture Committee:** Ralph Knibbs, Committee Chair, highlighted the scrutiny taking place around compliance for training, Supervisions and Appraisals and the ongoing actions to address the gaps, which include improving local-level accountability. Ralph explained that oversight of the Making Room for Dignity transformation has been shared between People and Culture Committee, Finance and Performance Committee and Quality and Safeguarding Committee, to ensure the correct measures are embedded. The Board noted the range of activities that are underway to expand the workforce, including a more proactive 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. In relation to the 2023 staff survey results, Ralph emphasised the importance of supporting the identified actions through local ownership. Tony asked if People and Culture Committee monitors delivery of the actions and Selina questioned how the Trust is to reflect improvement around some of the themes identified. Rebecca confirmed that the Committee ensures actions are progressed and the focus has been on instilling confidence that the Trust is listening. Arun pointed out the link to the leadership strategy and psychological safety. **Audit and Risk Committee:** Geoff Lewins, Committee Chair, reported that all elements of the year end reporting are on track, despite the challenging timing overlap with financial planning. Mark highlighted the limited assurance on the Board's Well Led Action Plan. Whilst the outstanding actions are on target for completion by September, it was agreed to revisit this with the Executive Leadership Team. **Action.** **RESOLVED: The Board of Directors noted the Board Assurance Summaries.**
DHCFT/ 2024/053	**<u>ASSURANCE FROM THE QUALITY AND SAFEGUARDING COMMITTEE</u>** These reports were received for information and noting, having previously provided assurance to the Quality and Safeguarding Committee on 12 March. **Guardian of Safe Working (GOSW):** this quarterly report 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.

DRAFT

	RESOLVED: The Board of Directors received full assurance that the duties and requirements as set out in the 2016 Junior Doctor terms and conditions of service are being met. **Sexual Safety:** the report provided assurance that the Trust has signed up to the sexual safety in healthcare charter, making clear its intention and commitment to provide a safe environment for staff, patients, carers and visitors which is free of unwanted sexualised behaviour. **RESOLVED: The Board of Directors noted that the organisation is a signatory to the NHS England charter on sexual safety and supported the approach outlined in terms of actions to meet the ten charter principles.**
DHCFT/ 2024/054	**<u>ASSURANCE FROM THE PEOPLE AND CULTURE COMMITTEE</u>** These reports were received for information and noting having previously provided assurance to the People and Culture Committee on 26 March. **Gender Pay Gap:** the report analysed the differences in average pay between males and females; black, Asian, and minority ethnic (BME), and white employees; and between disabled and non-disabled employees, along with suggested recommendations for actions to increase equality in the pay bands of colleagues with different protected characteristics. Ashiedu pointed out that the statement at the end of the report, *"we know that sustained improvements will take time but have confidence in the targeted actions being applied",* was ambiguous with no intentionality and asked for this to be rephrased, suggesting there should be some robust and targeted indication of what the Trust is doing to address. **ACTION, Rebecca.** **RESOLVED: The Board of Directors noted the information contained in the Gender Pay Gap Report and the suggested amendments.** **Modern Slavery:** the 2023/24 annual statement was considered and supported by the People and Culture Committee as evidence that the Trust has met the criteria for the preceding financial year. **RESOLVED: The Board of Directors approved the revised Modern Slavery Statement for sign off by the Chair and Chief Executive and for publishing on the Trust's website, replacing the previous version.**
DHCFT/ 2024/055	**<u>IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)</u>** It was agreed that the timelines for the Making Room for Dignity programme should be reviewed, along with the finance elements in context of the deficit risks. Selina and Justine took away an action to ensure the Board Development programme includes a session on risk appetites.
DHCFT/ 2024/056	**<u>MEETING EFFECTIVENESS</u>** Observers at the meeting had been inspired by the patient story and commented on the open and honest discussions and the focus on patient care, along with the obvious passion in the room. Sandra thanked Dave for his support in her newly appointed role. Mark and Selina thanked everyone for their attendance and emphasised that observers are welcomed at this public arena and that the Board is accountable to the community it serves.

DRAFT

The next meeting to be held in public session will be held in person at 9.30am on 2 July 2024 in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.

ACTION MATRIX - BOARD OF DIRECTORS (PUBLIC) - JULY 2024							
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
05-Sep-2023	DHCFT/2023/101	Action Matrix - Board Assurance Framework (BAF) Update	Trust Secretary	Triangulation of BAF and scheduling of Board Committee meetings to be assessed.	31-Mar-2024	We will trial bringing forward th Finance and Performance Committee meetings to the day before the Board meetings for the remainder of 2024/25 and re-visit the schedule when devising the 2025/26 corporate calendar. The frequency of BAF scheduling at the Quality and Safeguarding Committee (QSC) has reduced to avoid duplication	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.	03-Sep-2024	In review and new format to be presented at Sep-2024 Board meeting.	Yellow
07-May-2024	DHCFT/2024/040	Patient Story	Director of People, Organisational Development and Inclusion	Psychological safety to be included in the Leadership Strategy so there is triangulation of inclusive and compassionate leadership.	30-Jul-2024	The Leadership Strategy is currently being reviewed to incorporate psychological safety and will be completed by 30-Jul-2024.	Amber
07-May-2024	DHCFT/2024/045	Chief Executive's Report	Medical Director	Self-assessment tool to support the reduction of health inequalities to be completed at a Board Development Session.	18-Sep-2024	The outcome of the self-assessment is scheduled into a Health Inequalities session on 18-Sep-2024.	Yellow
07-May-2024	DHCFT/2024/046	Integrated Performance Report (IPR) - Operations	Chief Delivery Officer	Finance and Performance Committee (F&P) to oversee assurance on inpatient flow plans, which includes reducing length of stay, bed occupancy and inappropriate out of area (OoA) placements.	23-Jul-2024	Finance and Performance Committee will receive assurance reports on the Recovery Action Plan (RAP) for inpatient flow as part of the performance report agenda item (from the next meeting on 23-Jul-2024).	Amber
07-May-2024	DHCFT/2024/046	Integrated Performance Report (IPR) - People	Director of People, Organisational Development and Inclusion	Ensure correct process in place for monitoring training compliance. The People and Culture Committee to oversee Training and Education Group.	30-Jul-2024	The Training and Education Group has now been aligned to report into the People and Culture Committee. The last Training and Education Group meeting was held mid-Jun-2024 and any escalations will be reported into the next People and Culture Committee, 30-Jul-2024.	Amber
07-May-2024	DHCFT/2024/046	Integrated Performance Report (IPR) - Quality	Interim Director of Nursing and Patient Experience	Clear escalation route for non-compliance of Care Planning Approach - amended approach to governance and oversight via Divisional Performance Reviews.	02-Jul-2024	This is established with a daily review to ensure plans are in place, underpinned by a weekly audit of care planning quality. Care Planning compliance is also included in the divisional performance review template going forward.	Green
07-May-2024	DHCFT/2024/046	Integrated Performance Report (IPR) - Quality	Interim Director of Nursing and Patient Experience	Increased assurance around the outcomes to address patients Clinically Ready for Discharge and Falls to be overseen by Quality and Safeguarding Committee.	14-May-2024	This was presented at the May Quality and Safeguarding Committee meeting.	Green
07-May-2024	DHCFT/2024/049	Making Room for Dignity (MRfD)	Director of Finance	Increased scrutiny of £5m MRfD capital shortfall at Finance and Performance Committee.	TBA	Discussions are ongoing with NHSE national colleagues with the support of Derby and Derbyshire Integrated Care Board. At present, no decision has been confirmed by NHSE due to national capital allocations for 2025/26 not yet known. Updates continue to go to Executive LEadership Team (ELT) and Finance and Performance Committee as part of MRfD regular progress reports.	Amber
07-May-2024	DHCFT/2024/049	Making Room for Dignity	Director of People, Organisational Development and Inclusion/ Senior Responsible Owner	Contingency Plan required in the event of not having staffing in place at Go Live.	31-Jul-2024	Currently being worked on and expected agreement by the end of Jul-2024	Amber
07-May-2024	DHCFT/2024/051	Board Assurance Framework	Interim Director of Nursing and Patient Experience/ Senior Responsible Owner	Review of Risks 1B and 1D - to ensure risks extended to match MRfD timelines (2025) in relation to full eradication of dormitories.	18-Jun-2024	Risk 1B dates have been updated to coincide with expected go-live dates for each unit, with the exception of the Radbourne Unit, for which the review date of end Nov-2024 has been added, when there will be a firm go-live date for Ward 32 and the Trust will know if the Ward 35 refurbishment is being funded and is proceeding. Risk 1D not updated as the actions Dave has added are not connected with the MRfD builds; noting full eradication of dormitories will be Mar-2026 if refurb of Ward 35 is funded and approved.	Green
07-May-2024	DHCFT/2024/051	Board Assurance Framework	Director of Finance	Review Finance risks in context of deficit.	TBA	The review of risks and updates are underway and work in progress. These will flow into the next Finance & Performance Committee and Board following the plan resubmission impact which was completed on 12-Jun-2024.	Amber
07-May-2024	DHCFT/2024/052	Board Committee Assurance Summaries - Quality and Safeguarding - Patient and Carer Experience Strategy	Chief Delivery Officer/ Interim Director of Nursing and Patient Experience	Patient and Carer Experience Strategy to link in with new Trust Strategy - assurance at Quality and Safeguarding Committee (QSC) before presentation to Board Jul-2024.	16-Jul-2024	Revised strategy on QSC agenda 16-Jul-2024.	Amber
07-May-2024	DHCFT/2024/052	Board Committee Assurance Summaries - Audit and Risk Committee - Well Led Action Plan	Director of Corporate Affairs and Trust Secretary	Revisit at Executive Leadership Team (ELT).	30-Jun-2024	Programmed into Executive Leadership Team (ELT) schedule for 15-Jun-2024.	Green
07-May-2024	DHCFT/2024/054	Assurance from the People and Culture Committee - Gender Pay Gap	Director of People, Organisational Development and Inclusion	Rephrase ambiguous statement to ensure robust and explicit intention.	31-Jul-2024	The Gender Pay Gap report is currently being reviewed to include a statement refresh and action plan review.	Amber

`

Key:	**Action Overdue**	RED		**0**	**0%**
	Action Ongoing/Update Required	AMBER		**8**	**53%**
	Resolved	GREEN		**5**	**33%**
	Agenda item for future meeting	YELLOW		**2**	**13%**
				15	**100%**

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 2 July 2024

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 7 May 2024. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. Service visits are very important to me in my role as Chair. In this reporting period I had the opportunity to visit the Liaison Team North, the Hub and the Hartington Reception Team on 21 May. I also visited the Information Management, Technology and Records (IMT&R) team on 2 June and the Beeches Perinatal Mental Health Services on 18 June. I was pleased to be able to speak to a couple of the mums on the unit who were complimentary about their care and the environment. Diversity of the patient intake was impressive and suggests the service is getting wider reach and traction with different communities.

   I observed the team had organised samosas and other foods for a patient to keep the feeling of Eid celebrations going and to lessen any feelings of homesickness.

   On 19 June I visited the Kedleston Unit and had a tour of the environment and the facilities. I spoke with some of the patients, and they shared their predictions for the European cup finalists.

   I was pleased to see the gym equipment was in working order. At my last visit one of the pieces of gym equipment was not in use. These service visits are invaluable in understanding the work of the Trust but also in triangulating the reports we receive at Board on quality, safety, performance, finance, risk and staffing. My thanks to all the team managers and colleagues who spoke to us and shared their experiences of working for the Trust. Their passion and commitment shone through and was both inspiring and uplifting to see.

2. On 19 June, rather opportunistically, I managed to have a conversation with some of our newly qualified nursing staff who are on their preceptorship. Preceptorship is a period of structured transition to guide and support newly qualified practitioners from students to autonomous professionals. They were at the Ashbourne Centre for a morning on Health and Wellbeing. I was struck by the diversity with representation from Cameroon, Ghana, Nigeria, Zimbabwe and that was just in the small group that I spoke to.

3. On 22 May, I attended the Virtual Staff Conference along with several of the Non-Executive Directors. The workshops provided an opportunity to further consult with our staff colleagues on the values as part of the supporting work in the development of the new Trust Strategy.

4. I attended the Reserves Day Celebration with Justine Fitzjohn, Executive Sponsor for the Armed Forces Network and Mark Powell, CEO on 19 June. It was a very well attended event and provided an opportunity to see the excellent partnership work taking place between the Trust, Derby University and Derbyshire Community Health Services (DCHS).

Earlier in the year, we formally received Gold Standard accreditation in recognition of the Trust commitment to providing veterans the same access to our services and a commitment to providing support to access services as well as removing any barriers to access that they may face. A special thanks to Gemma Saunders, Chair of the Armed Forces Community Staff Network. Gemma has worked tirelessly to ensure the work of the Armed Forces Network is embedded in the Trust and that it has a profile both within the Trust and outside.

5. I invited Dale Bywater, NHSE Regional Director, to visit our new Making Room for Dignity (MRfD) facilities, the Carsington Unit at Kingsway. He was very complimentary about the vision that we have for the programme. He appreciated the complexity and scale of the programme and the difference it will make for our patients. As the build comes closer to completion the scale of the transformation becomes ever more evident. It is an exciting time for the Trust and our patients. The Programme team continues to do an outstanding job in ensuring the work keeps to timescales and in budget whilst minimising the disruption that comes with such a large-scale capital and refurbishment programme over multiple sites.

Council of Governors

6. On 21 May I held my regular informal coffee morning with Governors at the Hub in Chesterfield. These informal sessions are useful in understanding the concerns that Governors have or are picking up through their engagement activities. We spoke about the impact of the funding cuts on the Voluntary and Community Sector (VCS) and consequently on various service user groups, gaps in services and opportunities for collaboration. Also, on 5 June, I held a virtual informal meeting with Governors and an in-person meeting on 18 June at Kingsway. My thanks to all the Governors who took part, their insights, curiosity, challenge, and perspectives all assists in maintaining a positive culture and is an important component in strong governance.
7. I met with Susan Ryan, Lead Governor and Deputy Lead Governor, Hazel Parkyn on 5 June. I updated them on issues and progress on developments. The purpose of the meetings between the Trust Chair and the Lead Governor and Deputy Governor is to ensure that we are open and transparent around the challenges and issues that the Trust is dealing with. They are also an important way of building a relationship and understanding of the workings of the Board and the Council of Governors.
8. On 12 June, the Governance Committee met, chaired by Marie Hickman, one of our Staff Governors. Governors were consulted on the brand identity and also on the new Trust vision and values work as part of the development of the Trust Strategy.
9. The next Council of Governors meeting will then be on 3 September 2024 and the next Governance Committee takes place on 6 August 2024.

Board of Directors

10. The Board forward plan has regular Board development days which enable the Board to concentrate on Board strategy, horizon scan, identify areas for Board development, as well as hear from external partner stakeholders on areas of interest to the Trust. In this period, we held two development days. On 15 May, the Board focussed on the Trust vision, values and a new accountability framework building on all the engagement work with Trust colleagues, led by Vikki Ashton Taylor, Deputy CEO and Chief Delivery Officer. Arun Chidambaram, Medical Director, led a session on the development of a Clinical Strategy as an enabling strategy to the Trust strategy. This was followed by an interactive session led by Tony Edwards, Deputy Chair.

On 11 June, we had a follow up training session for senior leaders on Freedom To Speak Up (FTSU) led by Tam Howard, the Trust's FTSU Guardian. Deborah Good, Non-Executive Director (NED) and James Sabin, Director of Finance, provided an update on the Trust's Green Plan and facilitated a discussion on the next steps to developing a wider sustainability strategy for the Trust.

11. The Board also held a Confidential Board meeting on 11 June.
12. On 19 June, the Remuneration and Appointments Committee met to approve some Board changes and year end actions in preparation of finalising the annual report.
13. I attended the Audit and Risk Committee on 19 June. This meeting with the Internal and External Auditor is customary practice and is held prior to final sign-off for any further clarification before finalising the annual report and accounts.
14. I have also continued to meet with all Non-Executive Directors (NEDs) individually on a quarterly basis. In the last quarter, I have met with Geoff Lewins, Lynn Andrews, Ralph Knibbs and Deborah Good. We use these quarterly meetings to review progress against their objectives and to discuss any issues of mutual interest and areas of development.

System Collaboration and Working

15. On 13 May, I met with Julie Houlder, Chair at Derbyshire Community Health Services NHS Foundation Trust (DCHS), as part of our regular catch ups. These meetings provide a useful opportunity to explore any issues that have arisen and also foster collaboration at a place/locality level.
16. The Provider Collaborative Leadership Board (made up of the Chairs and CEOs of the provider trusts) also met on 13 May. We received progress updates on areas of collaboration, mainly efficiencies in corporate services and a deeper exploration of services which are fragile for varying reasons, but predominantly weak infrastructure either in terms of size or insufficient staffing to meet the demands. We agreed that we require pace and transformation and to look beyond these two areas as we face an ongoing financial challenge as a system.
17. On 23 May, I joined Dale Bywater for the recruitment of the Trust Chair at Coventry and Warwickshire Partnership NHS Trust, alongside Danielle Oum, Chair of Coventry and Warwickshire Integrated Care Board (ICB).
18. The ICB instigated a meeting to discuss system development. This was Kathy McLean's first meeting in her capacity of ICB Chair. The format of the meeting was that of workshops with specific topics to discuss. The topics were selected to reset, refocus priorities in a climate of limited growth and gather greater pace of delivery.
19. On 21 June, I met the incoming Chair of University Hospitals of Derby and Burton (UHDB), Prem Singh. He brings a wealth of experience and knowledge of the Derbyshire System. I, and the other Provider Chairs, look forward to working with Prem.

Regulators, NHS Providers and NHS Confederation and others

20. I attend fortnightly briefings from NHS England for the Midlands region, which has been essential to understand the challenges and expectations of Provider Trusts.
21. 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 continues to be a theme.

22. As a Trustee of NHS Providers, I attend the NHS Providers Board meeting. The meeting held on 9 May was focused on the NHS Providers Strategy and the associated plan of delivery. We discussed the likely impact of a new government on NHS Providers and the likely priorities of the new Government.
23. On 12 June, I attended the NHS Confederation Annual Conference held in Manchester with Mark Powell, CEO and Arun Chidambaram, Medical Director. Due to the forthcoming elections, there was no input from the Secretary of State for Health, nor the Shadow Secretary, as is customary. Amanda Pritchard, CEO of NHS England, delivered the keynote speech, which was uplifting, inspiring and recognised both the extraordinary work NHS staff do despite challenges and the opportunities to deliver good healthcare and innovation. The Confed Expo, as it is known, provides a platform to learn about latest developments, share good practice and innovation and understand the policy environment.

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 and Equality Impact Risk Analysis

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

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

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. I have also continued to develop my own awareness and understanding of the inclusion challenges faced by many of our staff.

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

Demonstrating inclusive leadership at Board level

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

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

Recommendations

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 July 2024

Chief Executive's Report

Purpose of Report

This report provides an update on current local issues and national policy developments since the last Board meeting. As we are in a pre-election period, my report is much shorter than normal.

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

The planning process for 2024/25 has concluded with the submission of the final Joined Up Care Derbyshire (JUCD) plan to NHS England. The financial, clinical and operational delivery landscape remains incredibly difficult and challenging.

The Derbyshire system has committed to a 5% cost improvement plan and an overall deficit which will not exceed the 2023/24 outturn. This means that the JUCD plan relies on ongoing productivity and efficiency improvements to deliver the operational and activity requirements of the national planning guidance and as a system we will continue to balance our aspirations for service delivery alongside the finite resources available.

There are opportunities where collaboration between providers can result in efficiencies, and the Provider Collaborative Leadership Board is currently exploring these.

Infected Blood Inquiry final report

It was sobering to read the final report of the Infected Blood Inquiry, originally launched by the UK government in 2017. It is clear that the NHS played a role in the incredible suffering and the loss of all those infected and affected.

On behalf of NHS England, Amanda Pritchard issued a public apology, *"In particular, I want to say sorry not just for the actions which led to life-altering and life-limiting illness, but also for the failures to clearly communicate, investigate and mitigate risks to patients from transfusions and treatments; for a collective lack of openness and willingness to listen, that denied patients and families the answers and support they needed; and for the stigma that many experienced in the health service when they most needed support".*

Although DHcFT wasn't directly involved, there are lessons for the whole of the NHS to learn about preventing harm, duty of candour and giving patients a voice.

Local Context

Our Trust and Staff

In June, our colleague Simon Stansfield, a long-standing and highly valued member of the Crisis Resolution and Home Treatment Team in Chesterfield, sadly passed away after a short period of illness. Simon, who was a Lead Nurse within the team, had worked for the Trust since 2008 and had over 40 years' service in the NHS. We are making arrangements to remember Simon as our colleague. My thoughts and condolences are with Simon's family, friends, and colleagues at this very sad time.

Improving the care pathway for our adult acute patients and service users

A multi-agency discharge event (MADE) took place across the Radbourne Unit and Hartington Unit this spring. This focused on supporting appropriate discharges from our wards, working together with partner organisations to proactively remove any barriers preventing people from returning home. The week had a positive impact in terms of improving the flow of patients and helping create much-needed bed capacity.

As a result of the MADE event and a series of other actions being taken, it is also pleasing to see improvements and changes across the whole pathway, including in our Crisis Resolution and Home Treatment teams, who are looking after more service users to avoid hospital admission, in turn helping reduce the number of patients who we seek beds for out of Derbyshire.

Neurodevelopmental (ND) Service

Over the last year we have been working together with Derbyshire Community Health Services (DCHS) to deliver a collaborative neurodevelopmental service across Derby and Derbyshire. Through this work we have agreed a Memorandum of Understanding (MoU) to formalise the partnership. It is not intended to be a legally enforceable contract but further supports alignment between the two trusts in respect of this service.

In summary, the document sets out the services which are in scope, the operating arrangements, and the proposed structure. The MoU has been discussed and developed at the ND Steering Group (which is a meeting which has representatives from DCHS and DHcFT, it is jointly chaired by the DCHS Director of Nursing, Quality and Allied Health Professionals and the DHcFT Medical Director) and at internal meetings within DHcFT and DCHS.

Feedback and comments have been received and the document amended to reflect them. The ND Steering Group is now recommending the MoU be presented to respective Boards for approval. It is envisaged that the MoU will remain under regular review to be adapted to ensure that it reflects the current working arrangements as the partnership evolves.

The MoU is attached at Appendix 1.

Recognising the achievements of our staff

The Autism Assessment Team and Community Learning Disability Team, part of our Adult Neurodevelopmental Services, were recognised at the National Learning Disabilities and Autism Awards ceremony on Friday, 21 June. Both teams were finalists. I am pleased for the Autism Assessment Team for winning the Great Autism Practice Award and being heralded by the judges for having a "profound impact on the community". Learn more about both teams, and why they were shortlisted, on our website.

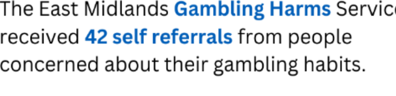
Congratulations to **Vicky Swinard, Administration and Secretarial Support Manager at the Radbourne Unit** who (**alongside wider admin colleagues at the Unit)** is our winner for May's DEED of the month. Vicky was nominated for being "amazingly efficient, understanding, and professional" for the excellent support she provided to a new colleague joining the Trust and their subsequent transition and development.

The Icare programme team have been shortlisted for a national HPMA Excellence in People Award for supporting the emotional, educational and wellbeing needs of newly employed Healthcare Support Workers (HCSWs). The team was celebrated for combining both pastoral support and training on key topics relevant to the role of HCSWs in delivering safe and effective care in mental health services. The award celebrates the very best teams, professionals and projects working in workforce, organisational development and HR in healthcare. Very best of luck to the team who will find out if they have won at an award ceremony taking place in October.

Trust activity

The following infographic shows some of the different ways we have supported local people during April and May 2024, and some of the achievements of Trust teams.

Our **Work Your Way** employment service successfully supported **48 people** open to community mental health services into **permanent work in roles of their choice.**



The Derbyshire Mental Health **Helpline** and Support service helped **5,070 people**

Derbyshire Healthcare received **234 compliments** from service users, carers, families and students

849 mothers received care from our community, outpatient and inpatient **perinatal services**

The Derbyshire Healthcare **website** was visited by **40,446 people** on **68,426 separate occasions**

Talking Mental Health Derbyshire received **2142 referrals** and helped **1225 people** complete a course of treatment

2,705 young people and parents used the **ChatHealth** service to get advice from the school nurses and health visitors

64 service users agreed to participate in research projects and we were the **first Trust in the UK** to have a **service user participant** in a commercial project on major depressive disorder

Board of Directors and Council of Governors

I'm pleased to confirm that Rebecca Oakley was appointed the Trust's substantive Director of People, Organisational Development and Inclusion in May. Thank you to everyone who was part of the interview process for this role. We are also now advertising for a substantive Director of Nursing, Allied Health Professionals, Quality and Patient Experience, with interviews taking place later this month.

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:

1. Scrutinise the report and seek further assurance around any key issues raised
2. Approve the Neurodevelopmental service MoU with DCHS.

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

Memorandum of Understanding (MoU)
For the Provision of Neurodevelopmental (ND) Services

1. SIGNATORY ORGANISATIONS

The Parties to this Memorandum of Understanding ("MoU") are:

- Derbyshire Community Health Services (DCHS) NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust

2. BACKGROUND

In early 2022 Derbyshire Community Health Services NHS Foundation Trust (DCHS) and Derbyshire Healthcare NHS Foundation Trust (DHcFT) agreed to take forward a partnership arrangement to help stabilise and improve Neurodevelopmental (ND) Services and patient outcomes, as well as working to reduce unwarranted variation in the offer across the full population of Derbyshire. Teams across the Trusts have worked closely together since then to put in place effective pathways to aim to harmonise services and improve the parity of the offer across the whole county. This has included a clinical delivery model that spans across the two Trusts. In addition, DCHS has undertaken its own internal restructure, as well as work from leaders and teams across both Trusts working closely together resulting in being stepped off NHS England escalation for ND in Derbyshire.

3. PURPOSE

- 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;
- To make the best use of capacity and improve performance against national performance benchmarks and metrics against which both Trusts are assessed;
- To make the best use of financial resources: improving the financial position of both Trusts;
- To have a greater breadth and depth of clinical, scientific and managerial expertise by drawing upon the knowledge, skills and experience of staff from both Trusts;
- To standardise clinical practice in accordance with best published evidence; and
- To address workforce challenges and provide greater resilience in service provision.

4. ETHOS

Beyond the list of responsibilities outlined within this document, the signatories to it pledge:

- To work together in a partnership approach to overcome challenges that we face in delivering the aims of this MoU.
- To always act in ways that are fair, honest, and open.
- To build a positive working environment and good working relationships
- To recognise that misunderstandings and mistakes will occur but that we will work together to resolve them and any issues that arise.

5. SCOPE OF JOINT WORK

The Trusts already work closely together in a number of areas. This will continue through future development from within the specialities and services provided by the Trusts, subject to the agreement of each Trust Board.

The following ND services are within the scope of this agreement:

- Assessment and Treatment Unit
- Short Break Service
- Intensive Support Team
- Community Learning Disability Team
- Specialist Autism team
- Forensic Team
- Medical Team
- Admin Team
- Outpatient Service

The Trusts will work in partnership to jointly develop and implement future pathway design and ensure it is aligned to the Trust's and JUCD strategic direction.

6. PERIOD OF OPERATION

- This agreement will commence on 1 April 2024
- The MoU will be reviewed in 12 months' time to ensure it is still fit for purpose for the working arrangements between the two Trusts.

7. OPERATING ARRANGEMENTS

Staffing

- An integrated leadership structure will be implemented via a single Head of Service – the current GM for ND that sits with DHCFT will be seconded to this role and will jointly report to the respective Trust's Deputy Chief Operating Officer/Managing Director.
- The ASM level will report to the Head of Service. This is already the arrangement for the DHcFT employed ASMs. DCHS employed ASMs will transfer line management to the Head of Service from 1 April 2024.

Policies

- For patient care, policies will be developed collaboratively as determined by the Clinical and Operational Assurance Group
- For all other policies outside the scope of patient care, staff will follow the policies of the employing Trust.

Budget Management

- Total budget oversight will be put in place for the service, which will work on the principle of transparent open book accounting. Over time there will be a move towards a fully pooled budget which will be jointly managed and have a single CIP, with decisions on savings, investment, reinvestment or major change made as a collective and applied once. The budget will not cross-subsidise individual teams.
- Financial risks or benefits will be shared between both Trusts.

People Services

- Vacancy control – the partnership sees the value in recruiting to staff from both DHcFT and DCHS. As vacancies arise, these will be reviewed collectively by the Head of Service, with the MD / Deputy COO for each Trust to ensure both organisations remain well represented in the employees within the partnership.
- A single Divisional People Lead will be identified to act on behalf of both Trusts, with responsibility for interfacing with respective internal HR colleagues and FTSU representatives as required and appropriate.
- The working environment for all staff will be one in which they are treated with respect and has a zero-tolerance approach to help eliminate discrimination, harassment and victimisation, and to advance equality of opportunity and foster good relations and an inclusive culture.

- Where employee information needs to be shared between Trusts for the purpose of line management responsibilities and safe working, this will be kept to the minimum information necessary and accessible on a ‘need to know’ basis only.

Information Sharing and Governance

- Patient records will be accessible and will be able to be created and edited by staff in the partnership regardless of employing Trust.
- Staff will have a right of access to clinical information as part of the partnership agreement between both Trusts.
- In cases where staff are entering in to their non-employing organisation’s electronic patient record (EPR), the Trusts agree to allow the EPR’s data controller to scrutinise and release content of the record as appropriate under Subject Access Request policies and procedures.
- Managers in both Trusts will ensure that any system access will be revoked across both organisations when a member of staff leaves or transfers employment.

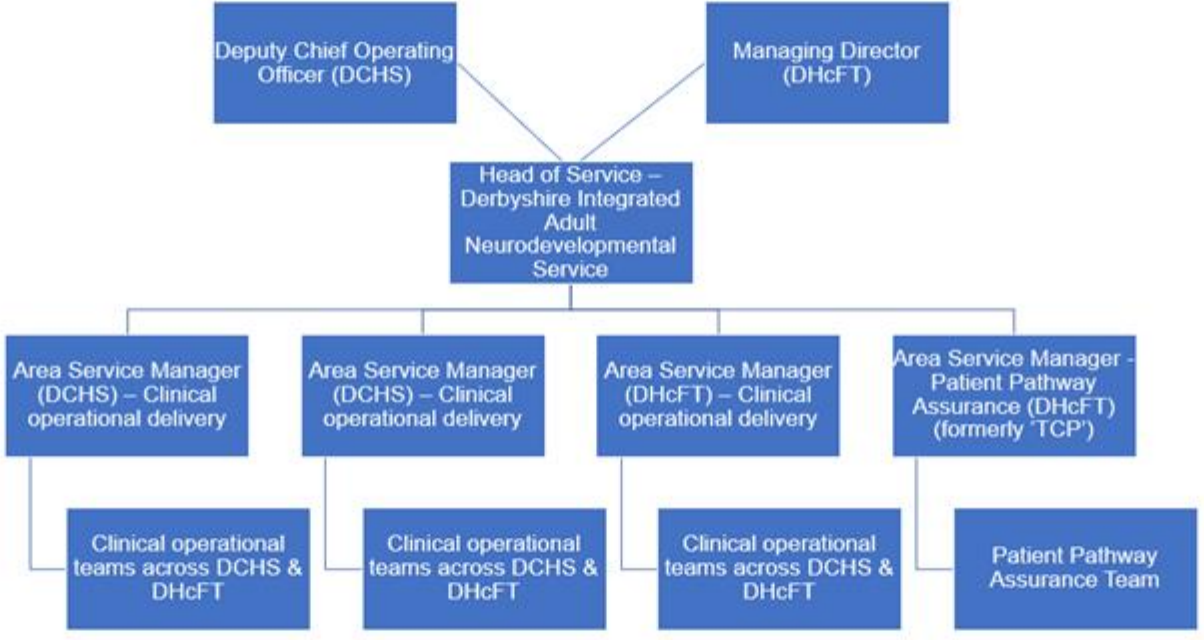
Equipment

- Equipment will be provided to staff by the employing Trust.

Estate

- Where the ND partnership services are being delivered out of each Trust estate, there will not be a charge made in relation to the estate or IFM.

8. PROPOSED STRUCTURE



9. GOVERNANCE

- Risks will be managed collectively through the joint governance arrangements, and the risk registers of both Trusts will detail risks related to the partnership.
- Each organisation retains sovereignty of their information and risk. The CQC will not use information from one Trust against another Trust, either positively or negatively.
- It is understood and accepted that the delivery model will mean blended use of operational tools, where this occurs, performance/service accountability remains true to the commissioning position.

10. DISPUTE RESOLUTION

- Every reasonable attempt will be made to resolve disputes in line with the ethos of this agreement and to do so between the parties involved.
- If this is not possible the dispute will be considered by the DCHS COO / DHcFT Managing Director
- If after these steps the dispute remains it will escalate to a specially convened Exec to Exec Meeting.

11. LAW AND JURISDICTION

The Parties recognise that the MOU is not intended to be legally binding and no obligations or legal rights shall arise between the Parties from this MOU. The Parties enter the MOU intending to honour, observe and perform all their obligations.

12. NO PARTNERSHIP OR AGENCY

- Nothing in this MoU shall be construed as creating a partnership.

- No Party shall be deemed to be an agent of any other Party and no Party shall hold itself out as having authority or power to bind any other Party in any way.

- No Party shall have any liability to the other Party for any redundancy costs arising either from delivery of the services or by the termination of the MoU, whether by the passage of time or any earlier termination.

13. LIABILITIES

- Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU.

- The Parties shall remain liable for any losses or liabilities incurred due to their own actions and those of their employees and engaged persons. No party intends that any other party shall be liable for any loss it suffers as a result of the actions of another party (or its employees or engaged persons) under this MoU.

- Each party will have a policy of insurance or an indemnity arrangement in place to provide an adequate level of cover in respect of all risks arising from the activities its staff undertakes in relation to the design, management, and conduct of the Service.

14. CONFIDENTIALITY / DATA SHARING

All sharing of Personal data is governed by the General Data Protection Regulation 2016, the UK Data Protection Act 2018, The NHS Caldicott Principles and NHS codes of practice for confidentiality and data sharing.

15. TERMINATION

- If the partnership is not achieving the intended purpose set out in this MoU the two Trusts will convene a meeting to discuss the future arrangements.

DECLARATION

Signed for and on behalf of **Derbyshire Community Health Service NHS Foundation Trust:**
Name:
Position:
Signature:
Date:

Signed for and on behalf of **Derbyshire Healthcare NHS Foundation Trust:**
Name:
Position:
Signature:
Date:

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 July 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 May 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**, which has resulted in waits of two years plus
- Community paediatric waiting times continue to increase month on month – **ongoing recruitment challenges, high levels of demand and pathway issues**
- NHS Talking Therapies waiting times from first to second treatment
- Memory Assessment Service waiting times – waits from referral to assessment are currently around 35 weeks. **Ongoing significant demand for the service, which continues to exceed capacity**
- Inappropriate out of area placements and inpatient bed occupancy levels – enduring high-level of need for inpatient treatment. **The adult acute inappropriate out of area position has much improved recently, which should be reflected in the data next time.**

Most improved areas:

- The number of adult autistic spectrum disorder assessments completed each month has increased significantly for the last nine months and **46% of the annual target has been exceeded already, after just two months**
- Psychological services waiting times continue to reduce and the number of people waiting has dropped significantly
- Child and Adolescent Mental Health services (CAMHS) waits continue to reduce. The level of assessments completed is being carefully managed in order to enable services further down the system to cope with the demand, while at the same time not having a negative impact on assessment waits
- NHS Talking Therapies 6-week referral to treatment has significantly improved and **the target has been achieved** for the past two months
- The NHS long term plan targets for dementia diagnosis, perinatal access, and community mental health access were all achieved.

Areas of ongoing success:

- National standards for early intervention in psychosis two-week referral to treatment, NHS Talking therapies 18-week referral to treatment, and three-day follow-up of discharged inpatients are all consistently achieved
- The rate of 28-day readmissions post discharge remains very low.

Finance

At the end of May, the year to date (YTD) position is a deficit of £1.9m which is on plan.

The forecast position remains in line with the plan submission of £6.4m deficit.

The financial plan for 2024/25 has recently been submitted on 12 June. The previous plan deficit of £6.4m remains.

The risks discussed as part of the planning sign off remain:

- Delivery of the £12.5m efficiency programme in full, with a significant proportion delivered recurrently
- Management of Adult Acute out of area expenditure in line with the reducing trajectory
- Management of in-patient expenditure to a reduced run rate
- Additional costs related to supporting the complex patient
- Management of agency expenditure within budget.

The Board Assurance Framework (BAF) risk that the *Trust fails to deliver its revenue and capital financial plans*, remains rated as **Extreme** for 2024/25 due to the inherent risks that are built into the financial plan.

Efficiencies

The plan includes an efficiency requirement of £12.5m with a higher proportion phased from quarter 2. The plan assumes that 71% of savings are delivered recurrently.

At the end of May efficiencies were behind plan by £0.3m. However, work continues in progressing the identified schemes through the sign off process. A significant proportion of schemes will be transacted in month 3 as they progress through the sign off process.

Key next steps

- **Continuation of the QEIA process to sign off the remaining schemes that have been identified**
- **Identify new initiatives to close the current gap.**

Agency

Agency expenditure YTD totals £1.1m which is on plan. This includes £0.4m 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 May is 4.6%. NHSE use of resources includes an action to improve workforce productivity and reduce agency spend to a maximum of 3.2% of the total pay bill across 2024/25.

The full year plan for agency expenditure totals £6.3m which is 3.7% of total pay expenditure.

Out of area placements (OOA)

The plan for out of area expenditure has been set at £3.5m and is based on a reducing trajectory from 22 to zero beds by the end of the financial year.

At the end of May, expenditure for OOA placements of £1.1m was £151k above the budget. Expenditure in the month of May was only slightly above plan by £2k, therefore, showing a reduction in actual placements compared to April. Further improvements have been made throughout June and therefore, expenditure is likely to be within plan by the end of quarter 1.

Capital expenditure

At the end of May, very little capital expenditure has been committed. A total of £73k has been committed against Estates staffing, backlog maintenance and urgent requests. The phasing of the resubmitted capital plan reflects the YTD actuals.

The capital plan resubmission has been adjusted to reflect the issues that the system will no longer receive the additional performance allocation and that we need to be compliant with the IFRS16 allocation. The new allocation also takes into account a further reduction in capital in light of the new financial regime. This has meant that our Business as Usual (BAU) capital expenditure has reduced by a further £0.3m.

It is important to note that the BAU plan includes the 5% planning assumption, which will need to be managed in-year.

Cash

Cash at the end of May is at £24.0m (£33.2 last month) which is slightly below plan by £0.4m. The reduction in cash levels at the end of May is due to the payment of some high value capital invoices related to the Eradication of Dorms schemes.

2023/24 Annual Accounts

Annual Accounts for 2023/24 have been approved by the Audit and Risk Committee on 19 June 2024, following the external audit sign off. No changes to the financial statements have been made, only minor presentational changes to the disclosure notes.

All supporting documents are due to be submitted to NHS England on 28 June.

People

Annual appraisals

Appraisal compliance continues to remain high, seeing a month on month increase to 89.36%, falling just short of the 90% target. The low compliance rate within Corporate Services remains a particular challenge. However, measures put in place continue to support gradual improvements, seeing an increase 4.5% since the last reporting period. The improvement plan remains in place to support the two lowest performing corporate areas.

Annual turnover

Overall turnover continues to remain in line with national and regional comparators, despite a slight increase seen since the last reporting period.

Compulsory training

Overall, the 85% target has been achieved for the last 24 months. Operational Services are currently 92% compliant and Corporate Services are at 87%, both seeing a slight increase in compliance since the last reporting period. Whilst overall compliance of the 20 training elements remains high, there have been challenges with two mandatory training elements dropping just slightly below target in the reporting period and two role-specific compulsory training elements which are classroom based. Plans are in place to work towards bringing them back within target.

Staff absence

The annual sickness absence rate is running at 6.09% and compared to the same period last year, remains 0.19% lower. Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by other musculoskeletal problems and gastrointestinal problems (joint second highest reason) and surgery as the third highest reason for 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 is due to end 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 May, 89% of funded posts overall were filled with contracted staff. At the start of the financial year, new investment is released which creates brand new vacancies, initially reducing the percentage of funded posts filled. This year will see a staged release of funding throughout the year.

Bank and agency staff

Agency usage has reduced significantly over recent months. However, there has been a temporary increase in agency usage this period due to a requirement for increased clinical observations. Agency usage still remains high overall 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 at 82% (an increase of 4% since the last reporting period) and management supervision at 84% (an increase of 2% since the last reporting period). A slight decrease in compliance has been seen from last month and efforts continue towards achieving the 100% target. An audit of supervision processes has now been completed, undertaken by 360 Assurance. The outcome of the audit was limited assurance and several recommendations have been made which will now assist the Trust towards achieving its target for both clinical and non-clinical supervision.

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.

Compliments

Between March and May 2024, an average of 122 compliments per month were received, which is a 9% increase. In relation to patient feedback, there are over 100 teams (including sub-teams) that are live on the platform, with over 600 patient feedback responses across the teams received to date. This is currently undergoing an evaluation which will be published in July with recommendations in relation to what resource will be required to ensure the sustainability of the project.

Complaints

The number of complaints received reduced from 11 to five and continues to be under the Trust target of 12 complaints. The Trust total proportion of patients under the Care Programme Approach (CPA) who have had their care plan reviewed within 12 months has increased by 16% between March and May 2024 and is currently at 86% as per the Trust CPA review compliance report.

Clinically ready for discharge

The number of patients who are clinically ready for discharge (CRD) increased from 11% to 13% between March and May 2024. The lack of identification of appropriate housing, establishing funding, and availability of social care placements continue to be cited as the main barriers for discharge. A twice weekly CRD meeting is in place and the Trust has 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 Trust transformation project manager is currently reviewing learning from the Multi Agency Discharge Event (MADE) in April 2024 on this will be used to improve system-wide flow.

Employment and settled accommodation

Patients open to the Trust in settled accommodation has reduced from 50% to 48% between March and May 2024 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.

Incidents

The number of medication incidents between March and May 2024 has fallen from 72 to 60 (17%) and continues in line with common cause variation. It should be noted that the medication incidents reported continue to be categorised as of low-level harm.

The Number of DATIX incidents occurring recorded as moderate at catastrophic harm have increased from 65 to 85 between March and May 2024. Analysis suggests that this is due to a sustained increase in the number of incidents routinely reported by staff and a sustained rise in incidents recorded as “self-harm” and physical assault from patients to staff and patient to patient. 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 the increase in physical restraint of 48% and a 41% increase in prone restraint between March and May 2024.

The female acute wards and older adult wards continue to have the majority of incidents attributed to them. The increase in episodes of physical restraint is attributed to the sustained rise in self-harm incidents and staff intervention required to prevent individuals harming themselves or to prevent further harm. There was also an overall increase in physical restraint incidents on the perinatal ward which is unusual for this area and a reduction is expected in the next report. 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 Assurance Team meetings (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 recommended level is significant assurance: there is a generally sound system of control designed to meet the system's objectives, however, some weakness in the design or inconsistent application of controls puts the achievement of particular objectives at risk
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
Director of People, Organisational Development and Inclusion

Dave Mason
Interim Director of Nursing and Patient Experience

Report prepared by:

Peter Henson
Head of Performance

Rachel Leyland
Deputy Director of Finance

Rebecca Oakley
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

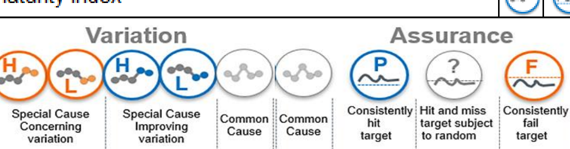
Areas of Improvement	Areas of Challenge
Operations	
• Adult ASD assessments completed – highest level to date and after two months 46% of the full year target has been achieved already • Psychological services waiting times continue to reduce and the number of people waiting has dropped significantly • CAMHS waiting times continue to reduce • NHS Talking Therapies six-week referral to treatment has significantly improved • Inappropriate out of area placements have significantly reduced in recent weeks. This is yet to be reflected in the most recent month end data contained in this report but will be seen in the next report.	• Adult ASD assessment waiting times – to date over 200 people have been waiting over two years • Community paediatric waiting times continue to increase month on month • NHS Talking Therapies waiting times from first to second treatment • Memory Assessment Service waiting times – around 35 weeks.
Finance	
• Adult acute out of area expenditure has improved in May and early June • Agency expenditure reduction continues to reduce excluding those driven by CQC and the high-cost exceptional case • Outline CIP plans have a larger proportion of recurrent schemes but QEIA process still to conclude.	• Financial deficit and achievement of the financial plan • Effective management/mitigation of cost pressures including those CQC driven aspects • Ensuring efficiency delivery in full, with as much identified recurrently as possible • Capital expenditure constraints restricting ability to drive environmental improvements and efficiency • Long term plans to progress back to financial sustainability and balance.
People	
• Annual appraisals • Compulsory training • Supervision continues to improve overall.	• Staff absence • Bank staff use • Agency staff use.
Quality	
• Reduction in formal complaints • Care plan reviews gradual improvement continues • Friends and family test feedback remains positive.	• Clinically ready for discharge increased significantly • Incidents of moderate to catastrophic harm remains high • Physical restraint • 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	7	4	7	10	8
1b	Waiting list - older adult CMHT - average wait to be seen	L	P	1	4	1	3	2
2a	Waiting list - adult CMHT SPOA - number waiting			818		765	992	878
2b	Waiting list - older people CMHT SPOA - number waiting			76		26	124	75
2c	Older people mental health 4 week referral to treatment	H		95%		14%	88%	51%
2d	Adult mental health 4 week referral to treatment	H		90%		4%	86%	45%
2e	Waiting list - ASD assessment - average wait to be seen	L		62		66	74	70
2f	Waiting list - ASD assessment - number waiting at month end			2,093		2065	2293	2179
2g	ASD assessments	H	?	82	26	14	64	39
3a	Waiting list - psychology - average wait to be seen			18		12	55	34
3b	Waiting list - psychology - number waiting at month end	H		476		665	824	745
4a	Waiting list - CAMHS - average wait to be seen	L		9		15	22	19
4b	Waiting list - CAMHS - number waiting at month end	L		316		343	498	421
5a	Waiting list - community paediatrics - average wait to be seen	H		49		28	35	32
5b	Waiting list - community paediatrics - number waiting at month end			2,189		2129	2496	2312
B1	3 day follow-up		?	88%	80%	77%	96%	86%
D1	Community Mental Health Access (2 plus contacts)	H	F	11,920	11,899	10493	11385	10939
E1	Children & Young People Mental Health Access (1 plus contact)	H		3,475		3054	3239	3146
E4	Children & Young People Eating Disorder Waiting Time - Routine		P	94%	95%			
E5	Children & Young People Eating Disorder Waiting Time - Urgent		P	n/a	95%			
G3	Early intervention 14 day referral to treatment - complete		P	78%	60%	67%	101%	84%
G3	Early intervention 14 day referral to treatment - incomplete		?	63%	60%	57%	118%	88%
H0	IAPT 6 week referral to treatment	H	F	85%	75%	52%	73%	62%
H1	IAPT 18 week referral to treatment		P	100%	95%	98%	101%	99%
H2	IAPT 1st to 2nd Treatment over 90 Days	H	F	40%	10%	11%	36%	23%
H7	IAPT patients completing treatment who move to recovery		?	53%	50%	42%	60%	51%
I1	Individual Placement and Support Access	H	?	645	343	169	448	309
K2	Total inappropriate out of area bed days	H	F	3,365	0	1,617	2,519	2,068
K2	Average patients out of area per day - adult acute	H	F	11	0	2	17	9
K2	Patients placed out of area - adult acute	H	F	21	0	4	26	15
K2	Average patients out of area per day - PICU	H	F	19	0	11	22	16
K2	Patients placed out of area - PICU	H	F	29	0	20	33	27
L1	Perinatal Rolling 12 Months Access	H	F	10.6%	10%	6%	7%	7%
L2	Perinatal Access Year to Date	H	F	1,120	1,070	336	752	544
N4	Data quality maturity index	H	P	99%	95%	96%	99%	97%

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	H	F	89%	90%	79%	84%	81%
2	Annual turnover		P	12%	8-12%	12%	13%	12%
3	Compulsory training	H	P	91%	85%	88%	90%	89%
4	Staff absence		?	6%	5%	5%	8%	6%
5	Clinical supervision	H	F	84%	95%	75%	80%	77%
6	Management supervision	H	F	82%	95%	72%	78%	75%
7	Filled posts	L	F	89%	100%	90%	96%	93%
8	Bank staff use		?	7%	5%	4%	7%	6%

C. Quality

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Compliments received		?	116	119	74	175	125
2	Formal complaints received		P	5	13	-2	35	16
3	Proportion of patients clinically ready for discharge	H	F	14%	3.5%	5.8%	12.9%	9.4%
4	CPA reviews		F	70%	95%	58%	73%	65%
5	Patients in employment	H		12%		10%	13%	11%
6	Patients in settled accommodation	H		49%		33%	45%	39%
7	Number of medication incidents			60		52	116	84
8	No. of incidents of moderate to catastrophic actual harm		P	82	48	24	85	54
9	No. of incidents requiring Duty of Candour		?	1	1	0	4	1
10	No. of incidents involving prone restraint		?	17	12	0	26	12
11	No. of incidents involving physical restraint		?	109	46	33	120	76
12	No. of new episodes of patients held in seclusion		?	17	14	3	35	19
13	No. of falls on inpatient wards		?	41	30	15	57	36

Key to symbols[1]:

Blue dots indicate special cause variation, better than expected.

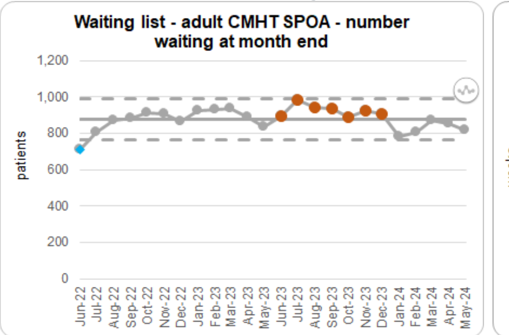
Orange dots indicate special cause variation, worse than expected.

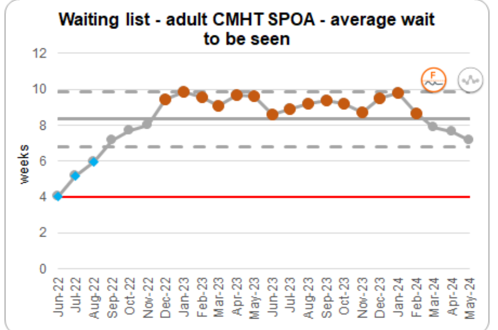
[1]The rating symbols were designed by NHS Improvement

Operations

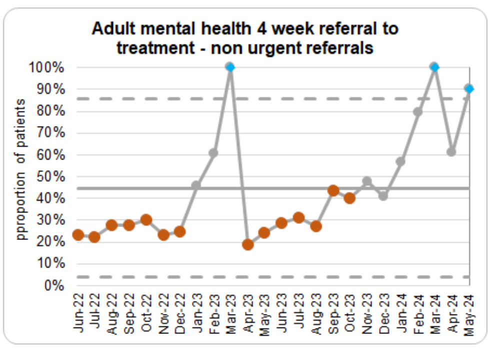
Operational Performance

Waiting Times – Adult Community Mental Health





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



4 week referral to treatment performance is based on referral to second contact. The data does not show patients who are currently waiting for their second contact.

Currently showing phase 1 compliance and does not take into account SNOMED codes or specific interventions.

All data is for episodes referred within the selected years.

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. In the most recently published national benchmarking data, the Trust's median days between referral to community mental health team and first contact was 27.5 days, which was above the peer median of 18 days. Median length of stay in community mental health services from referral to discharge was 132 days, which was considerably higher than the peer median of 62 days. (https://model.nhs.uk/)

Recovery action plan

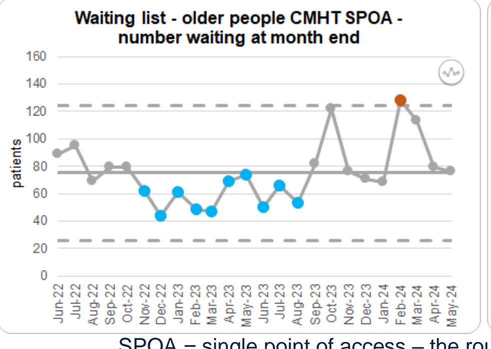
The Adults of Working Age Community Mental Health Services division have developed a productivity plan and associated recovery action plan. To address the waiting lists, reducing numbers waiting and length of time waiting, there is a focus on productivity within all parts of the service pathway to ensure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

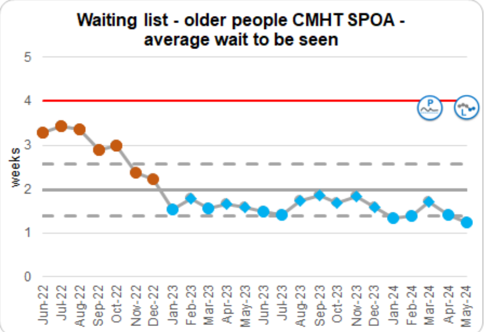
- Targeted messaging – accountability, back to basics, getting it right
- Setting expectations – number of contacts; caseload numbers vs productivity
- Consistent use of the Employee Improvement Policy and Procedure
- QI approach to outpatient caseload management
- Data, productivity and performance conversations are business as usual via use of screens in team bases displaying relevant dashboards*
- Optimised caseloads within the long-term offer
- Increased compliance with 4-week referral to treatment

By when we will have recovered the position

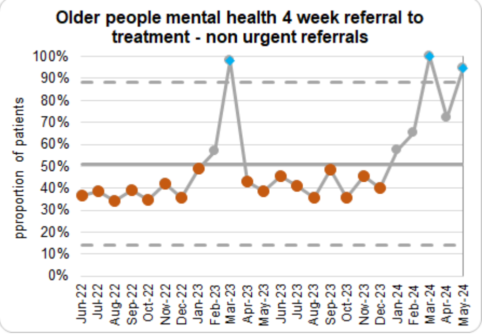
The plan is expected to have positively impacted on waiting times by the end of October 2024

Waiting Times – Older People Community Mental Health





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



4 week referral to treatment performance is based on referral to second contact. The data does not show patients who are currently waiting for their second contact.

Currently showing phase 1 compliance and does not take into account SNOMED codes or specific interventions.

All data is for episodes referred within the selected years.

Summary

The number waiting for older people CMHT SPOA has reduced to normal levels in recent months, and the average wait time remains very low.

Some challenges have experienced in 2 areas (South Derbyshire and Derby City), where there are vacancies and some sickness, but the waiting well policy is being followed.

Dementia Assessment Pathway

A collaborative piece of work is underway between memory assessment services and the community mental health teams, looking at the required referral information, training around triage and engaging with referrers, which will help to ensure people end up within the correct pathway.

https://livingwellderbyshire.org.uk/

Mental Health services that are available in the community to support people with severe mental illness are changing and improving. Health services, Social Care and the Voluntary Community and Social Enterprise (VCSE) sector are developing new ways of working and modernising Community Mental Health services for adults and older adults, taking into account the particular needs of each local area. In Derbyshire, this is called the Living Well Derbyshire programme. In Derby, it is called the Derby Wellbeing programme. The new services went live during 2023/24:

- August 2023: High Peak
- September 2023: Derby City
- October 2023: Chesterfield
- January 2024: North East Derbyshire/ Bolsover
- February 2024: Amber Valley, and Erewash
- March 2024: Derbyshire Dales, and South Derbyshire

Community Mental Health Framework/Living Well Programme

DHcFT is one partner in the programme alongside he voluntary, community or social enterprise sector and the local authorities. Go live of the Living Well sites commenced in 2023/24 (August to March) so it is early days to yet understand true impact, however we can already see positive impact in terms of case load sizes (long term caseloads reducing whilst short term caseloads have increased). In addition, there are early indications of reducing referrals to MH Liaison Teams which frees up capacity to provide greater support to complex cases in the community and therefore to reduce presentations at A&E:

Caseload sizes

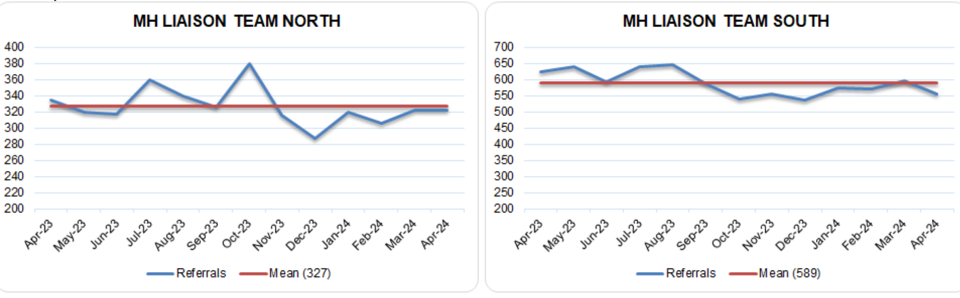
Over time you would expect to see long term offer caseloads reducing, and short term offer caseloads increasing. The right hand 3 columns give the proportion of caseload that is long term offer in each team:

	Long term			Short term			Long term %		
Team	Apr-23	Oct-23	May-24	Apr-23	Oct-23	May-24	Apr-23	Oct-23	May-24
BOLSOVER & CLAY CROSS	328	299	278	0	0	0	100%	100%	100%
CHESTERFIELD	501	492	407	2	21	111	100%	96%	79%
HIGH PEAK	105	128	122	3	54	104	97%	70%	54%
KILLMSH & N. CHESTERFIELD	184	229	184	0	0	0	100%	100%	100%
NORTH DALES	81	99	131	0	0	0	100%	100%	100%
AMBER VALLEY	395	386	452	0	0	0	100%	100%	100%
EREWASH	346	370	353	0	1	20	100%	100%	95%
SOUTH DALES	199	157	118	0	0	0	100%	100%	100%
SOUTH DERBYSHIRE	166	228	263	0	0	25	100%	100%	91%
DERBY CITY B	267	243	222	20	94	106	93%	72%	68%
DERBY CITY C	318	282	263	31	100	110	91%	74%	71%
Grand Total	**2890**	**2913**	**2793**	**56**	**270**	**476**	**98%**	**92%**	**85%**

The data demonstrate that this is the case already in Chesterfield, High Peak, and Derby City B and C, with long term offer caseloads reducing month on month.

Mental health liaison presentations

One aim of living well is to free up capacity within secondary care mental health community teams to be able to provide support to more acutely unwell patients in the community. In theory this should result in fewer presentations at A&E.



The data demonstrates a reduction in presentations in recent months in both the north and south.

Adult acute inpatient bed demand

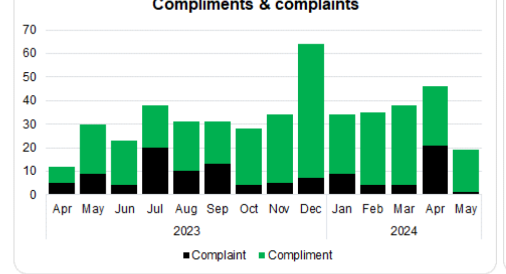
In theory the increased community support of more acutely unwell patients might also result in a reduction in admissions. The table below is a calculation of the 85th percentile of adult acute inpatients per day per calendar year, both in Trust beds and out of area, which demonstrates the number of adult acute beds needed to meet demand most of the time:

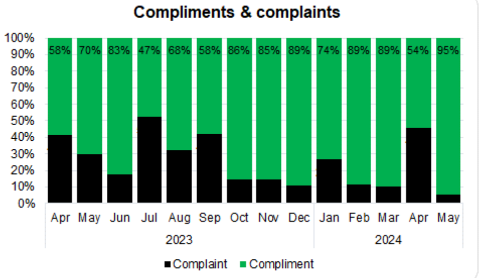
Calendar Year	North Female	North Male	North Total	South Female	South Male	South Total	Total Female	Total Male	Grand Total
2023	33	28	60	55	55	98	79	78	156
2024 to date	37	36	69	55	61	99	83	85	166
Increase	**12%**	**28%**	**15%**	**0%**	**11%**	**1%**	**5%**	**9%**	**6%**

Currently overall demand for adult acute inpatient beds is exceeding demand last calendar year by 6%.

Complaints versus compliments

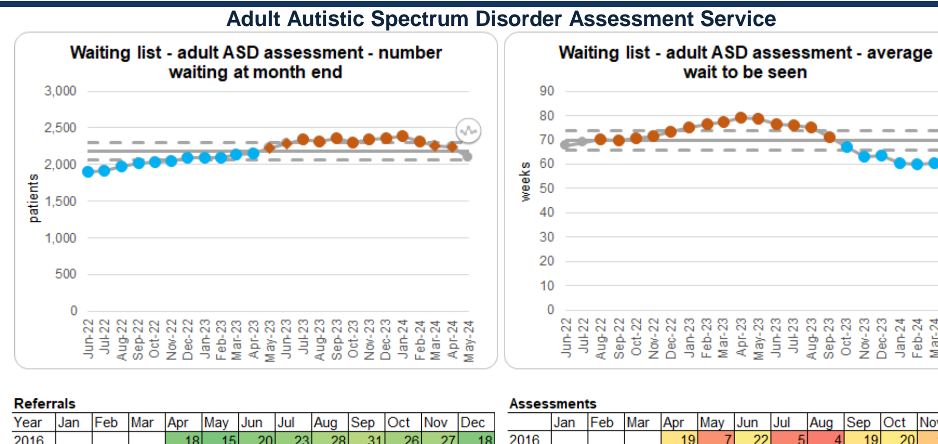
Initially an increase in complaints might have been expected, as inevitably a proportion of people will be unhappy with change.





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	82	34							

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	26	20	33	34	35	66	53	73	47
2024	68	74	66	60	82							

Summary

The number of completed assessments per month has remained high and in just 2 months 46% of the full year contractual target has been achieved.

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 Thursday 19 June 2024, current inpatient numbers are: ICB = 14, 3 under trajectory; adult provider collaborative = 17, 1 over 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.
- 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.

Community Support

- To support efficiency improvement with ND, both the community LD nursing team and physiotherapy team are trialling outpatient clinics to deliver assessment and treatment. With the support from the transformation team, the outputs and outcomes are being assessed and will include benefits around travel, contact time, skill mix, and waiting times. Alongside this, patient experience will be reviewed. Nursing results are currently being reviewed. Early results for Physiotherapy this has significantly reduced waiting times from approximately 1 year 1 week to 22 weeks. Further work planned over the next 12 weeks to reduce this further and improve flow.
- IST parity project underway with a new management structure over both DCHS and DHcFT teams to review service offer and SOP

Awards

Two teams shortlisted as National finalists for the National Learning Disability and Autism Awards 2024.

Psychology & Psychological Therapies

Introduction

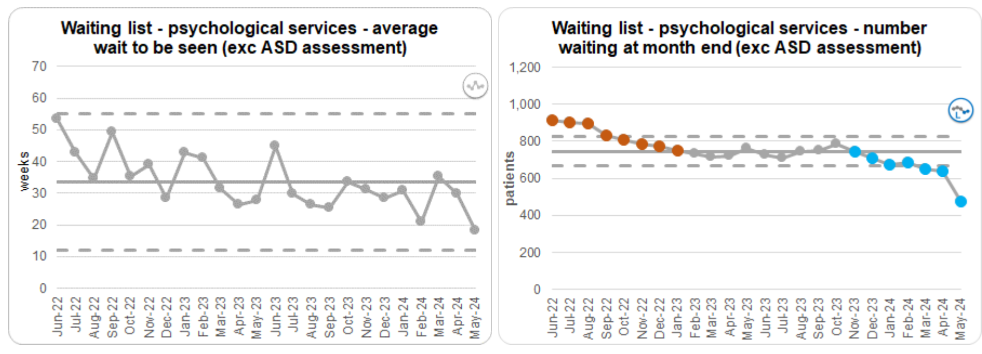
The Division has maintained its excellent reputation in the region for being a fantastic place for psychologists to work and remains the employer of choice.

Workforce update highlights:

- Trainees: New intake of trainee clinical psychologists starting in September. Within the employing trusts DHCFT is now a popular choice.
- LD psychology in the North of the county: The Lead psychologist for the North LD teams started last week. She will build the team over the next 6 months; services have already started to come online with CST, IST and FST staff now starting to deliver care. Supervision and management are in place.
- TMHD: 6 week treatment target achieved. Reductions in staffing and focus on productivity.

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

- Amber Valley Adult Psychology received 9 responses and 100% were positive
- Bolsover & Clay Cross Psychology received 2 responses and 50% were positive
- Cognitive Behavioural Therapy received 28 responses and 100% were positive
- Derby City Psychology received 18 responses and 94% were positive
- NHS Talking Therapies received 1,763 responses and 98% were positive.
- Psychodynamic Psychotherapy received 4 responses and 100% were positive
- South & Dales Adult Psychology received 8 responses and 88% were positive
- South & Dales Older Adult Psychology received 2 responses and 100% were positive



Waiting lists and referrals

Overall, there has been sustained reduction in the number of people waiting for psychological input from 55 weeks to 18. This is an average figure and there are a small handful of outliers who we are looking at separately. These have longer waits for specific reasons (e.g being in an acute phase of illness).

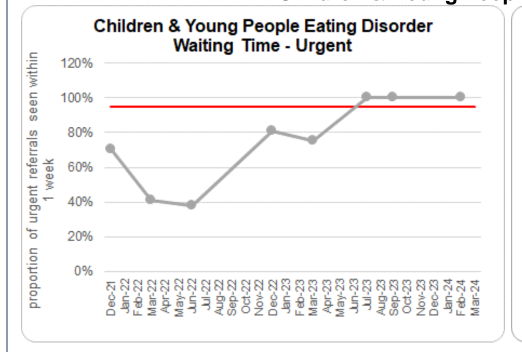
KPIs

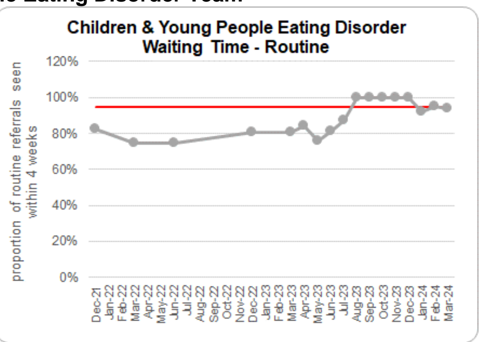
Supervision, appraisal: clinical and managerial supervision remain high at 94% and 92% respectively. IPR completion stands at 95%. RTW interviews have risen from 48% to 68% since our last report.

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 with 2 per month delivered.
- The trauma informed strategy / guide to the journey was completed and approved at ELT last month. Currently raising awareness through engagement hours; delivering training and conversations. Animation will be available Trust wide from July.
- We continue to support colleagues through provision of reflective practice, debrief and supervision.

Children & Young People Eating Disorder Team



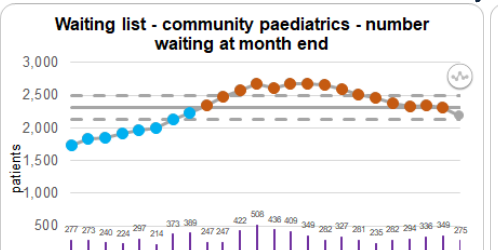


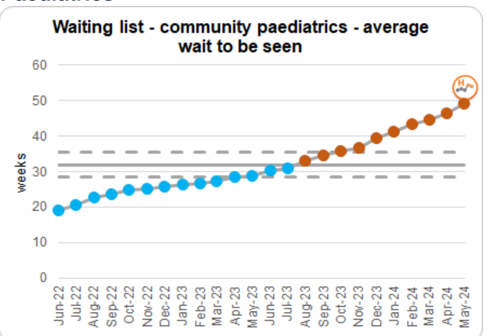
Summary

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: 2023/24 quarter 1 - 11 days, quarter 2 - 4 days, quarter 3 - 4 days, and quarter 4 – 8 days. 2024/24 quarter 1 to date – 1.3 days.

Operational Performance

Community Paediatrics





Summary

At the end of May 2024 there were 2,189 children waiting to be seen and the average wait time was 49 weeks. The worldwide ongoing ADHD medication supply disruption, attributed to the combined effect of manufacturing issues and increased global demand, continues to impact. Children on current prescriptions are continuing to be prioritised.

Internal factors:

- There continues to be limited triage of cases coming into services prior to them being placed on the paediatricians' waiting lists.
- Community paediatrician vacancies and skill mix challenges remain. Nationally there are not enough consultant paediatricians to meet demand (19% shortfall), which makes recruitment very challenging. Currently there are almost 1,300 vacant consultant paediatrician posts being advertised nationally.

External factors contributing to increased demand on Community Paediatricians:

- ASD/ADHD demand for specialist assessment increased by 400% from 2018 to 2023 (for example, in 2022/23 4,575 referrals were received, however South Derbyshire has a maximum system capacity to assess 1,900 children per annum).
- The volume of referrals to community paediatricians because of developmental delay increased following the pandemic.
- The increased complexity of children & young people's presenting needs post the pandemic has resulted in longer appointments, reducing capacity to see more patients.
- 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.

Actions:

- Transformation work for the CYP neurodevelopmental pathway underway.

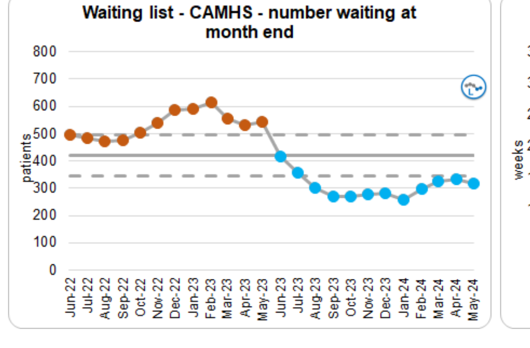
Actions (cont.):

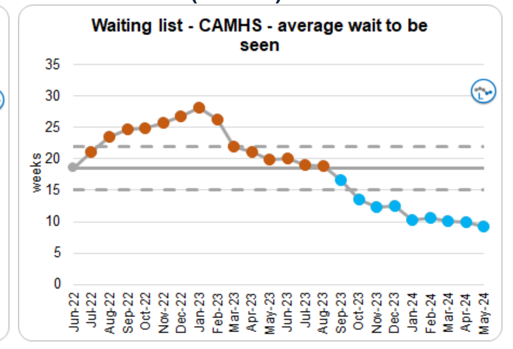
- Triage review of long waiters, with a system decision made to focus on education/ schools in order to reduce referrals by offering advice, support and signposting as needed.
- Review of vacant posts continues, including consideration for skill mixing some of these posts. Worked with the recruitment team to update job descriptions to make them more attractive to the very limited pool of potential applicants.

Trajectory for community paediatric wait times:

Waiting times for community paediatrics are likely to continue to rise. Our ongoing challenge is to reduce the growth and speed at which this takes place.

Child & Adolescent Mental Health Services (CAMHS)





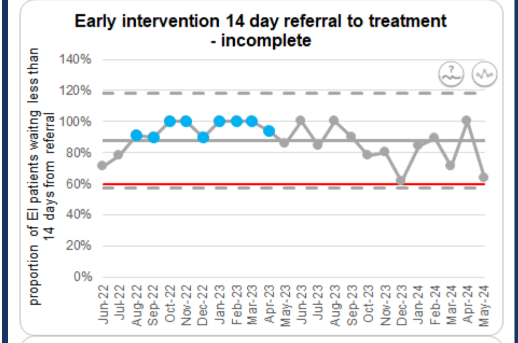
Summary

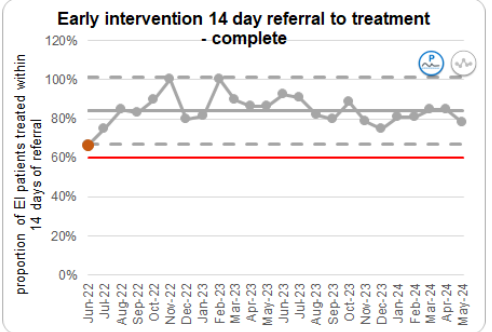
At the end of May 2024, 316 children were waiting to be seen and the average wait time was 9 weeks. The average wait is slightly skewed through seeing priority assessments within 4-6 weeks and routine assessments closer to 11 weeks, however this is still a significant improvement from where we were in 2022.

Actions

- The triage and assessment team are continuing to positively impact on external waiting times and are adhering to the Trust waiting well policy. Owing to the efficiency of the Triage and Assessment Team, it is necessary to limit the rate of assessments so that the teams further down the pathway do not become overwhelmed, however a close eye is being kept on this to ensure it does not result in average wait times going up again.

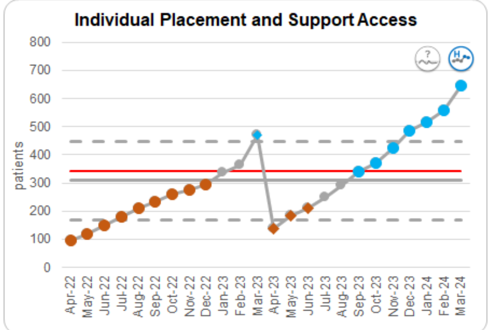
Operational Performance





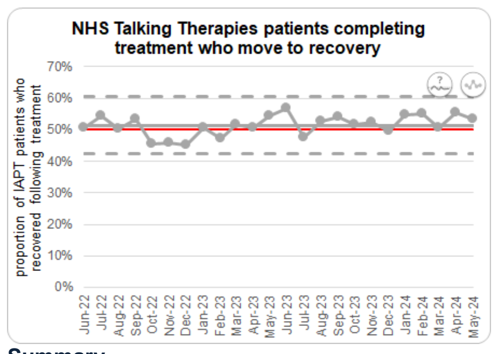
Summary
Patients with early onset psychosis are continuing to receive very timely access to the treatment they need. Occasionally delays result from difficulties contacting patients to arrange appointments, or patients not attending their planned appointments.

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.

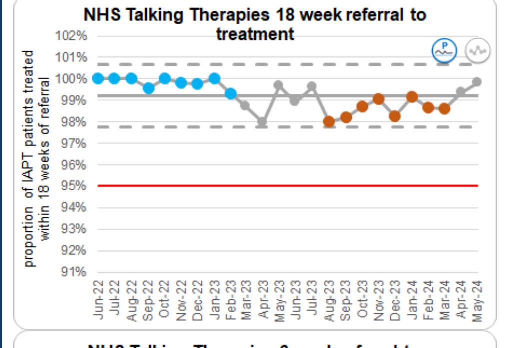


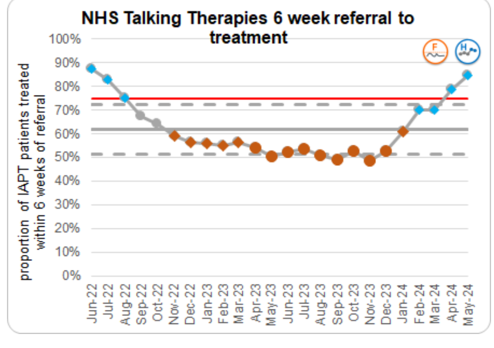
Summary
Work Your Way is a team of employment specialists and peer support workers helping people using community mental health services in Derbyshire to find work and stay in work.
The team is continuing to be extremely productive and in the financial year 2023/24 supported 645 people to access the service, and supported people to find permanent work in 176 jobs in roles of their choice. This financial year to date a further 56 people have been supported into employment.

NHS Talking Therapies



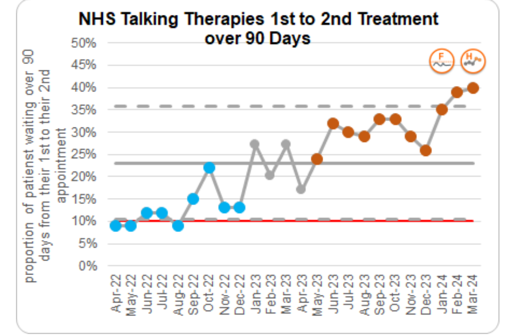
Summary
Recovery Rates continue to be above target into May at 53.4%. Reliable Improvement achieved 70% (5% above target) and Reliable Recovery achieved 49% (against a target of 48%).





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 achieved target for 2 months in a row.

Actions
- In house productivity reporting against agreed therapist targets has improved booked contacts.
- Concentration on expected levels of discharges/ attended contacts and booked contacts going forwards.



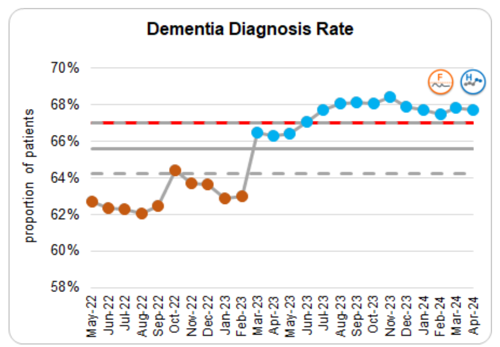
Summary
1st to 2nd treatment waits remain significantly high and continue to increase for CBT and trauma work (exceeding the remaining length of the current contract).

Actions
- Paused to referrals for 6-8 weeks with a review at 6 weeks.
- Reset of the acceptance criteria to reduce levels of risk on our waiting lists when we re-open.

By when we will have recovered the position
- We expect wait times over 90 days to reduce around quarter 3 of 24/25.

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.

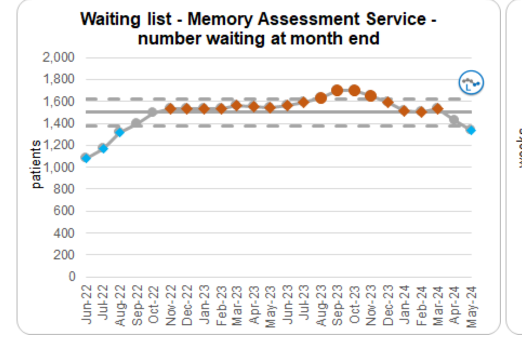
Dementia Diagnosis Benchmarking Data

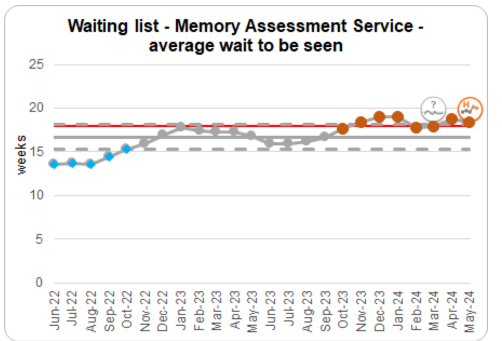
Type	Code	Diagnosis Rate
National	ENG	64.6
ICB	QF7	75.1
ICB	QOP	73.3
ICB	QNC	72.4
ICB	QWE	72.4
ICB	QT1	70.2
ICB	QKK	69.6
ICB	QUY	68.8
ICB	QWO	68.8
ICB	QE1	68.4
ICB	QHM	68
ICB	QHG	67.9
ICB	QNQ	67.8
ICB	QJ2	67.7
ICB	QXU	67.1
ICB	QYG	67
ICB	QMJ	67
ICB	QJM	66.2
ICB	QH8	66
ICB	QRV	65.1
ICB	QK1	65
ICB	QM7	64.4
ICB	QPM	64.1
ICB	QR1	63.9
ICB	QUA	63.9
ICB	QNX	62.7
ICB	QU9	62
ICB	QRL	61.8
ICB	QMM	61.5
ICB	QHL	60.9
ICB	QOC	60.8
ICB	QMF	60.7
ICB	QOX	59.9
ICB	QJG	59.7
ICB	QT6	59.6
ICB	QKS	59.4
ICB	QUE	59.4
ICB	QJK	58.9
ICB	QOQ	58.4
ICB	QWU	57.1
ICB	QVV	56.9
ICB	QSL	55.1
ICB	QGH	53.8

Primary Care Dementia Data, April 2024 - NHS England Digital

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

Dementia Diagnosis Waiting Times





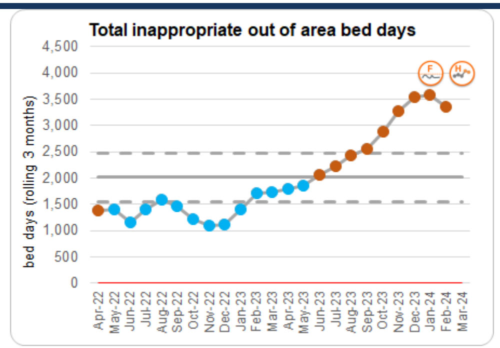
Summary
At the end of May 2024 there were 1,337 people on the waiting list, with an average wait of 18 weeks, which includes people currently waiting as well as those who were assessed in month. Waits from referral to actually being assessed are currently around 34-35 weeks. the dementia assessment pathway work in the action plan below has potentially led to the slight decrease in the numbers awaiting memory assessment service assessment (we are continuing to monitor this) but this is likely to lead to longer wait times within the community mental health teams (CMHT).

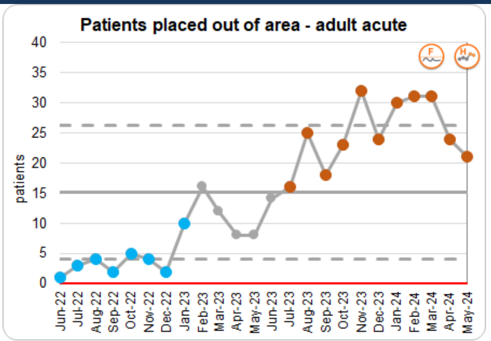
Reasons for underperformance
- There continues to be an extremely high demand for the service which exceeds capacity.
- The prevalence of dementia is predicted to increase significantly by the end of the decade so the situation in unlikely to improve.

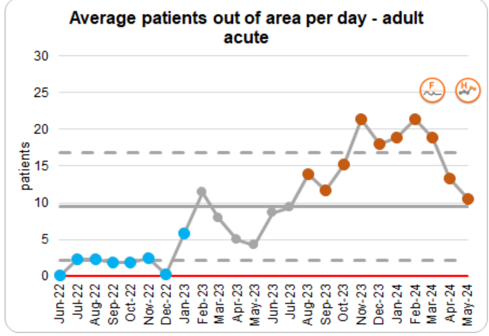
Action plan
- Completion of quality improvement project to maximise and make best use of current resource, to ensure maximum capacity and quality of current provision.
- Work is underway on the Dementia Assessment Pathway (DAP). Revised referral information has been communicated out to all referrers 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

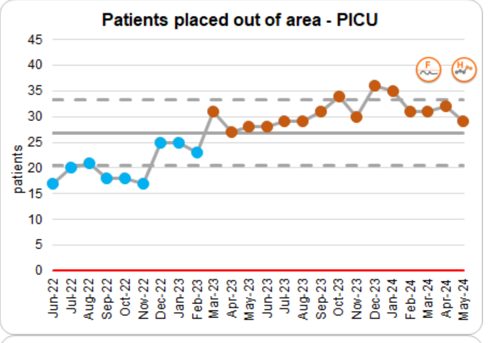
By when we will have recovered the position
Quality improvement actions to optimise performance within the current service offer and financial envelope will be fully implemented by September 2024.

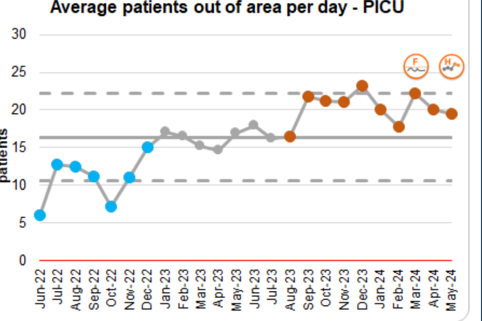
Operational Performance











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 100%, however leave beds are being utilised where safe to do so. Step down beds to help with discharge flow and crisis house beds are utilised to help avoid admissions where safe to do so. 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.

Significant improvement has been made recently, which is yet to be reflected in the data, and at the time of writing there are just 5 people in inappropriate out of area acute beds.

Recovery action plan

- A comprehensive recovery action plan has been developed.
- Continuity of care principles have been achieved for 6 female beds at mill lodge and 12 male beds at Sherwood Lodge.

Recovery action plan (cont.)

- The demand for inpatient beds for learning disability & autism 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.
- The number of patients identified as clinically ready for discharge has been reducing and an escalation process has been established.
- Implementation of community based Clozaril initiation, avoiding the need for admission to hospital.
- Gatekeeping function and purposeful admission to comply with the crisis fidelity model. Fully implemented.
- 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 to be implemented in June 24. This consists of one vehicle staffed by a paramedic and a mental health nurse.

Recovery action plan (cont.)

- MADE event took place in April 2024. Learning to be implemented and ongoing commitment to MADE process over the next 12 months.

By when we will have recovered the position

- End of March 2025

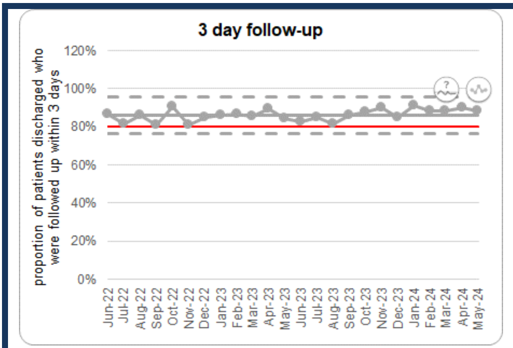
Summary

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 enhanced care ward for females.

Actions

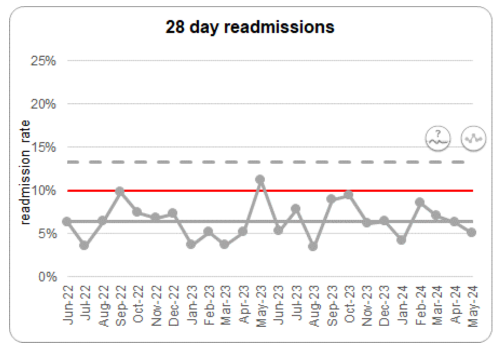
- Provision of a PICU and enhanced care ward in Derbyshire in order to be able to admit to a unit that forms part of a patient's usual local network of services in a location which helps the patient to retain the contact they want to maintain with family, carers and friends, and to feel as familiar as 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

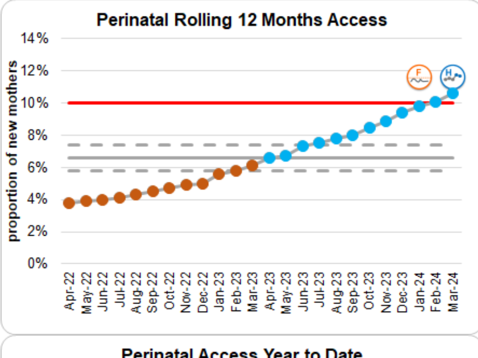


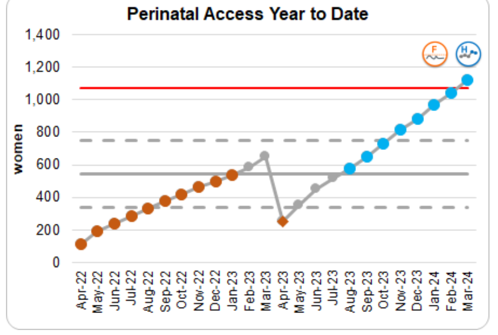
Summary
Patients are followed up in the days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during the period when they are potentially at their most vulnerable. The national standard for follow-up has been exceeded throughout the 24-month period.

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
The rate of patients readmitted within 28 days of discharge from inpatient wards has remained within common cause variation throughout the reporting period and below the 10% contractual target for the vast majority of the time.





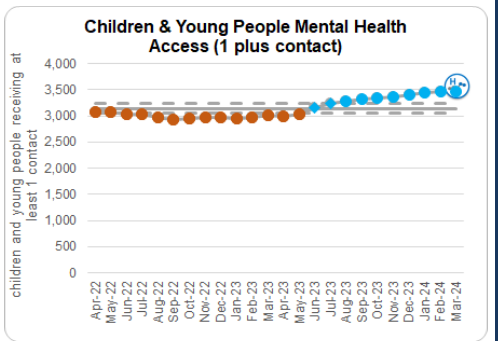
Summary
This is a measure of the number of women accessing services in the 12-month period as a percentage of Office for National Statistics (ONS) 2016 births (target 10%). There has been a significant increase in access when compared with last financial year.

As a result of significant developments and quality improvement activities within teams the full year 10% target was exceeded a month early, in February 24 and the year-end position was 10.6%.

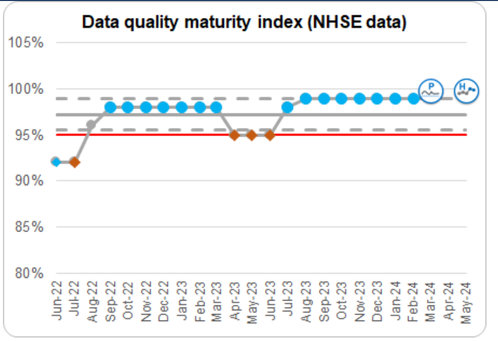
Referrals into the service remain consistent. The self-referral pilot was successful and has now been embedded within the services referral pathway. Community outreach streams continue to improve parity of access.

Actions needed to maintain target

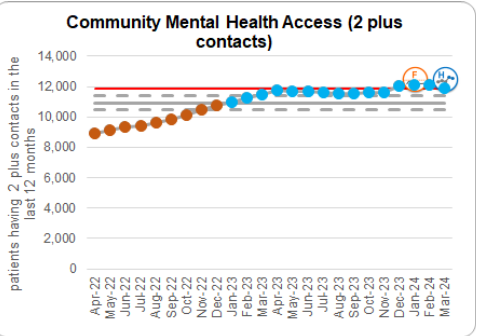
- Agreed CPN job plans and target caseloads to be maintained.
- Psychology posts to be recruited into
- Specialist assessor role across North and South teams.
- Further stakeholder event, to ensure referrers are up to date with care pathways and referral processes.
- Recovery action plan in place regarding community waiting lists for community teams.
- Waiting well offer in place to support patients whilst on the waiting lists.



Summary
Performance has been significantly high for the last 10 months.



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

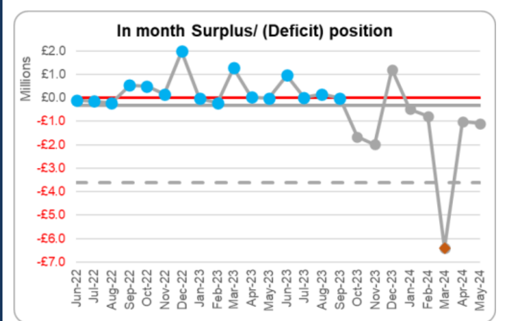


Summary
The ICB was set a challenging target to increase the number of adults and older adults receiving 2 or more contacts in a year from community mental health services to 10,044 by the end of March 2023, which was an increase of 14% on current performance. The target was achieved.

This financial year the year-end target has been increased to 11,899 and for the last 4 months the target has been exceeded.

Finance

Financial Performance

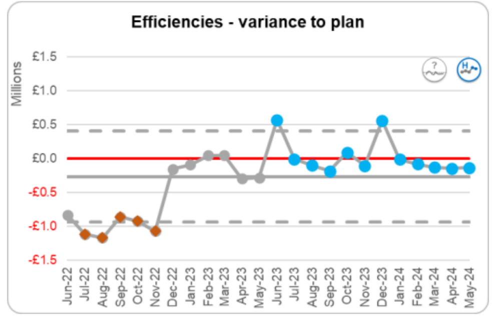


Summary
At the end of May the position is a deficit of £1.9m which is on plan.
The forecast position remains in line with the plan submission of £6.4m deficit.

Risks:

- Delivery of efficiencies in full
- Management of Adult Acute out of area expenditure
- Management of in-patient expenditure to budget
- Additional costs of complex patient
- Management of agency expenditure within budget

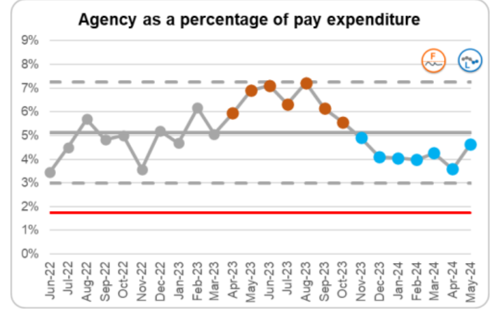
The Board Assurance Framework (BAF) risk *that the Trust fails to deliver its revenue and capital financial plans for 2024/25,* remains rated as EXTREME due to the financial risks above.



Summary
The plan includes an efficiency requirement of £12.5m with a proportion phased from quarter 2. The plan assumes 71% of the savings are delivered recurrently.

At the end of May efficiencies are behind plan by £0.3m. Work continues in progressing sign-off of the project initiation documents (PIDs) and quality & equality impact assessments (QEIAs). A higher proportion of schemes will be transacted at month 3 as they move through the approval process.

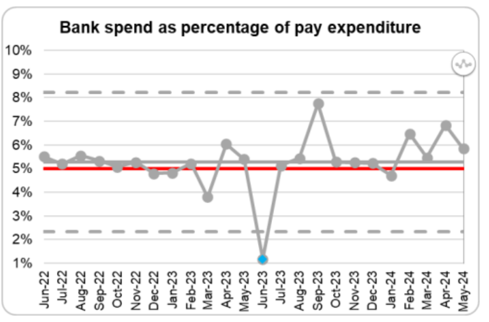
The weekly Efficiency Delivery Group has been revised and will now become a fortnightly meeting, with Executive Director leadership once a month. The revised format of the group will provide greater governance and support going forward.



Summary
Agency expenditure YTD totals £1.1m which is on plan. This includes £0.4m 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 May is 4.6%.

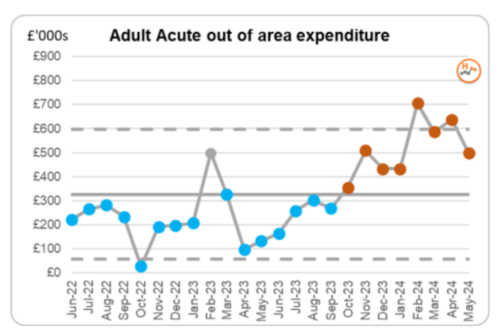
NHSE use of resources includes an action to improve workforce productivity and reduce agency spend to a maximum of 3.2% of the total pay bill across 2024/25.



Summary
Bank expenditure YTD totals £1.8m, which is above plan by £0.4m.

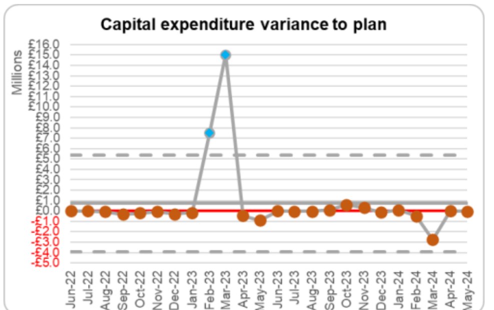
Some of the additional staff on the wards in relation to CQC actions are through bank use, where the plan was set against agency.

Financial Performance



Summary
The plan for out of area expenditure is based on a reducing trajectory from 22 to zero beds by the end of the financial year.

At the end of May expenditure is £1.1m which is £151k above plan. The number of placements in May reduced compared to April and continues to reduce further throughout June.

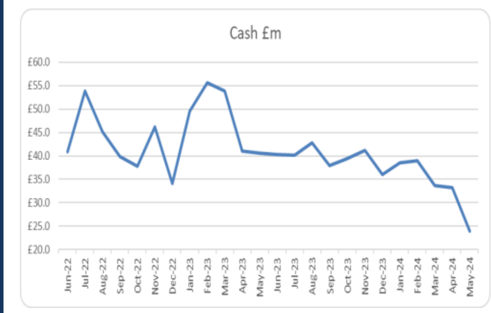


Summary
Capital expenditure at the end of May is slightly below plan by £0.2m.
The capital plan has been reduced by £0.3m and rephased across the year in the plan resubmission that took place on 12th June.

The revised plan still includes an additional 5% of capital expenditure which will need to be managed in year.

Additional risks relate to any new leases, which due to the changes in accounting treatment, will now need to be funded from the capital allocation.

The plan does include £4.8m of national funded capital in relation to the Eradication of Dorms scheme.



Summary
Cash at the end of May is at £24.0m (£33.2 last month) which is slightly below plan by £0.4m.

The reduction in May is due to the payment of some high value capital invoices related to the Eradication of Dorms schemes.

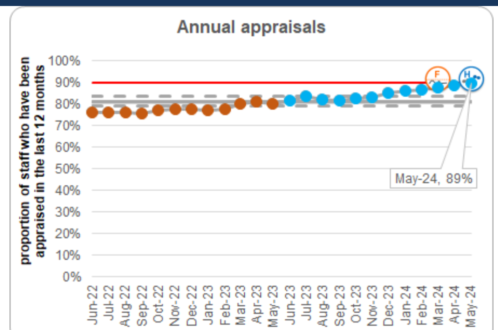
Other areas to note:

Annual Accounts for 2023/24 have been approved by the Audit and Risk Committee on 19th June 2024, following the external audit sign off. No changes to the financial statements have been made, only minor presentational changes to the disclosure notes.
All supporting documents are due to be submitted to NHS England on 28th June.

The financial plan for 2024/25 has been resubmitted on 12th June. There have been no changes to the previous revenue plan deficit of £6.4m. The capital plan has been reduced by £0.3m to £2.6m for business as usual capital expenditure.

People

People Performance



Summary

Operational Services are currently at 90% and Corporate Services at 82%, against a target of 90%. Overall, significant improvement has been seen month on month for the last 12 months.

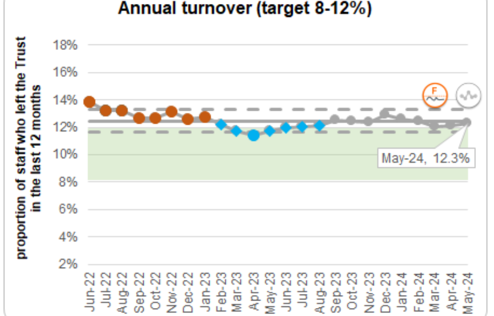
Actions

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 4.5% since the last reporting period, however, more needs to be done to increase this further to achieve target. The two services within Corporate Services with the lowest compliance are Nursing & Quality directorate at 53% (increase of 5% since the last reporting period) and Corporate Central at 77%. The following measures are now in place to increase compliance further:

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

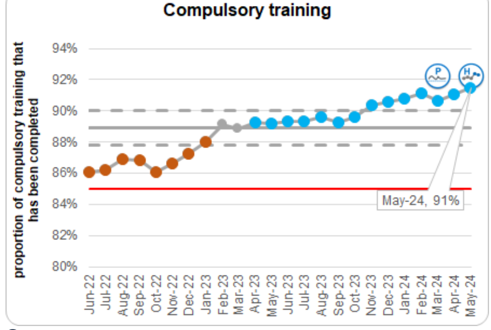


Summary

Overall turnover has been slightly above 12% for the last 11 months but remains in line with national and regional comparators.

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 where possible.
- 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.
- The review of staff benefits to support engagement and retention has been completed and in particular, included a review of the Trusts salary sacrifice schemes. A re-launch of the salary sacrifice scheme and offering is due to commence in July 2024 along with a new intranet page to promote all options and packages available.
- The Trust continues to run a vacancy control panel to monitor all recruitment activity.



Summary

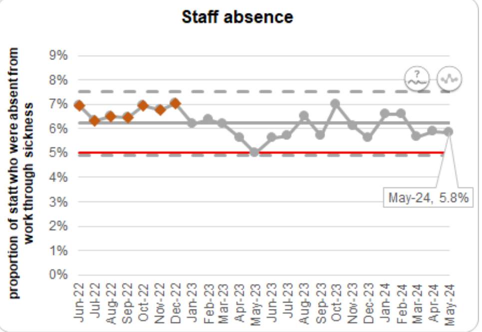
Overall, the 85% compliance target has been achieved for the last 24 months. Operational Services are currently 92% compliant and Corporate Services are 87%.

Actions

Whilst overall compliance of the 20 training elements remains high, there have been challenges with two mandatory training elements dropping just slightly below target in the reporting period and two role-specific compulsory training elements which are classroom based. 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 remain in place to support this as follows:

- 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 above the 5% target and has averaged 6.2% over the 24-month period. In May 2024 the overall absence rate was 5.8% (Operational 6%, Corporate 4%).

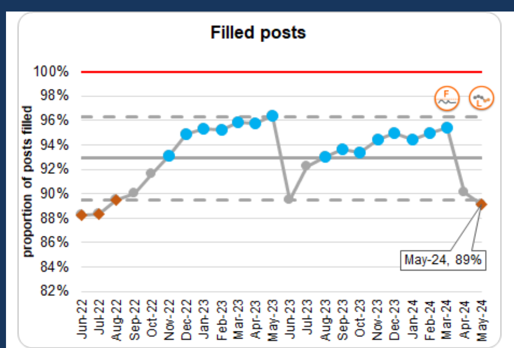
Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by Other Musculoskeletal problems and Gastrointestinal Problems (joint second highest reason) and Surgery as the third highest reason for absence.

Long-term sickness absence represents 57% of all sickness absence and short-term represents 43%. Compared to the previous reporting period, long term sickness absence has increased and short-term sickness has decreased.

Actions:

- A review continues to take place with a view to ensure early intervention takes place at an earlier stage.
- All long-term absences are reviewed each month with the Director of People, Organisational Development & Inclusion and the Employee Relations to ensure a supportive and robust approach continues to be taken to managing all absences.
- The event recently held at Cubley Court to raise awareness of musculoskeletal issues and how to avoid them following an increase in musculoskeletal absences in the area, is now being looked at being replicated in other services. This will include a series of stands, activities and advice.

People Performance

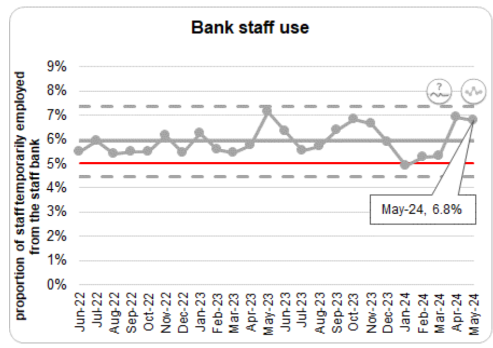


Summary

At the end of May 2024, 89% of posts overall were filled. New investment released from April 2024 onwards has created brand new vacancies.

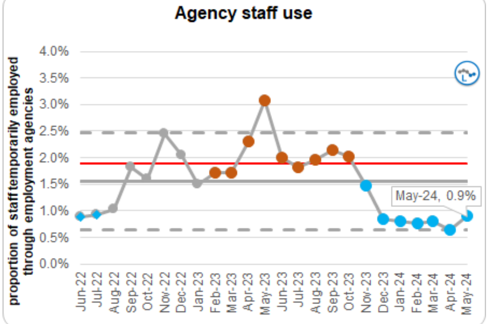
Actions

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



Summary

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.



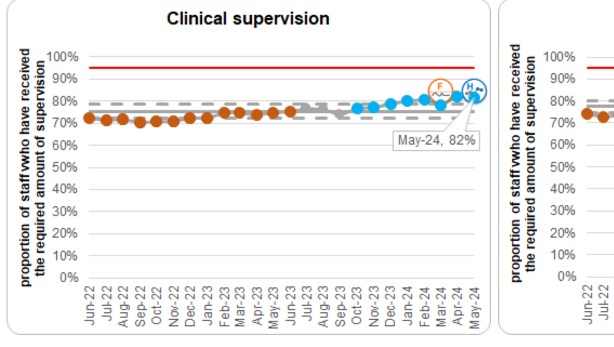
Summary

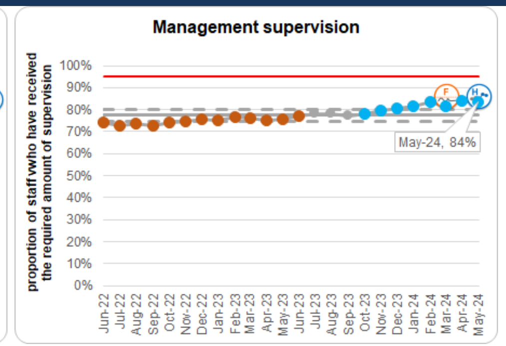
Agency usage has reduced significantly over recent months, however there has been a temporary increase in agency usage for May due to a requirement for increased clinical observations.

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 82% for clinical supervision and 84% 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: 88% versus 63% and clinical: 85% versus 31%).

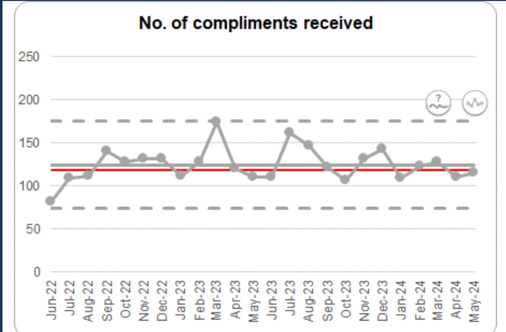
Actions

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 was limited assurance and has recommend the following actions take place:

The Trust needs to review:
• the Supervision Policy and consider whether a full review/refresh is required based on the findings in this report and the responses to the survey of Trust staff
• arrangements for documenting and recording supervision to ensure these are clearly outlined within the policy and ensure these responsibilities and communicated and compliance is monitored
• training arrangements for supervisors
• governance arrangements in place to monitor supervision compliance to ensure forums are in receipt of sufficiently detailed reports to oversee and scrutinise performance of all types of supervision
• the actions in place to improve supervision and the performance reporting in place to ensure these are consistent across Operational and Corporate Services
• reporting across the Trust covers all areas of supervision required as outlined within the Trust's policy. minimal supervision expectations and how these are allocated throughout the year and update reporting to reflect this requirement to assess compliance

Quality

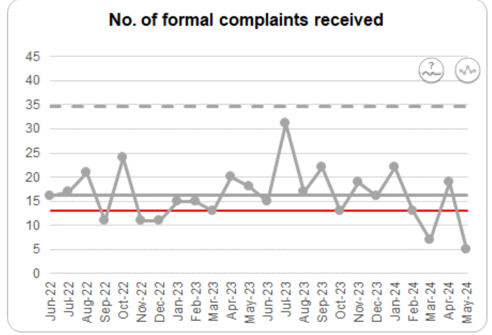


Summary

The number of compliments recorded remain within common cause variation and has remained between 110 and 134 between March and May 2024.

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 over 600 patient feedback responses across the teams received to date. This is currently undergoing an evaluation which will be published in July with recommendations about the sustainability of the project.
- 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.

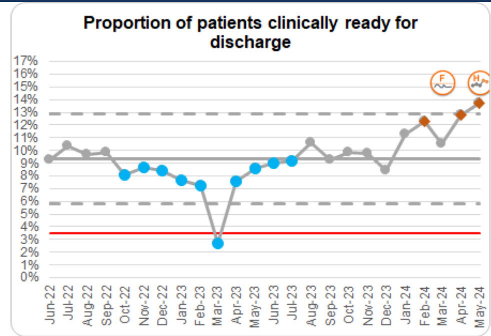


Summary

The number of complaints recorded reduced from 11 to 5 between March and May 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.
- The number of outstanding actions has reduced from 24 to 12 between March and May 2024. A new member of staff has been temporarily allocated to the patient experience team and a complaints investigator has been identified for the urgent assessment services which may have contributed to the reduction in outstanding actions.
- The number of outstanding actions following complaints investigations is monitored and reviewed as part of the Trust Patient Experience Committee meeting and a quarterly summary report is completed by Heads of Nursing and shared with both operational teams within the Trust along with patient and carer groups.



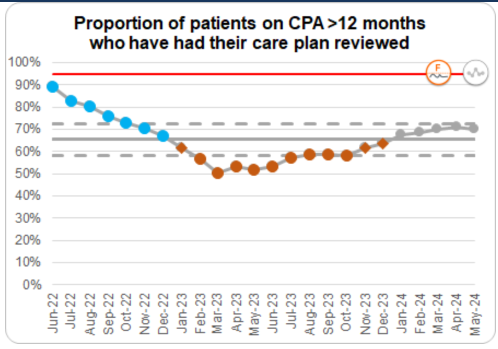
Summary

The number of service users meeting the criteria as clinically ready for discharge (CRD) (formally called delayed transfer of care (DTOC), increased from 11% to 13% between March and May 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.

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.
- A Trust transformation project manager is currently reviewing learning from a Multi-agency Discharge Event (MADE) in April 2024 on this will be used to improve system wide flow.



Summary

The current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months is 86% on average as of the 12th of June 2024 according to the Trust CPA review compliance report.

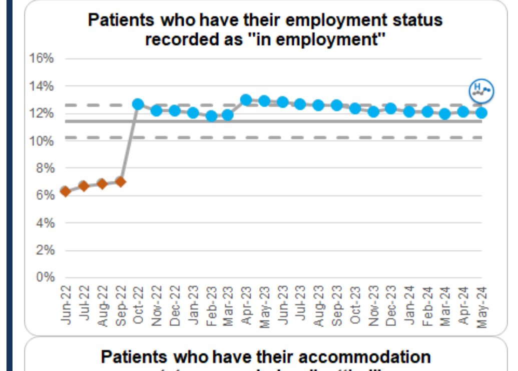
Staff vacancies, sickness, industrial action, and patient acuity have all contributed to the percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months.

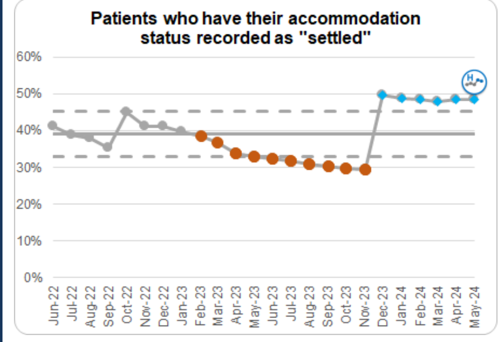
Actions

The Trust services with compliance lower than 85% have identified action plans to improve care plan, risk screen and CPA compliance as below:

- 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.
- As of June 2023, the CMHT are 67% compliant on average in relation to having a CPA review in the last 12 months as per the Trust CPA review compliance report. However it should be noted that overall care plan compliance is at 85%.
- The Head of Nursing has been asked to coordinate an improvement plan and an update will be provided within the next report on the progress. With improved care plan compliance, it is expected that more timely reviews of CPA will follow. There is also a working group in place which meets monthly to review the Trust approach to CPA which is now expected to start in July 2024 following a delay due to changes of staff.

Quality Performance

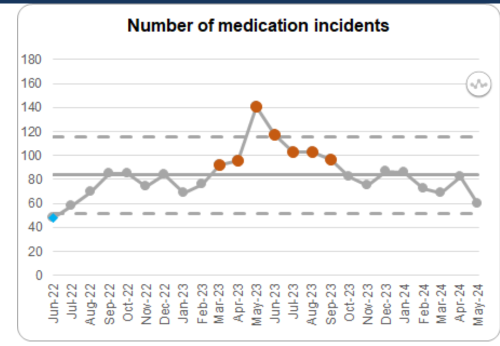




Summary
Patients open to the Trust in settled accommodation has increased from 48% to 49% between March and May 2024 and the number of patients open to employment has continued to remain consistent since August 2022. This measure continues to be monitored by individual services.

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 March and May 2024 has fallen from 72 to 60 (17%) and continues in line with common cause variation. It should be noted that the medication incidents reported are largely of low-level harm.

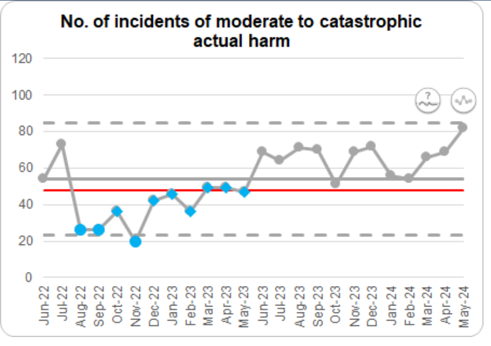
Actions

- 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.

- 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. The number of incidents increased between March and May 2024 from 65 to 85 incidents.

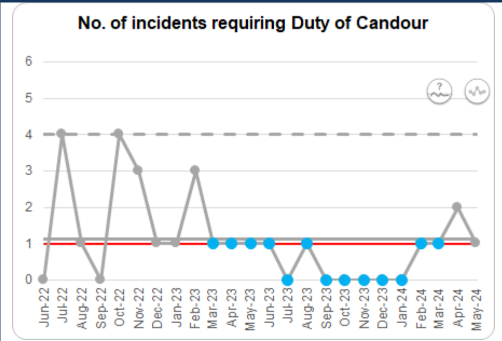
Analysis suggests that this is due to a sustained increase in the number of incidents routinely reported by staff and a sustained rise in incidents recorded as "self-harm" and physical assault from patients to staff and patient to patient.

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 continued anecdotal reports from staff that acuity on the inpatient wards is high and this is most prevalent on the female acute wards.

There has also been a sustained high level of reporting from the mental health helpline and support service.

This is monitored by the Patient Safety team and the Heads of Nursing/Practice.

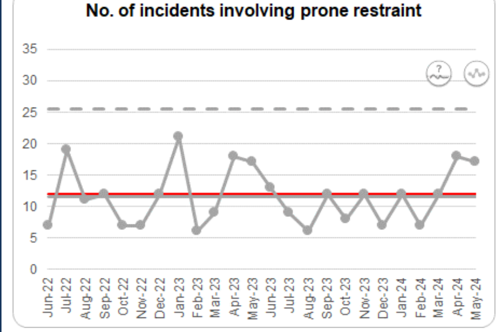
Quality Performance



Summary
Between March and May 2024, the number of incidents meeting the threshold for Duty of Candour (DoC) fluctuated between 1 and 2.

The Trust Family Liaison Office has created information leaflets and standard operating procedures to support staff in completing duty of candour communications. Furthermore, these are reviewed twice weekly within serious incident groups.

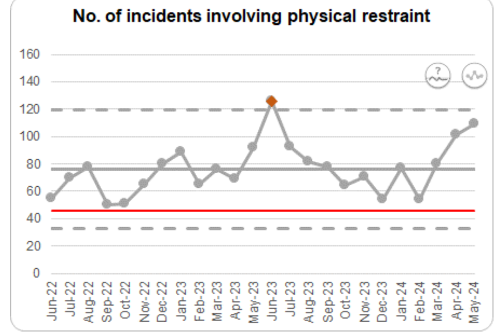
Actions
- Training around accurately reporting DoC continues within clinical teams and the Family Liaison Officer with support from the patient safety team review each DoC incident as they occur and request support from the HoN team as required.



Summary
Incidents of prone restraint have increased from 12 to 17 incidents between March and May 2024. This is in above the Trust target of 12 incidents. This is not unexpected in relation to the increase in incidents involving physical restraint.

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 was expected to start in May 2024 however this has been delayed until June 2024 dependent on funding. This will include interventions that would expect to improve and sustain a reduction of prone restraint.

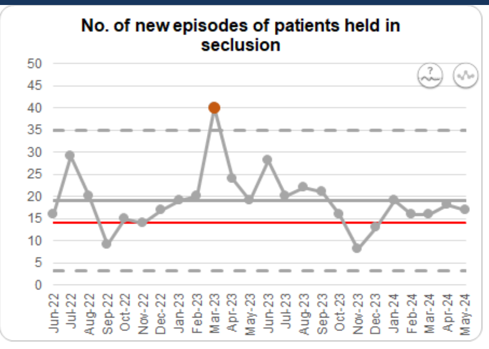
- The PSST have developed training around alternative injection sites and a poster produced in collaboration with the pharmacy department is now available to staff identifying which route common medications can be given. The training is due to start in April 2024. These interventions are expected to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



Summary
Physical restraints have increased from 81 to 120 incidents between March and May 2024.
The female acute wards and older adult wards continue to have the majority of incidents attributed to them. The increase in episodes of physical restraint is attributed to a sustained rise in self-harm incidents and staff intervention required to prevent individuals harming themselves. There was also an overall increase in physical restraint due to repeated incidents on the perinatal ward which is unusual for this area and a reduction is expected in the next report.

Restrictive interventions are continuously reviewed within the monthly 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 82% for teamwork and 71% for breakaway training. The slower than anticipated increase in compliance is due to staff who were previously identified as medically exempt, now requiring training. Compliance with training is monitored in monthly divisional assurance review meetings and the monthly Reducing Restrictive Practice group. The PSST team expect to get both breakaway and teamwork training to 85% by August 2024 due to the increase in staff who require training



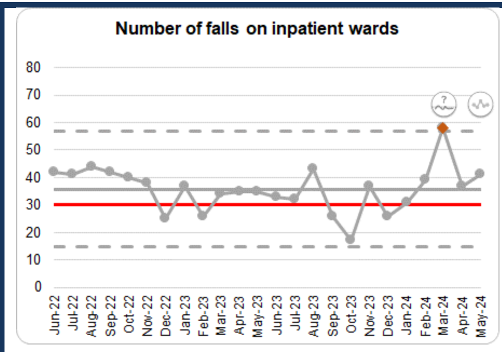
Summary
Episodes of seclusion between March and May 2024 have increased by 1 from 16 to 17. This is in line with common cause variation and below the mean of 19.

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 March and May 2024 has decreased from a high of 58 to 36. The high was due to several repeated incidents attributed to a small group of patients with challenging conditions.

It should also be noted that 96% of the falls recorded over this period were categorised as minor or insignificant meaning that no harm came to the individuals involved.

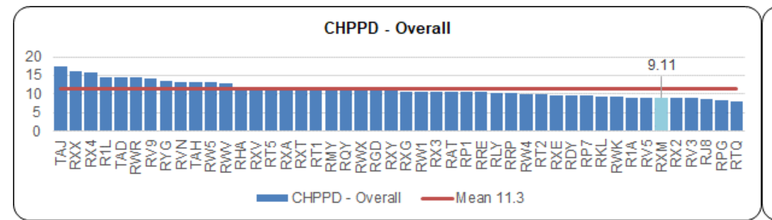
Actions

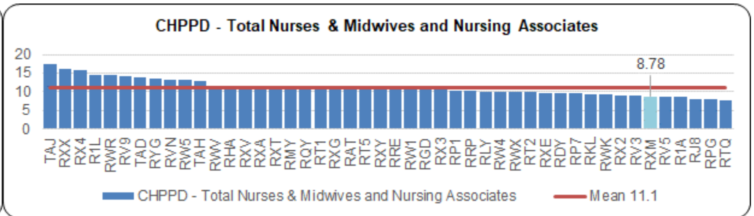
- All patients who have fallen or are identified as at risk of falling have fall prevention care plans in place, and a dedicated falls prevention Physiotherapist returned following a long absence in April 2024.
- The number of falls reported is monitored via the Falls Lead Occupational Therapist, Head 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)

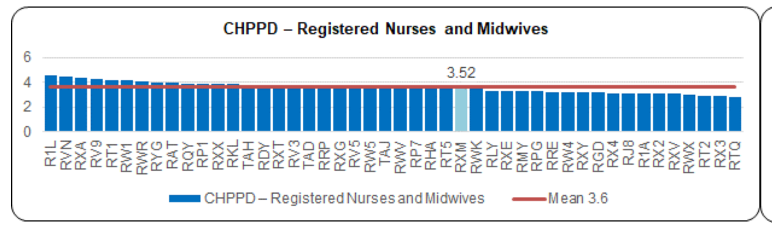
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying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

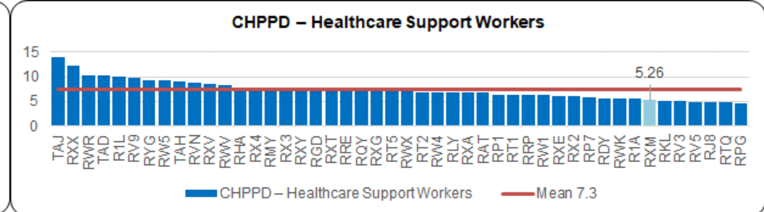
The charts below indicate that the Trust's CHPPD overall achieved 9.11 hours, which was below average when benchmarked against other mental health trusts in the country (11.3). For total nurses and nursing associates the Trust achieved 8.78 hours against the national average of 11.1 hours:





For registered nurses the Trust achieved 3.52 hours against the national average of 3.6 hours. For healthcare support workers the Trust achieved 5.26 hours against the national average of 7.3 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:

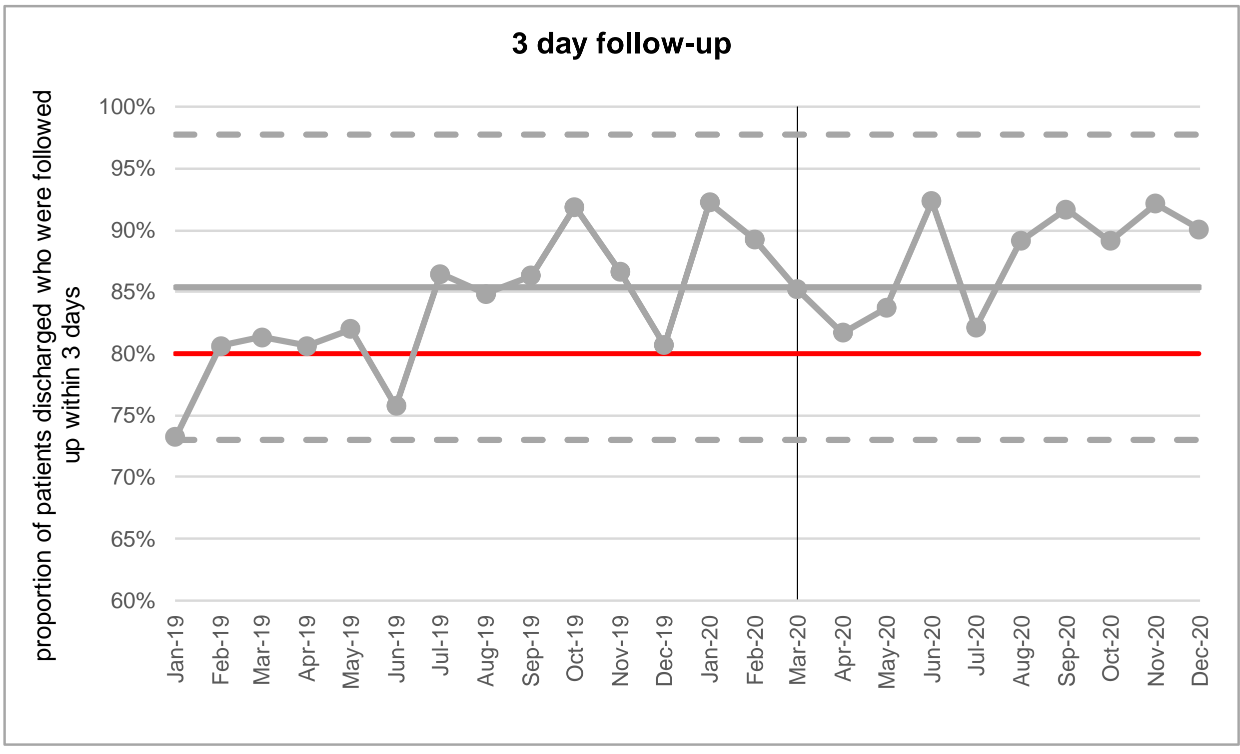
Trust Code	Total Responses	Total Eligible	Percentage Positive	Percentage Negative	Mode of Collection						
					Mode Electronic Discharge	Mode Electronic Home	Mode Paper Discharge	Mode Paper Home	Mode Telephone	Mode Online	Mode Other
	23,245	**865,001**	**86%**	**7%**	**1,479**	**350**	**5,640**	**1,304**	**436**	**9,752**	**1,658**
	22,547	**853,658**	**86%**	**7%**	**1,314**	**350**	**5,485**	**1,304**	**436**	**9,627**	**1,463**
	23,245	**865,001**	**86%**	**7%**	**1,187**	**350**	**5,300**	**1,303**	**436**	**9,261**	**1,658**
RR7	22	140	100%	0%	0	0	22	0	0	0	0
R8B8U	5	5	100%	0%	0	0	0	0	0	5	0
R1F	34	2,330	100%	0%	0	0	0	14	0	20	0
RYK	13	1,614	100%	0%	0	0	0	0	0	0	0
NQL	94	3,550	99%	1%	0	0	0	0	0	0	0
RQ3	36	29	97%	3%	0	0	0	0	0	36	0
O2F3D	102	274	97%	3%	0	0	102	0	0	0	2
R0B	159	1,908	97%	3%	0	0	105	0	0	54	0
RV9	195	4,933	96%	1%	0	0	195	0	0	0	0
R1L	81	15,373	96%	1%	*	*	*	*	*	*	*
NNF	171	2,705	96%	2%	0	0	46	0	0	92	*
TAJ	207	17,311	96%	0%	0	0	0	0	0	0	60
RXL	103	1,426	95%	2%	0	0	0	59	0	42	0
RY6	677	3,132	95%	2%	0	0	90	0	0	582	0
RW4	501	20,389	94%	2%	*	*	*	*	*	*	0
RT1	210	2,775	93%	2%	51	0	1	66	0	79	0
RWV	273	6,509	93%	3%	0	0	0	85	20	168	0
RDY	399	6,686	93%	5%	0	42	0	24	0	331	0
RX3	1,473	151,724	92%	3%	354	0	856	0	0	157	0
RXG	360	12,710	92%	5%	1	0	157	0	0	202	0
RP7	817	5,046	91%	2%	0	9	0	49	0	746	301
RXM	360	17,519	91%	4%	0	0	127	0	0	233	43
RRP	597	9,027	91%	3%	0	0	597	0	0	0	3
RVN	442	6,174	90%	4%	0	0	93	252	0	97	0
RWX	467	28,034	90%	5%	39	0	17	0	0	411	0
NR5	159	2,200	89%	11%	0	0	0	0	0	33	561
RQY	694	21,029	88%	6%	415	0	0	0	0	0	0
RT2	1,235	11,863	88%	4%	0	0	809	0	46	268	0
RLY	186	13,356	88%	5%	0	0	0	84	0	0	0
RXT	368	18,529	88%	4%	0	0	323	0	0	45	0
R1C	199	2,036	88%	6%	0	98	0	0	0	55	0
RXY	496	14,353	88%	3%	0	0	478	0	0	18	0
RXV	561	35,046	88%	7%	0	0	0	0	0	0	0
RRE	338	24,877	88%	9%	0	0	0	0	0	295	0
RXX	404	9,190	87%	4%	33	0	51	0	0	310	0
RX4	401	34,527	87%	8%	0	0	269	0	0	0	*
RXE	385	19,470	87%	8%	*	*	*	*	*	*	0
RW5	1,259	45,547	86%	10%	0	0	0	0	358	901	207
RTQ	175	3,795	86%	6%	0	0	0	0	0	175	13
RXA	742	12,470	86%	7%	0	0	68	0	0	0	0
RGD	137	7,360	85%	7%	0	0	0	17	0	120	0
RTF	27	799	85%	7%	0	0	0	0	0	0	141
RKL	107	10,685	85%	12%	0	0	70	0	0	37	0
TAD	45	9,257	84%	7%	0	0	45	0	0	0	0
RV5	363	39,663	84%	7%	0	0	81	0	0	282	0
RNK	113	2,664	84%	5%	0	0	113	0	0	0	0
TAF	205	1,629	83%	8%	0	5	0	0	0	200	0
RAT	946	11,742	82%	10%	0	0	0	0	0	946	*
RPG	937	14,686	80%	6%	63	64	151	152	0	214	0
RWK	546	33,701	80%	9%	0	0	0	12	0	408	*
RV3	308	25,182	80%	6%	0	0	54	0	0	244	0
RWR	746	12,447	78%	11%	*	*	*	*	*	*	33
NMJ	165	2,144	76%	8%	165	0	0	0	0	0	0
RT5	595	11,612	76%	16%	66	0	0	0	12	104	*
RMY	301	28,259	76%	18%	0	0	0	0	0	0	0
RW1	1,279	10,973	74%	18%	0	0	297	187	0	795	68
RP1	340	8,197	72%	20%	0	132	0	198	0	9	94
RX2	537	12,522	72%	18%	0	0	0	0	0	537	*
RHA	134	15,121	71%	14%	0	0	0	104	0	10	0

Data source: NHS England » Friends and Family Test data – March 2024

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



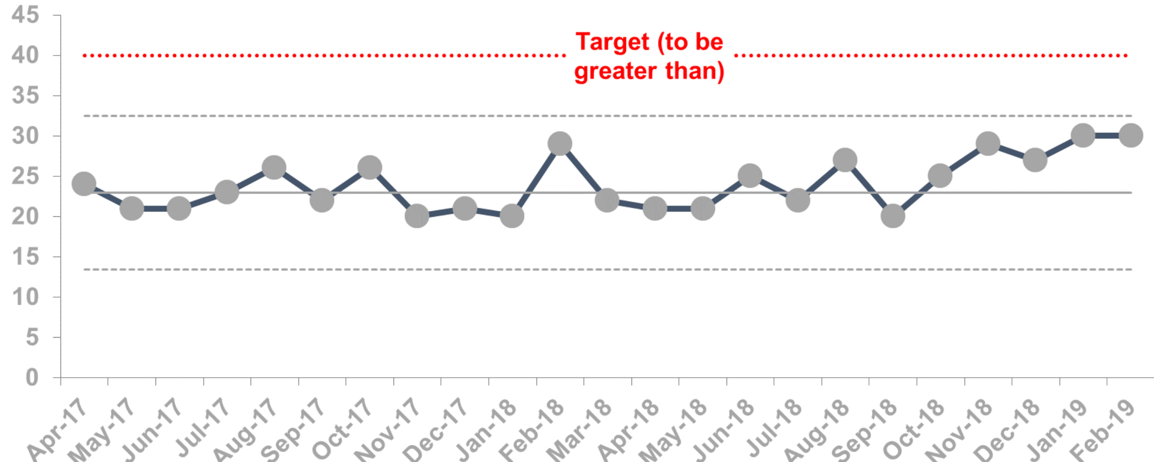
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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.

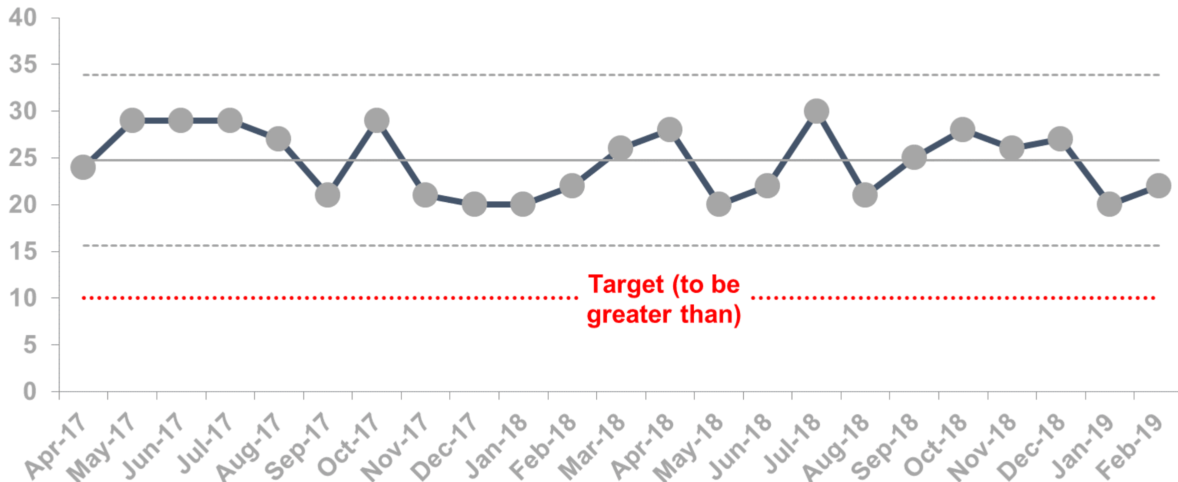
Things to look out for:

1. A process that is not working



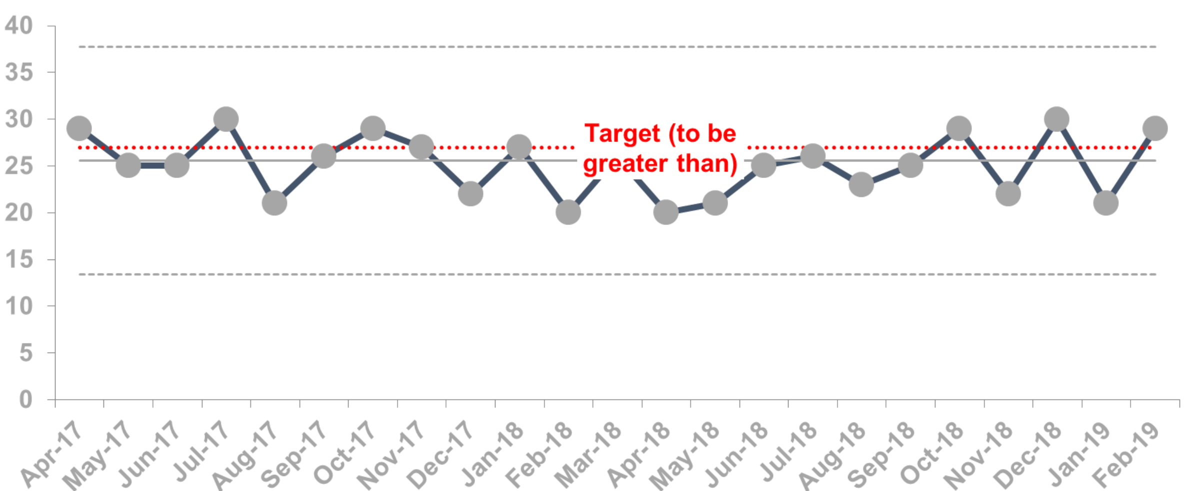
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

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

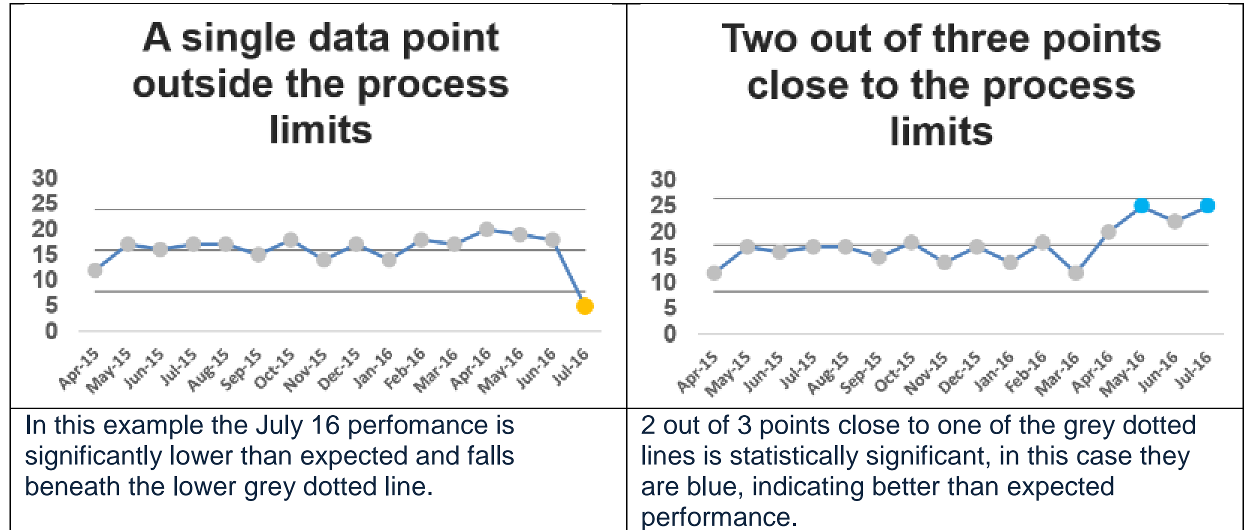


In this example the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

4. Unusual patterns in the data

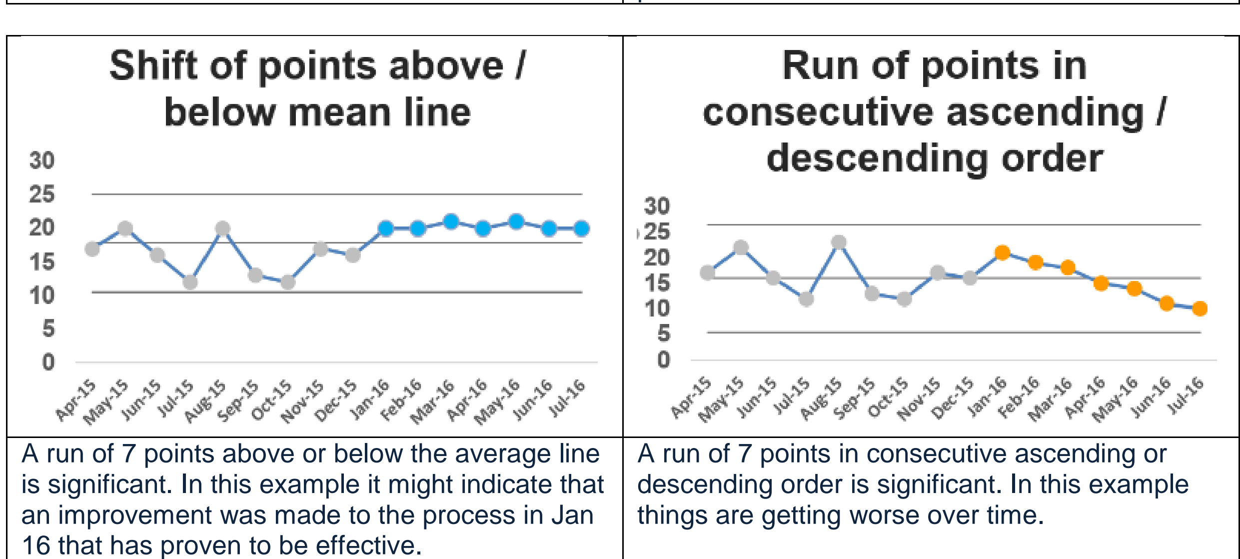
If there is anything unusual in the data, the grey dots will change colour. Orange means it is unusually worse than expected and blue means it is unusually better than expected. These unusual patterns should be looked into to establish why it is happening.

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)

Appendix 2

Assurance Ratings

- **Full Assurance** can be provided that the system of internal control has been effectively designed to meet the system's objectives, and controls are consistently applied in all areas reviewed
- **Significant Assurance** can be provided that there is a generally sound system of control designed to meet the system's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk
- **Limited Assurance** can be provided as weaknesses in the design or inconsistent application of controls put the achievement of the system's objectives at risk in the areas reviewed
- **No Assurance** can be provided as weaknesses in control, or consistent non-compliance with key controls, could result [have resulted] in failure to achieve the system's objectives in the areas reviewed.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 July 2024

Fit and Proper Persons Test - Chair's Annual Declaration

Purpose of Report

To inform the Board of the Board members compliance against the Fit and Proper Persons Test Framework.

Executive Summary

Under the Fit and Person's Test regulations (Health and Social Care Act 2008 Regulation 2014) all provider organisations must ensure that Director level appointments meet the 'Fit and Proper Persons Test' and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent or Non-Executive Director under given circumstances. The regulations have been integrated into the CQC registration requirements and fall within the remit of their regulatory inspection approach.

The Trust has processes in place to ensure that the appropriate checks are made on appointment of Board Director level posts, including interim appointments over six weeks, and that relevant checks and supporting information relating to existing post holders have been provided and there are proactive processes set in place to ensure the ongoing review and monitoring of the filing system for all Board Directors. A summary of the checks is included at **Appendix 1.**

Due to a technical issue, four members of the Board are currently being covered under supervision waivers whilst awaiting their enhanced DBS checks. Standard DBS checks are being processed in the interim period and all individuals have completed self-declarations against the requirements.

The NHS Leadership Competency Framework (LCF) is now being incorporated into the recruitment processes for Board Directors and will form the basis of their appraisals for 2024/25.

Each Board Director has completed an annual self-declaration under the Fit and Proper Persons Policy and each new Board Director has completed one on commencement with the Trust.

During the 2023/24 appraisal process, the Chief Executive reviewed the information for the Executive Team, confirming he believes they are fit and proper. The Senior Independent Director reviewed the Chair's information during her appraisal and has confirmed he believes the Chair is fit and proper. The Chair has completed the review of the NEDs' information as part of their 2023/24 appraisals and has confirmed she believes they are all fit and proper.

It is the responsibility of the Chair to discharge the requirement placed on the Trust to ensure that all Board Directors meet the fitness test and do not meet any of the 'unfit' criteria. Under the new Fit and Proper Persons Test Framework, the Chair is required to complete a review of the whole Board annually and submit a template confirming compliance to NHS England. This has been sent off by the 30 June deadline. The Chair's declaration covers 2023/24 and is included at **Appendix 2.**

A summary of the Framework requirements is included as **Appendix 3.**

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.	

Assurances

- The Board can receive assurance that due process has been followed in line with the Trust's Fit and Proper Persons Policy to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria
- That comprehensive files have been established and maintained for each relevant post, evidencing compliance and that proactive processes have been set in place to monitor the filing system.

Consultation

This report has not been considered by other groups/committees. However, confirmation of Fit and Proper Person Test compliance for Non-Executive appointments is reviewed by the governor Nomination and Remuneration Committee, and confirmation of compliance with Fit and Proper Persons Test requirements have been overseen by the Remuneration and Appointments Committee for Executive Director appointments made in year.

Governance or Legal Issues

- It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that NHS bodies undertake a 'fit and proper person test'
- The regulations have been integrated into the CQC's registration requirements and falls within the remit of their regulatory inspection approach.

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.

Recommendation

The Board of Directors is requested to:

1. Receive full assurance from the Chair's declaration that that all Board Directors meet the fitness test and do not meet any of the 'unfit' criteria and that the Board is fit and proper
2. Note the compliance against the national Fit and Proper Persons Test (FPPT) Framework.

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

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

Appendix 1

Fit and Proper Person Checks introduced as part of FPPT framework.

1. All new appointments are subject to a full FPPT that includes:

1.1. Standard employment checks as per the Trust's Recruitment and Selection Procedure

1.2. References, using the board member reference template that cover a six-year continuous employment history

1.3. An enhanced DBS for a person who will be acting in a role that falls within the definition of a 'regulated activity'

1.4. Search of insolvency and bankruptcy register

1.5. Search of Companies House register to ensure that no board member is disqualified as a Director

1.6. Search of the Charity Commission's Register of Removed Trustees

1.7. Employment Tribunal Judgement check

1.8. Web/social media search

1.9. Satisfactory completion of the self-attestation form

2. For annual assurance, the FPPT includes:

2.1. Annual completion of the self-attestation form

2.2. Annual Declaration of Interest for Directors in post

2.3. DBS check at least every three years

3. All Board leavers:

3.1. Completed Board Member exit reference based on template to be kept on file, irrespective of whether a reference is requested from another NHS employer.

Requirement to hold certain FPPT data in the Electronic Staff Record (ESR)

New data fields in ESR will hold individual FPPT information for all Board Members. A privacy notice is issued to all Board Members.

Appendix 2

Fit and Proper Persons Test Chair's Declaration

DECLARATION:

I hereby declare that appropriate checks have been undertaken in reaching my judgment that I am satisfied that all Directors of the Trust, including Non-Executive Directors, and Executive Directors (including voting, non-voting and Acting) are deemed to be fit and that none meet any of the 'unfit' criteria. Specified information about Board Directors is available to regulators on request.

Signed

Selina Ullah – Trust Chair – June 2024

Appendix 3

Summary of the Key points from the NHS England Fit and Proper Test Framework[1] for Board Members

Source - NHS Providers Next Day Briefing – 3 August 2023

- **The framework is positioned in the wider context of good governance, leadership and board development and applies to all board members of specified NHS organisations, including interim appointments and non-voting members.** Integrated care board (ICB), CQC and NHSE board members are now within its scope, in addition to NHS provider trust and foundation trust (FT) board members.

- **The majority of the requirements echo those that already existed in previous FPPT guidance.** Core elements that continue to be assessed are, good character; possessing the qualifications, competence, skills and experience required; and financial soundness. These are in addition to standard employment checks such as CV checks, proof of identity and right to work.

- The statutory requirements of the FPPT are set out in Regulation 5 of the Health and Social Care Act 2008 (Regulations 2014). This is a non-statutory framework, based on the recommendations of the Kark Review.

- The framework introduces a new **standardised board member reference**. These should be created whenever a board member leaves an NHS organisation, regardless of whether they are moving immediately to another NHS role and should be sought by employing NHS organisations when making a job offer. The reference is based on the NHS standard reference template but includes additional questions relevant to the FPPT.

- **The Electronic Staff Record (ESR) will be used to store information related to FPPT checks and references**. This will provide a standard way to record and report compliance internally. Retrospective population of data is not proposed.

- **From 30 September, the board member reference template should be used** for all new board appointments, and new references completed and retained locally for any board member leaving after this date.

- The full framework should be fully implemented by **31 March 2024**.

- A full FPPT against the core elements of the framework should be undertaken whenever new appointments are made, if a board member moves to a new board role in their current organisation, and annually thereafter.

- Annual self-attestations by board members to confirm adherence to the regulations will continue.

- **The chair of the board is accountable for taking all reasonable steps to ensure the FPPT is effectively implemented** in their organisation. NHSE regional directors are responsible for ensuring chairs of provider trusts/FTs and ICBs meet the requirements.

---

[1] https://www.england.nhs.uk/publication/nhs-england-fit-and-proper-person-test-framework-for-board-members/

- Dispute resolution arrangements differ depending on whether the individual was appointed by NHSE. Processes to resolve disputes about data and information and about the outcome of FPPT assessments are detailed.

- Appendix 8 accompanying the framework announces an evaluation of its effectiveness 18 months following this launch and advises that future consideration will be given to implementing a public facing register and including other 'significant roles' within scope.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 July 2024

Improving the Working Lives of Doctors in Training

Purpose of Report

NHS England issued an open letter to NHS Trusts and Foundation Trusts ('Trusts') on 25 April 2024 (NHS England » Improving the working lives of doctors in training), which outlines a commitment from NHS England, as *"the people responsible for training and employing doctors in training, there is much more we can and should do collectively to improve their working and learning experience in the NHS"*.

Whilst the letter outlines many commitments from NHS England, it is also clear that will need to be a collaborative endeavour with Trusts. It calls upon Trust Boards to *"take responsibility for this agenda"*.

This short reports aims to assure DHcFT's Board that work is underway to deliver the asks set out within the letter from NHS England.

Executive Summary

1. The doctors in training referred to in the letter are those employed on the 2016 Junior Doctor Contract, and who are on rotational training programmes within a specific geographic region.
2. The letter outlines expectations from Trusts within this collaborative endeavour. Broadly these include:
    a. Better rota management and deployment (contractual notice periods will be monitored, ensuring consultation with doctors where changes are needed with less than six weeks' notice, technological solutions for rota management)
    b. Reducing pay errors (service level agreements with board governance frameworks to address errors swiftly)
    c. Valuing doctors in training (reducing the burden of mandatory training, protecting training time, understanding the unique difficulties caused by rotational training programmes)
3. Point 2c specifically calls upon *"identifying a senior, named individual to oversee the implementation of these actions"* with respect to valuing doctors in training. The Guardian of Safe Working Hours (GOSWH), who chairs the Junior Doctor Forum, and is independent of Trust management structures, has been proposed as this named individual.
4. The NHS England Planning Guidance (2024/25 priorities and operational planning guidance (england.nhs.uk)) advises that NHS England will be looking to *"strengthen the role of Guardians of Safe Working"*, which aligns with the proposal in point 4.
5. To deliver on these expectations, the Trust will need collaboration between the representative doctor groups (eg, the Junior Doctor Forum), Medical Education, Medical Staffing and HR. There will need to be associated administrative support to facilitate this close working and timely delivery on the objectives through a task and finish group.
6. Oversight and assurance can be provided through the Quality and Safeguarding Committee to the Board, for which the proposed task and finish group will report to.

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

- Assurances
  - Close relationships already exist between the GOSWH, Medical Education, and Medical Staffing
  - Some items are already being addressed through work prior to the issuing of this letter (eg, timely issuance of work schedules and rosters, seeking to use direct procurement for study leave expenses, protection of training time through personalised work schedules).
  - A workable plan through a task and finish group has been discussed
- Risks
  - Challenging timeframes to meet for some deliverables (eg, board governance framework for resolving pay issues due end July 2024, adopting relevant eLearning for Healthcare packages to streamline mandatory training by October 2024)

Consultation

Junior Doctor Local Negotiating Committee (LNC) representatives, LNC Chair, GOSWH, Executive Medical Director, Quality and Safeguarding Committee.

Governance or Legal Issues

None at present.

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:

No projected impacts.

Recommendations

The Board of Directors is requested to:

1. Support the proposed task and finish group to deliver on what is set out in NHS England's letter on improving the working lives of doctors in training, including the proposed reporting requirements to the Quality and Safeguarding Committee as a means of Board assurance
2. Agree on a lead for the task and finish group, noting the alignment NHS England's planning guidance on strengthening the role of the GOSWH.

Report presented by:	**Name**	Dr Arun Chidambaram
	Role	Executive Medical Director
Report prepared by:	**Name**	Dr Kaanthan Jawahar
	Role	LNC Chair and Guardian of Safe Working Hours

Board Committee Assurance Summary Reports to Trust Board – 2 July 2024

The following summaries cover key items discussed at the meetings that have been held since the last public Board meeting held on 7 May 2024 and are received for information.

- Quality and Safeguarding Committee – 14 May 2024 and 18 June 2024
- People and Culture Committee – 28 May 2024
- Audit and Risk Committee – 23 May 2024 and 19 June 2024
- Finance and Performance Committee – 21 May 2024
- Mental Health Act Committee – 14 June 2024

Key:

Colour	Meaning
Blue	**Full Assurance** received during the meeting with the accompanying report
Green	**Significant assurance** received during the meeting with the accompanying report
Amber	**Limited assurance** received during the meeting with the accompanying report
Red	**No Assurance** received during the meeting with the accompanying report
Grey	items shared **for information** to advise the committee on progress and next steps

Rating	Quality and Safeguarding Committee – key assurance levels for items 14 May 2024
Green	**Fundamental Standards Report** The report included the chronology of the unannounced inspection in April, including initial feedback and the concerns raised in follow-up correspondence. The Committee noted the progress against the action plan and that additional scrutiny and oversight structures that had been established to monitor completion of actions, with Executive and ICB quality team involvement. It was agreed that the pace to address training issues needed to improve and that the new format Divisional Performance Reviews will focus on performance and quality indicators. The report noted that the self-assessment of fundamental standards pilot was currently paused and will report to the Committee once commenced. The Committee accepted **significant assurance** on the processes in place to address the concerns identified by the CQC, noting that sustained outcomes are still to be achieved.
Amber	**Patient Safety Annual Incident Report** The annual report outlined areas of improvement, plans and achievements, with an overview of flow and developments for the past 12 months. Highlights included: • Improved process for monitoring progress of patient safety alerts • Improvements to post incident review and learning • Implementation of Stage 1 Mortality process within SystmOne • Amalgamation of some groups to increase effectiveness • Assurance given to the CQC via the Learning the Lessons sub-groups. The Committee noted it is not yet possible to demonstrate the embedded learning and it was agreed to improve assurance via risk management and exception reporting, to include specific actions and outcomes on how patient safety risks are being addressed. **Limited assurance** was accepted as the learning is not yet embedded.

Medicines Management Committee – Key Issues Report

The Committee received the update covering points of alert, advice and assurance arising from the Medicines Management Committee (MMC).

The following points were highlighted:

- controlled drug incidents continue to be investigated
- all current medicines-related risks identified on the Datix risk register are to be reviewed by the MMC.

The Committee received **full assurance** that previously agreed changes to reporting the governance of medicines are being made.

It was noted that following the strengthening of regulations, a working group will develop a framework of how to manage the Valproate Policy.

Limited assurance was accepted that valproate prescribing is consistent with regulation or policy.

Sign Off of Draft Quality Account 2023/24

The final version of the Quality Account was signed off by the Committee under delegated authority of the Trust Board. The Quality Account details the Trust's approach to quality and how the Trust has continued to drive through quality improvements, delivering high quality and innovative care.

Care Planning/Person-Centred Care

It was noted that the achievement of targets and quality will be audited separately, and the compliance target will be amended to 100%, with a focus on exception reporting of the gaps to give a clearer view of the position.

The Committee discussed the reasons behind inadequate compliance and noted obstacles as capacity, ability, user experience and in limited cases picking up non-compliance inappropriately. The Trust's Digital team continually reviews the electronic patient record (EPR) to improve data input agility and the digitalisation to DIALOG+ is scheduled for completion by 31 March 2025.

The Committee accepted **significant assurance** from the consistent improvements, month on month and commended the excellent paper which summarised the issues effectively.

Patient Flow/Delayed Discharges Analysis

The intention of the paper was to understand if there is a relationship between patients who are clinically ready for discharge (CRFD), where their discharge is delayed, and falls.

The recent multi-agency discharge event (MADE), had expedited 21 discharges, reduced lengths of stay and provided insight of the escalation process and elevation of discharges.

Analysis of falls data showed the significant proportion had been attributed to two patients, for whom it was proving a challenge to secure suitable, alternative placements. Oversight by the Falls Group was noted, and a further paper was requested to cover the quality and safety elements of the approach.

The Committee received **significant assurance** around the strategic approach that is being taken to review patients who are CRFD and escalation processes that are in place.

Limited assurance was accepted regarding CRFD patients, where their discharge is delayed, and falls.

Learning from Deaths/Mortality Annual Report 2023/24

It was noted that work continues around current themes with the relevant teams and whilst the process of shared learning is robust, there remains the element of pace and further development is required to embed this.

The Committee accepted **significant assurance** of the Trust's approach and agreed for the report to be considered by the Trust Board of Directors and then published on the Trust's website as per national guidance.

	Board Assurance Framework (BAF) – key risks identified: the Committee reviewed Risks 1A, 1D and MS1 and requested some minor amendments.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: None **Next scheduled meeting:** 18 June 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 June 2024	
	Fundamental Standards Report The Committee received an update on actions taken to improve quality of care, arising from the findings of the recent Care Quality Commission (CQC) inspections. The report also provided an update on the development of quality surveillance and continual quality monitoring arrangements. It was noted that the formal CQC report for the April 2024 inspection had not yet been received. Discussions focused on pace, accountability, sustainability of the culture transformation and development of the full improvement programme. The committee heard examples of where scrutiny had led to improvements and how zonal observation had mitigated clinical and safety risks. The Committee noted the cultural changes are starting to be observed, along with evidence that the impact of discussions is percolating through. The Committee accepted **significant assurance** that the Trust is comprehensively addressing the concerns identified by the CQC from the April 2024 inspection.
	Ligature Risk Reduction Report This report provided an update on ligature risk management arrangements against CQC requirements and current compliance in relation to managing ligature risks. Particular attention was drawn to the implementation of zonal observation, a review of ligature risk assessments and identification of the environmental risks. It was noted that all incidents are reviewed with lessons learned taken through to the training provided to staff, that environment risk assessments are meeting the trajectory and are signed off to the CQC plan. The Committee received confirmation that ligature risks have been reassessed for the new builds, to include movement monitoring and replication of door top alarms and that in addition to deploying two additional staff on wards. The Executive Leadership Team is considering three further options to mitigate the environmental risks in existing areas. It was concluded that **significant assurance** had been received on the identification and mitigation of fixed ligature risks within the built environment and linked with this, the blind spot reduction programme which has been completed.
	Regulation 28 Briefing and Response (MS) The Committee received an update on the Regulation 28 Notice served upon the Trust with regards to the risk of admitting patients during handover period. A Trust policy is now in place to ensure patients are not admitted during these times. It was noted that to enhance the sharing of relevant learning, the Trust now has a Learning from Deaths Policy and Procedure. The Committee heard that the investigation of incidents used

	our Quality Improvement approach which links in with Clinical Audit and Patient Safety teams as a whole. **Significant assurance** was accepted that actions taken will meet the coroner's requirements.
	Guardian of Safe Working Annual Report This report provided data about the number of junior doctors in training in the Trust and arrangements made to ensure safe working within their contract and arrangements in place to identify, quantify and remedy any risks to the organisation. The Committee noted the NHS England's recent announcement on improving the working lives for postgraduate doctors in training, that a senior named individual is required to oversee implementation. The Medical Director and Guardian of Safe working are reviewing options. **Significant assurance** was accepted that the duties and requirements as set out in the 2016 Junior Doctor terms and conditions of service are being met.
	Risk Report The extended version of the report summarised the current status of high/extreme-level operational and clinical risks, along with any changes, closed and new logged-risks within the period. It was noted that all high/extreme risks were in date and reviewed in line with requirements. The Committee agreed that the report provides helpful and clear information and has already resulted in deep dive requests. **Significant assurance** was accepted regarding the risk management and reporting strategy.
	Safeguarding Children Assurance Report An assessment of Safeguarding Children activity in the Trust against statutory and legislative requirements provided the Committee with **significant assurance**. The continued, high activity the Safeguarding team is engaged in was highlighted and that following a comprehensive Section 11 meeting in March, compliance for all five recommendations was met. It was noted that due to the experience and resilience of the team, the number of multi-agency risk assessment conference (MARAC) cases, which has doubled, have been managed effectively. It was noted that the Safeguarding Children Trainer commenced in January. The Named Doctor for Safeguarding Children post remains vacant, is being readvertised while cover and support exists. **Significant assurance** was accepted regarding Safeguarding Children activity, systems, and controls within the Trust.
	Safeguarding Adults Assurance Report It was noted that the team proactively reviews emerging themes and scrutinises effectively. The Committee noted that domestic homicide reviews are all on target and that the team proactively and tenaciously reviews emerging themes and scrutinises effectively. The Committee agreed **significant assurance** on the update.
	Special Educational Needs and Disabilities (SEND) Annual Report The report highlighted a 41% increase in requested Education, Health and Care (EHC) needs assessments. However, it was noted that Derbyshire County Council is in consultation around the withdrawal of some services, which will impact demand. The Committee discussed how the significant achievements compare with other providers and it was noted that the depth, experience and focus of the team puts the Trust at a distinct advantage. The Committee accepted **significant assurance** on progress and actions and applauded the achievements of the team, along with their experience and focus.

	Clinical Research – Annual Report and Plan It was noted that an Integrated Care System Research Strategy has been developed, which will help to identify research opportunities and create dashboards on population health, along with new models to secure funding. In addition, the Research and Development Group has been reinstated to provide support around risk management and maximisation of opportunities. The committee noted the work of the Library and Knowledge Management services and there is positive feedback from library users and increasing service usage. The Committee agreed that the scope has been increased and that the new clinical strategy will support areas requiring specific focus, for example population health and local community needs. **Significant assurance** was received from the high level of activity delivered through a small team and the plans to grow the service to maximise opportunity.
	Quality Dashboard The committee reviewed the dashboard with discussions focussed on the increase in restrictive interventions, and it was noted that specific, zonal observations are in place to mitigate environmental risks. The Committee received **limited assurance** overall on progress towards clinical performance targets.
	Patient Experience Report, Quarter 4 The report outlined that the Trust has moved into the new process of managing complaints via immediate response and scrutiny, aligned with the national framework for compliance. An overview of the analysis of complaints and incidents data for Quarter 4 of the financial year, 2023/24 was provided. The Committee noted that improvements on staff attitude and behaviour will be reported through the Divisional Performance Reviews and a Staff Behaviours Charter has been included as part of the new organisational Trust strategy. The committee received **limited assurance** based on the work in progress to implement the new framework.
	Care Planning/Person-Centred Care It was noted that there has been good progression over recent months, however, there are some reporting anomalies which has negatively influenced the compliance data. The Committee accepted **significant assurance** there is evidenced traction in this area and improved depth of reporting, presenting confidence that there is increased control and understanding of the hot spots.
	Divisional Performance Reviews (DPR) It was noted that a reviewed approach will be effective summer 2024. The DPR agenda will now be set by the Executives, rather than by the Division themselves. The frequency of meetings will be scheduled according to the bespoke successes and issues of that particular Division and will formally report into ELT. It was agreed that the option of Non-Executive Director (NED) attendance at these meetings would provide further assurance. **Significant assurance** was accepted from the report on the reviewed process.
	East Midlands Perinatal Mental Health Provider Collaborative The report provide assurance on the quality and safety elements that are monitored across both units of this service, of which DHcFT is the Lead Provider. The Committee noted the inclusion of quantitative data, as previously requested. There were no patient safety or quality concerns to be escalated.

	The Committee received the report which provided **significant assurance** on the quality and safety of services provided.
	Board Assurance Framework (BAF) – key risks identified: The Committee noted that requested amendments have been updated and confirmed it is content with the current position. It has been agreed that the committee would receive less draft version of each submission approximately bi-monthly, rather than monthly, submissions are made to the Committee as a trial for the remainder of 2024/25.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: None **Next scheduled meeting:** 16 July 2024
Committee Chair: Lynn Andrews	**Executive Lead: Dave Mason, Interim Director of Nursing and Patient Experience**

People and Culture Committee - key items discussed 28 May 2024	
	People and Inclusion Assurance Dashboard The Committee noted improvements in training compliance and the successes with conversion of relevant bank workers into substantive posts. Recurrent Freedom to Speak Up themes include the lack of development opportunities. **Significant assurance** was accepted on the progress shown for mandatory training, staff turnover, vacancies and recruitment, attendance and absence, bank usage and Freedom to Speak Up. The Committee accepted **limited assurance** on Employee Relations, Clinical Supervision and Annual Appraisals. It was noted that the 360 Assurance Audit Report on Supervision shows overall improvement since September 2023. However, the gaps in Annual Appraisal compliance and inaccuracies in the data are being investigated.
	Making Room for Dignity – Programme Update It was noted that the detailed recruitment plan and timeline, is aligned to the release of funding and recruitment of the roles essential for the safe opening of the refurbished units has been prioritised. As part of recruitment contingency planning, the proposed skill mix diversification was discussed along with alleviation of the risks around set ratios and the volume of newly qualified Mental Health Nurses. **Significant assurance** was received on the actions being taken to mitigate the risk of significant numbers of ‘hard-to-recruit’ and ‘national workforce shortage’ posts required, and the additional recruitment initiatives being implemented to address this. Following the update on the progress on cultural transformation, including the specifics on how this is to be embedded, the Committee accepted **limited assurance** on this point.
	Annual Medical Appraisal The Committee agreed **significant assurance** on medical appraisal and revalidation activity within the Trust during the 2023/24 cycle which was received in preparation for the re-validation of Doctors Compliance Statement that will be submitted to the Trust Board on 2 July. The purpose of medical appraisal is to assure the General Medical Council (GMC) and to protect public confidence in doctors.

People and Culture Committee - key items discussed 28 May 2024

Deep Dive – Leadership Development

The report provided details of the proposed approach and 12-month strategy for leadership development.

The Leadership Accountability Framework, built around the Trust Strategy, was noted, along with the adoption of the 70:20:10 learning principles.

Current initiatives include the development of a mid-level Aspiring to Be Programme, a General Manager Programme and enhancements to the coaching portal to incorporate mentoring.

The Committee discussed how planning can ensure leadership is representative of the workforce and the population served.

Significant assurance was accepted that a strategic approach to leadership development has been developed.

The Committee accepted **limited assurance** on delivery and outcome due to the infancy of the strategy.

Deep Dive – Health and Wellbeing

The Committee received a progress update on the 2023/24 plan and future actions for 2024/25.

Significant assurance was received on the range of benefits available to Trust staff and

limited assurance on the progress of integration.

Equality, Diversity and Inclusion (EDI) – Public Sector Equality Duty (PSED) and Equality Delivery System (ESD2)

The PSED Report was presented for approval prior to being published on the Trust's website.

The Committee noted that reduced diversity is a national concern within the NHS, for example difficulty for Band 5 professionals to progress and it was agreed that improved engagement is required to create the environment for others to be successful.

It was noted that the EDI framework domains, listed below, are broad enough to embrace significant change over the years:

- Leadership
- Addressing bullying, harassment, discrimination and abuse
- Inclusive recruitment and retention
- Inclusive progression and promotion
- Create a culture of inclusion and belonging.

The Committee endorsed both the annual PSED report and the EDS report and agreed the EDI Framework.

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: 30 July 2024

Committee Chair: Ralph Knibbs	**Executive Lead: Rebecca Oakley, Acting Director of People and Inclusion**

Audit and Risk Committee - key items discussed 23 May 2024	
	Progress Update on Annual Report and Accounts The Committee was provided with the latest version of the Annual Report and Accounts, including the summary of the changes between versions. The Trust's Auditors, both internal and external would be including some narrative around the CQC within their final report.
	Data Security and Protection Report The latest progress on 2023/24 Data Security and Protection (DS&P) toolkit was noted. This included the work of the DS&P Committee, DS&P risk and incident management and Information Commissioner's Office (ICO) concerns. DS&P training was at 98% compliance and there is a robust plan to support staff that haven't undertaken the training to complete it. The Committee was assured by the responses to the Data Security breaches and the learning from them. The Committee congratulated the team for their achievements and noted the **substantial assurance** and high confidence from our internal auditors in this work.
	Internal Audit Progress Report The Trust's action follow-up rate for 2023/24 was 100%. The Supervision of Staff report had been issued and the Lead Director would be attending the July Audit and Risk Committee to give an update on progress against the audit action.
	External Audit Progress Report The External Auditor confirmed they were on track to complete their external audit work, with nothing fundamental to report from their findings.
	Corporate Governance Framework The Framework brings together core governance documents, including a standard orders and delegation of powers. The document was renewed for another three years, noting that the latest Board committee Terms of Reference are added annually.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** 19 June 2024
Committee Chair: Geoff Lewins	**Executive Lead: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary**

Audit and Risk Committee - key items discussed 19 June 2024	
	This meeting was held to review and approve the Annual Report and Accounts 2023/24 under delegated authority of the Board. The Committee agreed **significant assurance** on the processes to produce the document. A technical issue raised by external audit on their completion report would delay the formal signing, however, the Committee was able to approve the document. The final Head of Internal Audit Opinion and Annual Internal Audit Report was also presented with a **significant assurance** outturn.

	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** 25 July 2024

Committee Chair: Geoff Lewins	**Executive Lead: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary**

	Finance and Performance Committee – key assurance levels for items – 21 May 2024
	Assurance on Estate Strategy – specifically Making Room for Dignity Programme (MRfD) Report taken as read. £7.5m cost pressure with ask for £5m contribution from national capital submitted. Discussions ongoing. NHSE setting up roundtable as a national capital delivery assurance group. Gateway set for September. VAT Certificates received. Also seeking wider support for another HMRC claim based on separate case. Lease progressing. Update also provides updates re s136 changes and delays. Clinical decision-making-led changes have occurred to the designs. Will pick up lessons learnt. Received and noted, with **limited assurance**.
	General Estate Strategy Update Report well received, recognising not received anything over the last year. Planning to reinstate six-monthly reporting of basic core estates related KPI and performance data. A lot of support to look at, not rushing into a plan. Board Development session planned. Linking in the Integrated Care Board (ICB) Infrastructure. Discussion around space utilisation. Forming the process, framework and principles. Received with **significant assurance**.
	Financial Performance, Month 1 Finance Report The report was well received. The focus on pulling out the key areas of risk was welcomed linked to our plan. Discussions around focus on CIP monitoring and tracking savings. Acknowledged work underway to close gap. **Significant assurance** re finance reporting and planning. **Limited assurance** re cost improvement programme (CIP) performance and planning.
	National Cost Collection – Pre-Submission Report All progressing and no concerns.
	Impact of Industrial Action in February 2024 Noted. Received previous at Quality and Safeguarding Committee but requested to come here noting the costs.

	Operational Performance Noted, recognising discussed in detail at Board. Updated in relation to the outcome from the multi-agency discharge event (MADE) and focused work around flow and discharge. Links to out of area (OOA) placements improvement plan. Deep dive looking into positive impact of home treatment input, which helped manage the closure to admissions within the female ward bed base, without a significant increase in OOA usage. **Limited assurance**.
	System Updates - ICB Finance Committee/System Directors of Finance (DoF) System operational plan slides shared for information including performance targets alongside workforce and financial plans. Brief system update, reflective of the latest ask from the ICB. National requirement to go further.
	Business Continuity Policy Policy approved with thanks. The main discussion was around the plan around ongoing testing and assurance of compliance. Also clarified, the NED lead, in the role as Chair of Finance and Performance Committee.
	Collaborations and Other Alliances Perinatal – Lead Provider Collaborative Highlight report received **limited assurance.** No major risks or concerns being escalated to the Committee. This is a primary item and more focus needed compared to the below agenda items.
	IMPACT Update noted for information. CAMHS Collaborative Update noted for information. East Midlands AED Collaborative Update noted for information. Gambling Harm Service Update noted for information. East Midlands Alliance for Mental Health and Learning Disabilities (LD) Update noted for information. General conversations, around how provider collaboratives are working for the Trust and underlying risks.
	Board Assurance Framework, 2024/25 Risks Overview Main discussion was around the progression of the Making Room for Dignity programme and focus moving to operational and mobilisation preparedness risks.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: None **Next scheduled meeting:** 23 July 2024.

Committee Chair: Tony Edwards	**Executive Leads: James Sabin, Executive Director of Finance**

Mental Health Act Committee - key items discussed 14 June 2024
Mental Health Act (MHA) Managers Report The MHA Quarterly Report covering MHA Office activity from 1 January to 31 March was considered. The report was previously discussed at the MHA Operational Group. Points of note included: • improvements in the follow-up reading of s.132 inpatient ward rights to patients but decline in reading of rights (admission and follow-up) in the Hartington Unit. The MHA Office is working to support the Unit • Compliance for the reading of Community Treatment Order (CTO) rights both at the commencement and follow up is positive across the Community Mental Health Teams, except for three teams where reading on commencement needs improvement • The use of Section 5(2) Doctors' holding power and Section 5(4) Nurses' holding power was noted • There will be a focused review on Section 62 Urgent Treatment Requests following an audit • CTO activity showed three lapses, these have been logged on Datix and will be subject of a review for learning and common themes • A number of Associate Hospital Managers (AHM) had recently been recruited and a training session for all AHMs was being arranged • Overview of the most recent CQC MHA visit at Pleasley Ward. **Significant assurance** was agreed on the improvement. **Limited assurance** on the decline of the reading of rights.
Legislative and Case Law Paper The Committee received an update report on: • The Government's response to the Joint Committee's review of the MHA Bill • A recent employment tribunal decision relating to the worker status of AHMs • The recent rapid review on current data on MH patient pathways and a recommendation. that every Board should provide MHA training so that at least half of their Non-Executive Directors are training as AHMs and participate in hearings to best understand the clinical care provided, the challenges, and the views of patients, families and clinical teams for the patients • The recent case law relating to patients in custody under s. 136.
Training Report An update was given on Mental Capacity Act (MCA) training within the Safeguarding Adults Level 3 class. Progress was noted overall despite not hitting 90% compliance for all targets. A report of those who are not compliant is sent monthly to support operational colleagues to complete the required learning.
Section 12 Doctor Assurance Report A review has been undertaken to embed compliance with S12(2) / Approved Clinician status. This includes a centralised monitoring system overseen at the MHS Operational Group. **Limited assurance** was given while the system embeds.
Advance Choice Documents (ACDs) Proposal ACDs are a tool developed to allow a patient to state and record a range of preferences when they are well, which they would like to be considered if they become ill. They can include a variety of issues from care and treatment preferences, and people they would like contacted, to their wishes and feelings on more personal and practical matters, such as who might make any financial decisions for them. The potential benefits of using ACDs were outlined including cost savings, improving health inequalities and improving therapeutic relationships as they will be built on personalisation, trust, and respect. The Committee supported the proposal.

Patient Experience Report

The report included themes and trends from complaints and concerns from patients detained under the Mental Health Act (MHA). The main concerns by topic were noted as: care planning, patient safety and staff attitude.

The Committee received **significant assurance** that all complaints are investigated on an individual level for learning and best practice.

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 MHA Committee, oversight of the Code of Practice or concerns highlighted within MHA 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 Practise Policy.

The report identified areas that require further improvement including physical restraint and absconsion and areas that had recently improved, including observations. The Locked Door policy and the Blanket Restriction Policy have recently been updated to reflect the changes in practice. The Committee agreed that **significant assurance** could be taken from overall performance progress.

Draft Joint Protocol for Crisis Home Treatment Team and Associated Mental Health Act Practitioner Team

The above protocol was supported, and it was suggested that the MHA Operational Group should be the ratifying body not the MHA Committee.

Section 136 Report from the Section 135/136 MHA Group

The report showed an upward trend in the use of S136. There are more custody admissions overnight and into the early hours of the morning and this is being escalated as there seems to be difficulties at times accessing the professional help line for guidance.

The Committee noted the current position and supported the continued ongoing work and improvements for the Section 135/136 Group.

Verbal Update from Associate Hospital Managers (AHMs)

The AHMs gave a verbal update on their activities, including numbers of AHMs in post and an assessment of their workload.

Approval of Policies

The Community Treatment Order Policy was approved.

Escalations to Board or other Committees: None.

Items added to the Board Assurance Framework: None.

Next scheduled meeting: 13 September 2024

Committee Chair: Ashiedu Joel (the June meeting was chaired by Geoff Lewins)	**Executive Lead: Dr Arun Chidambaram, Medical Director**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 July 2024

Learning from Deaths - Mortality Annual Report 2023/24

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each trust to collect and publish specified information on a quarterly basis. This report covers the period 1 April 2023 to 31 March 2024.

Executive Summary

- All deaths directly relating to COVID-19 are reviewed through the Learning from Deaths procedure unless they also meet a Datix red flag, in which case they are reviewed under the Incident Reporting and Investigation Policy and Procedure. During 2023/24 there has been one death reported where the patient tested positive for COVID-19. This death was in the community.
- The Trust received 2,444 death notifications of patients who had been in contact with our service in the last six months. There is very little variation between male and female deaths; 1,216 male deaths were reported compared to 1,228 females.
- One inpatient death (expected – end of life), one inpatient death (suspected suicide) and three patients died following transfer to the acute hospital for further treatment (two unexpected and one suspected suicide).
- The Trust has reported 26 Learning Disability deaths in the reporting timeframe and deaths of five patients with a diagnosis of autism.
- Medical Examiner Officers have been established at all Acute Trusts in England and their role will be extended to include deaths occurring in the community, including at NHS Mental Health and Community Trusts. The implementation of this process comes into force on 9 September 2024. Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area.
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.
- A process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure.

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.	
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

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

Consultation

- This report has been reviewed by the Medical Director
- Quality and Safeguarding Committee 14 May 2024.

Governance or Legal Issues

There are no legal issues arising from this report.

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

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

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- During 2023/24, there was very little variation between male and female deaths; 1,216 male deaths were reported compared to 1,228 female deaths
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

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

Report presented by: **Dr Arun Chidambaram**
Medical Director

Report prepared by: **Louise Hamilton**
Safer Care Co-ordinator

Learning from Deaths - Mortality Report

1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths[1]'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate, and learn from patient deaths, which should lead to better quality investigations and improved embedded learning.

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

The report presents the data for 1 April 2023 to 31 March 2024.

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

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. This will improve once Medical Examiners commence the process of reviewing the Trust's non-coronial deaths in September 2024. The Trust continues to meet with the Medical Examiners on a regular basis.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed 2 May 2024.

- A process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services.

- The Mortality Case Record review panel process has been evaluated and plans are in place to re-design this to act as an assurance and audit panel over incidents closed through the Operational Incident Review group.

- The Trust Mortality Committee has been evaluated and developed into a Learning the Lessons Oversight Committee which will improve governance around learning and drive quality improvement.

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

3. Data Summary of all Deaths

Note that inpatients and learning disability (LD) data is based upon whether the patient has an open inpatient or LD referral at time of death. The table below outlines information from 1 April 2023 to 31 March 2024.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Deaths Per Month	164	188	161	187	158	162	190	212	269	261	239	253
LD Referral Deaths	3	2	4	1	0	2	1	2	3	2	4	2

Correct as of 29 April 2024

From 1 April 2023 to 31 March 2024, the Trust received 2,444 death notifications of patients who have been in contact with our services.

Of these deaths 1,216 patients were male, 1,228 female, 1,847 were white British and 26 Asian British. The youngest age was 0 years, the oldest age recorded was 103.

The Trust has reported 26 Learning Disability deaths in the reporting timeframe and death of five patients with a diagnosis of autism.

4. Review of Deaths

Total number of Deaths from 1 April 2023 to 31 March 2024 reported on Datix	222 “Unexpected deaths” 1 COVID death 39 “Suspected deaths” 9 “Expected - end of life pathway” NB some expected deaths have been rejected so these incidents are not included in the above figure. One inpatient death (expected – end of life), one inpatient death (suspected suicide) and three patients died following transfer to the acute hospital for further treatment (two unexpected and one suspected suicide).
Incidents assigned for a review	270 incidents assigned to the operational incident group 1 incident are to be confirmed

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure.*

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

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHcFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/carer the Ombudsman, or where staff have raised a significant concern about the quality-of-care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not
- Death of a patient with Autism
- Death of a patients who had a diagnosis of psychosis within the last episode of care.

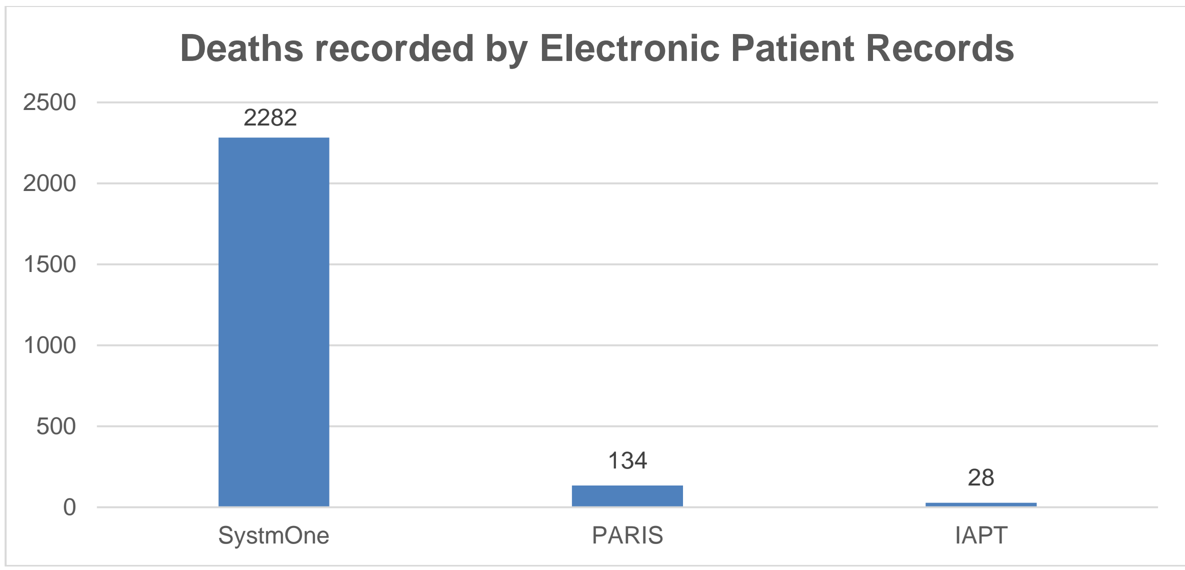
5. Learning from Deaths Procedure

The Trust has now completed a move in terms of its mortality process, a process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for Red Flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services, ensuring better sharing of information and identification of priorities for both services.

The Mortality team are conducting random weekly audits of deaths against the Red Flags to provide assurance that the new process is working as intended and changes will be made accordingly.

6. Analysis of Data

6.1 Analysis of deaths per notification system since 1 April 2023 to 31 March 2024



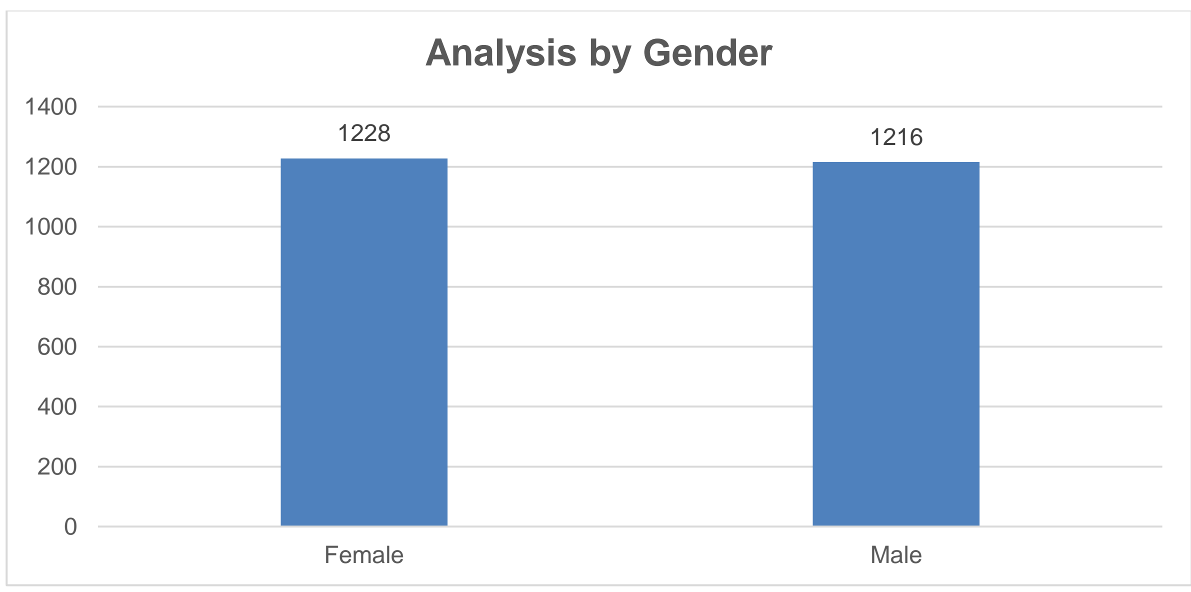
System	Number of Deaths
IAPT	28
PARIS	134
SystmOne	2282
Grand Total	**2444**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care.

From the 1 April 2023 to 31 March 2024, there has been one death reported where the patient tested positive for COVID-19. The patient was female and from a White British background and was within the community.

6.2 Analysis by gender

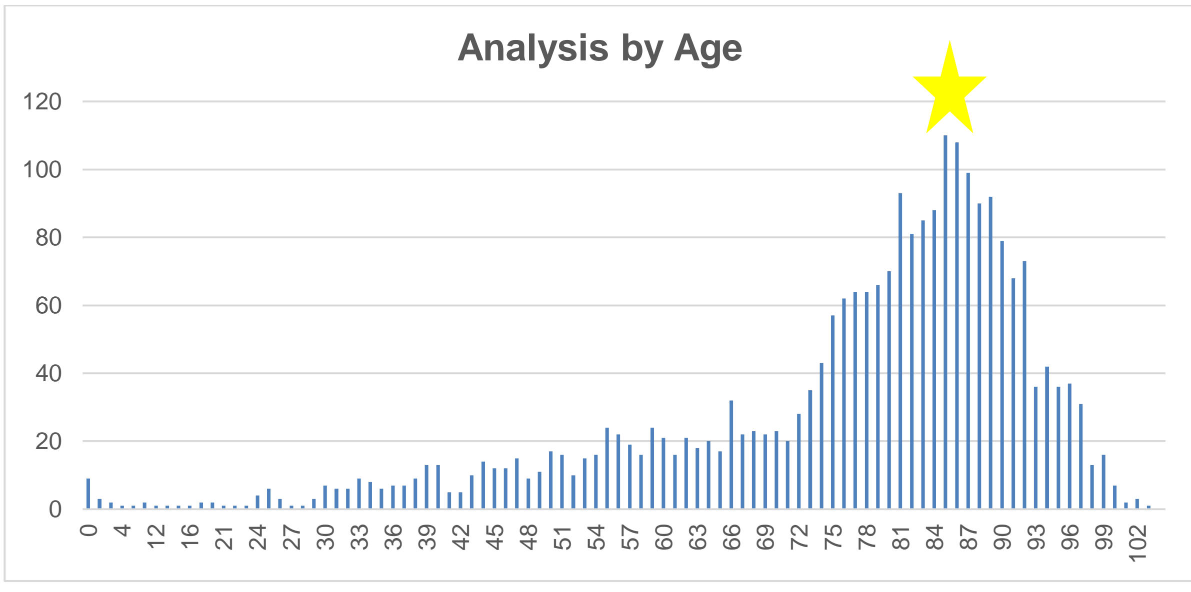
The data below shows the total number of deaths by gender 1 April 2023 to 31 March 2024. There is very little variation between male and female deaths; 1,228 female deaths were reported compared to 1,216 males.



Gender	Number of Deaths
Female	1228
Male	1216
Grand Total	**2444**

6.3 Analysis by Age Group

The youngest age was classed as 0, and the oldest age was 103 years. Most deaths occurred within the 83 to 89 age groups (indicated by the star).



6.4 Learning Disability Deaths (LD)

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

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the LeDeR programme. Scoping is planned with operational services through their Learning the Lessons subgroups to consider the most appropriate management process for Learning Disability deaths moving forward.

From 1 January 2022, the Trust has been required to report any death of a patient with autism. To date, ten patients have been referred.

During 1 April 2023 to 31 March 2024, the Trust has recorded 26 Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting. The Trust is currently awaiting the annual LeDeR report.

6.5 Analsysis by Ethnicity

White British is the highest recorded ethnicity group with 1,847 recorded deaths, 108 deaths had no recorded ethnicity assigned, and 32 people did not state their ethnicity. The chart below outlines all ethnicity groups.

Ethnicity	Number of Deaths
White - British	1847
Other Ethnic Groups - Any other ethnic group	369
Not Known	108
Not stated	32
White - Any other White background	24
White - Irish	16
Asian or Asian British - Indian	15
Asian or Asian British - Pakistani	6
Black or Black British - Any other Black background	6
Mixed - Any other mixed background	4
Asian or Asian British - Any other Asian background	3
Mixed - White and Black Caribbean	3
Black or Black British - African	3
Asian or Asian British - Bangladeshi	2
Black or Black British - Caribbean	2
Mixed - White and Asian	2
Mixed - White and Black African	1
Other Ethnic Groups - Chinese	1
Grand Total	**2444**

6.6 Analysis by Religion

Christianity is the highest recorded religion group with 1002 recorded deaths, 768 deaths had no recorded religion assigned and two people refused to state their religion. The chart below outlines all religion groups.

Religion	Number of Deaths
Christian	1002
Not religious	362
Church of England, follower of	97
Church of England	66
Methodist	17
Roman Catholic	16
Unknown	16
Religion NOS	12
Muslim	11
Christian religion	11
Christian, follower of religion	10
Sikh	9
Atheist movement	7
Catholic religion	7
Catholic: non Roman Catholic	4
Patient religion unknown	4
Atheist	4
Jehovah's Witness	4
Agnostic	3
Buddhist	2
Pagan	2
Protestant	2
Not Given Patient Refused	2
Jewish	2
Spiritualist	1
Catholic: Not Roman Catholic	1
Hindu	1
Islam	1
Sikh religion	1
Nonconformist	1
Anglican	1
Nonconformist religion	1
None	1
(blank)	763
Grand Total	**2444**

6.7 Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 1,453 recorded deaths. 980 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	**Number of Deaths**
Heterosexual	1419
Sexual orientation not given - patient refused	57
Heterosexual Or Straight	34
Sexual orientation unknown	12
Bisexual	9
Unknown	4
Female homosexual	1
Not Appropriate To Ask	1
Homosexuality NOS	1
(blank)	906
Grand Total	**2444**

6.8 Analysis by Disability

The table below details the top eight categories by disability. Gross motor disability was the highest recorded disability group with 445 recorded deaths.

Disability	**Number of Deaths**
Gross motor disability	445
Intellectual functioning disability	159
Patient reports no current disability	113
Hearing disability	61
Emotional behaviour disability	58
Physical disability	17
Walking disability	6
Behaviour and emotional	4

There were a total of 889 deaths with a disability assigned and the remainder 1,555 were blank (had no assigned disability).

7. Recommendations and Learning

The table below outlines the current themes arising from incidents.

Improvement issue	Improvement plan
Transfer, Leave and Discharge	Transfer of the deteriorating patient. Internal investigations highlighted themes around the transfer and return of patients between inpatient services for the Trust and Acute providers. This includes handover of information, and the way patients are conveyed. A quality improvement project has been undertaken between Derby Hospital and DHcFT to develop a transfer and handover proforma. Self-harm of patients whilst on leave from inpatient services and Section 17 leave arrangements A number of investigations have highlighted issues in relation to leave arrangements for inpatient services including follow up. A further thematic review was completed on conclusion of a cluster of inpatient suspected suicide incidents. An action plan has been developed. The Patient safety Team will support the review of the current processes and quality improvement actions. The works will include review of the pathway of communication and documentation (including risk assessments and care plan) between Crisis Resolution and Home Treatment/ Community teams and Inpatient Services when a patient is due to be on s17 leave/discharged.
Suicide Prevention	The Trust has identified the need to re-establish Suicide Prevention training across services, this is being led by the Trust Medical Director.
Training and awareness of Emotionally Unstable Personality Disorder	The Trust will develop a training and awareness package for all services in relation to EUPD which is being led by the Trust Medical Director.
Family liaison and engagement	A considerable amount of work has been undertaken to ensure that the Trust is complaint with regulation 20. Operating procedures are now in place, template letters for family engagement, set timescales for contacts, signposting to relevant support services and helping family members identify coping mechanisms. Benchmarking against key guidance has been undertaken, Duty of Candour training has been developed including a bereavement leaflet and guidelines for operational staff
Multi-agency engagement following incidents	It is known that patients are often known to multiple services both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support.

Physical Health management within inpatient environments	Quality improvement work in relation to improving physical healthcare management, observation and care planning within Older People's services. Enhancement of wound care management and infection prevention and control investigation and follow up within inpatient services. Introduction of RESTORE2 into ILS training framework including review of current ILS provision. Establish a physical health reporting working group to establish the new system one reporting frameworks to improve reports for assurance. Introduction of RESTORE2 into ILS training framework including review of current ILS provision. Notification of increased NEWS score via system one to senior colleagues to be reviewed.
MDT process improvements within CMHTs	Investigations have highlighted themes in relation to MDT processes within CMHTs and works are currently underway to review the EPR and recording documentation and MDT process to ensure this is fit for purpose and being adhered to.
Self-harm within inpatient environments including management of contraband	Improvement works in relation to Ligature risk assessment and care planning within inpatient services. Quality Improvement programme in relation to self-harm via sharps of females within inpatient services (local priority). Improvement to environment. Improvement to therapeutic engagements. Improvement to risk assessment and management including observation levels. To continue commissioned working group to review handheld clinical devices and compliance with observations including physical health observations.
Dissemination of learning and service improvements following incidents including assurance and governance	Work is underway to improve the way in which the trust learning and improves from incidents, this will include a revision to the processes in place in relation to internal investigation recommendations, Case Record Review learning, Incident Review Tool learning and the revised Trust Mortality process. Develop pathway to offer clear governance processes. Develop service line learning briefings specific to service learning. Trust-wide learning the lessons to share high level responses and learning. Develop better ways for monitoring and reporting emerging themes. Joined up working between services. Improved monitoring of high-profile cases and joined up working between services involved. Development of more collaborative learning responses.
Inappropriate admission to inpatient adult ward	Investigations into high profile incidents of inappropriate admissions to Adult Mental Health inpatient services brought to attention an on-going issue in this area. Review of lower grade incidents and discussions with the service line have confirmed a long-standing theme in this area. A review of inappropriate admissions is currently underway.

Application of red flags and flow of incidents resulting in death	Improvement in the application and identification of red flags for reporting death. Revision of current red flags for relevance given changes both nationally and locally. Redesign the function of the 'Mortality' process within structures through the Learning the Lessons subgroups. Review the purpose and function of the Mortality Case Record Review panel and redesign this to one of audit and assurance.
Interface between Mental Health and Substance Misuse service	Suspected suicide of a patient who has a dual diagnosis of substance misuse and mental health but has been rejected by Community Mental Health services is an area which has been noted through Case Record Review. This has been selected as a new local priority for the trust. Themes will be fed into Learning the Lessons subgroups for both services to jointly develop and improvement plan.
Substance Misuse services and Adult Acute Inpatient environments	Learning Responses for unexpected deaths post discharge/ whilst on leave have highlighted gaps around knowledge, support and process for the management and support of risk in relation to addiction and substance misuse. Currently several actions in place. Improvement plan to be developed and managed through the services Learning the Lessons subgroup.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 July 2024

Guardian of Safe Working Hours Annual Report
(June 2024)

Purpose of Report

This annual 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 Trust Board is requested to note:

1. Aggregated data for exception reports are provided in the main body of this report. Themes and numbers are similar to the previous year. One formal work schedule review was undertaken – the first the Trust has had.
2. The GOSWH was elected as the Local Negotiating Committee (LNC) Chair. There are synergies between the two roles, whilst also maintaining independence from Trust management structures.
3. Guidance on the use of personalised work schedules have been disseminated to doctors and their supervisors. This was done in conjunction with Dr Vishnu Gopal, the Director of Medical Education (DME). This tool allows the doctor to draw up a timetable with the supervisor that accurately reflects work commitments and builds in the training time required by the relevant training programmes. It will be disseminated annual to supervisors, and at each rotation for postgraduate doctors in training.
4. The GOSWH has been working with other GOSWH colleagues in the region to reinvigorate the regional network. This has since been ‘stood up’ and the GOSWH is the Chair of this network. Two meetings have been had so far, with the next scheduled for July. Meetings every two to three months are planned. The purpose is for peer support, and to share/discuss good practice between GOSWHs.
5. Extracontractual rates were agreed for all doctors across the Trust towards the end of 2023. Rota gaps that have arisen from time to time are now being readily filled by current staff owing to the attractive rates negotiated.
6. The Junior Doctor Forum (JDF) constituents are currently planning and discussing a junior doctor away day, utilising the available fines money. Consultant colleagues have already had an away day and there are plans for Specialist, Associate Specialist and Specialty (SAS) doctors to have similar. Therefore, it makes sense for the Trust to support this for junior doctors – the Committee is asked to formally support this.
7. The Making Room for Dignity programme has featured heavily in recent JDF meetings. Particular concerns have been raised about the workload increase with new inpatient wards in the south. The JDF have presented their concerns to relevant people in the project for consideration.

8. Resident doctor rotas, staffed by junior doctors, have used 'live' rotas on Microsoft Teams for some time. There is work underway to roll this out for other doctor groups to utilise existing secure technology. This will have several benefits, including ease of access of rotas, version control, faster facilitation of swaps and lessening the administrative burden on switchboard colleagues. Linked to this, the case is being made for a formal Rota Co-ordinator role.

Work is underway for direct study leave expenses procurement for doctors in postgraduate training. This coincides with NHS England's announcement to improve the working lives of junior doctors (NHS England » NHS sets out measures to improve the working lives of doctors), and this calls on a senior named individual to oversee implementation within each trust. NHS England's planning guidance comments on the role of the GOSWH (2024/25 priorities and operational planning guidance (england.nhs.uk), specifically looking to strengthen it. We will submit a return with an update of our planned response to this letter.

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 quarterly and annual reports to this Committee with the Joint Local Negotiating Committee (JLNC), the Trust Medical Training Committee (TMTC), the Junior Doctor Forum (JDF) and its constituent junior doctors. Following presentation to this Committee, this report will be shared with the next JDF meeting, its constituent junior doctors, the TMTC and the JLNC.

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 Trust Board is requested to:

1. Note NHS England's announcement in April on improving the working lives for postgraduate doctors in training, that a senior named individual is required to oversee implementation, and to consider how to take this forward
2. Note that the Quality and Safeguarding Committee received significant assurance 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: **Dr Arun Chidambaram**
Medical Director

Report prepared by: **Dr Kaanthan Jawahar**
Guardian of Safe Working Hours

GUARDIAN OF SAFE WORKING ANNUAL REPORT (June 2024)

1. Trainee data

Extended information supplied from 5 March 2024 to 9 June 2024. Annual aggregated data is not presented as this would be unclear in what it shows owing to variable rotation dates for junior doctors.

Numbers in post for doctors in training

Number of doctors in post WTE	North	South
FY1	3	5
FY2	3	5
GP ST	4	5.6
CT	11	12.6
HSTs	6	8
Paediatrics ST	n/a	2

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

Aggregated data, covering the period **6 April 2023 to 15 May 2024**.

Location	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	19	19	0
South	5	5	0
Total	24	24	0

Grade	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	13	13	0
ST4-7	4	4	0
GP	0	0	0
Foundation	7	7	0
Total	24	24	0

Action taken

Location	Payment	TOIL	Not agreed	No action required
North	2	19	0	0
South	1	4	0	0
Total	3	23	0	0

Response time

Grade	48 hours	7 days	Longer than 7 days	Open
CT1-3	0	4	9	0
Foundation	0	1	6	0
ST4-7	0	2	2	0
GP	0	0	0	0

- Exception reports for this period are similar to the previous annual report in type and distribution
- Broad themes include delays in leaving at shift conclusion on normal working days, and breaching non-resident on call rest requirements. This mirrors what is seen elsewhere in psychiatry in England
- No exception reports submitted by paediatric ST doctors, or GP registrars
- One formal work schedule review enacted owing to a doctor regularly staying late. Identified that scheduled ward reviews were the driver and these have been modified in conjunction with their clinical supervisor. A similar theme emerged with another exception report – this did not become a formal work schedule review, but the approach was similar (the issue in this case was around timetabling and site changes).

3. Work schedule reviews

One formal work schedule review conducted in the north with a CT1-3 doctor regularly needing to stay late. Further review noted that scheduled ward review times, linked to the medical staffing on the ward, meant this would likely continue. A solution has been identified and enacted between the doctor and supervisors.

This is the first formal work schedule review conducted at DHcFT.

4. Fines

- £342.68 levied in fines against the Trust since the last annual report. These have all arisen through breaches of non-resident on call minimum rest requirements
- The current total of fines available for the JDF to spend is £960.92 through cost code G62762
- Members of the JDF are currently looking to organise a junior doctor away day utilising these funds.

5. Locum/Bank Shifts covered (6 April 2023 to 30 April 2024)

	North	Cost	South	Cost
Locum/bank shifts covered	74	£41281.37	118	£66718.80
Agency locum shifts covered	0	0	0	0

6. Agency Locum

Nil.

7. Vacancies (5 March 2024 to 9 June 2024)

	North	South
CT1-CT3	0	0.4
ST4-7	1	1
GP Trainees	0	1.4
Foundation	0	0

8. Qualitative information

- The GOSWH was elected as the Local Negotiating Committee (LNC) Chair. There are synergies between the two roles, whilst also maintaining independence from Trust management structures
- Guidance on the use of personalised work schedules have been disseminated to doctors and their supervisors. This was done in conjunction with Dr Vishnu Gopal, the Director of Medical Education (DME). This tool allows the doctor to draw up a timetable with the supervisor that accurately reflects work commitments and builds in the training time required by the relevant training programmes. It will be disseminated annual to supervisors, and at each rotation for postgraduate doctors in training
- The GOSWH has been working with other GOSWH colleagues in the region to reinvigorate the regional network. This has since been 'stood up' and the GOSWH is the Chair of this network. Two meetings have been had so far, with the next scheduled for July. Meetings every two to three months are planned. Its purpose is for peer support, and to share/discuss good practice between GOSWHs
- Extracontractual rates were agreed for all doctors across the Trust towards the end of 2023. Rota gaps that have arisen from time to time are now being readily filled by current staff owing to the attractive rates negotiated.
- The JDF constituents are currently planning and discussing a junior doctor away day, utilising the available fines money. Consultant colleagues have already had an away day and there are plans for SAS doctors to have similar. Therefore, it makes sense for the Trust to support this for junior doctors – the Committee is asked to formally support this.
- The Making Room for Dignity programme has featured heavily in recent JDF meetings. Particular concerns have been raised about the workload increase with new inpatient wards in the south. The JDF have presented their concerns to relevant people in the project for consideration.

- Resident doctor rotas, staffed by junior doctors, have used ‘live’ rotas on MS Teams for some time. There is work underway to roll this out for other doctor groups to utilise existing secure technology. This will have several benefits, including ease of access of rotas, version control, faster facilitation of swaps and lessening the administrative burden on switchboard colleagues. Linked to this, the case is being made for a formal rota coordinator role.
- Work is underway for direct study leave expenses procurement for doctors in postgraduate training. This coincides with NHS England’s announcement to improve the working lives of junior doctors (NHS England » NHS sets out measures to improve the working lives of doctors), and this calls on a senior named individual to oversee implementation within each trust. NHS England’s planning guidance comments on the role of the GOSWH (2024/25 priorities and operational planning guidance (england.nhs.uk)), specifically looking to strengthen it. The Committee is asked to consider the next steps for this.

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 – 2 July 2024

Medical Appraisal and Revalidation in DHcFT Appraisal Year 2023/24

Purpose of Report:

To provide DHcFT Public Board with an update on medical appraisal and revalidation activity within the Trust during the 2023/24 medical appraisal cycle.

Executive Summary:

The purpose of medical revalidation and appraisal is to support and develop our medical workforce through reflection on clinical practice whilst complying with GMC frameworks to protect patients.

As of 31 March 2024, 121 doctors had a connection with DHcFT for appraisal. Of these:

- 74 doctors have completed their appraisal within the required time
- 30 doctors have not completed an appraisal during this time frame
- Of these 30 doctors, 11 doctors have had a GMC deferral of revalidation agreed after recommendation by the Responsible Officer
- All doctors without an appraisal have been contacted by the Medical Appraisal Lead and have a plan in place to support them to improve their compliance with appraisal.

During the last 12 months, we have moved to using L2P for medical appraisal and job planning. This has been a very positive move. Initially, it has been very time-consuming ensuring all of the necessary data was transferred to the new system and was accurate. Using L2P allows greater transparency of the appraisal data for individual doctors as well as for DHcFT as a whole. It provides a much easier platform for carrying out appraisals than the previous system. Built-in automatic reminders around time frames will help to improve compliance with appraisal submission dates.

Dr Chidambaram has set up the Responsible Officer Advisory Group within DHcFT. The Medical Appraisal Lead can report into this group to provide regular updates on appraisal data and can seek advice to identify early and support any doctors who are not on track to complete their appraisal in a timely manner.

The next 12 months will allow us to fully embed the use of L2P with the medical workforce and to support doctors who are not compliant with GMC requirements. This should lead to a reduction in the number of deferrals of revalidation dates.

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.	X

Risks and Assurances

- During the transition and embedding of L2P, DHcFT has continued to allow use of the previous electronic documentation for appraisal. This has been used by only a small number of doctors during the 2023/24 appraisal cycle and will not be used at all for the 2024/25 appraisal cycle
- The move to L2P has highlighted more clearly a small number of doctors who are significantly behind with their appraisals. This situation is being closely monitored by the appraisal lead and the doctors are being actively supported to take action to bring themselves in line with requirements.

Consultation

N/A.

Governance or Legal Issues

This report was approved by People and Culture Committee on 28 May 2024.

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 above has been considered but no impact has been identified.

Recommendations

The Board is requested to:

1. Note the compliance and the assurance received in People and Culture Committee
2. Submit the annual medical appraisal compliance report to NHS England.

Report presented by: Dr Arun Chidambaram
Executive Medical Director and Responsible Officer

Report prepared by: Dr Wendy Brown
Medical Appraisal Lead

Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction: 2
Designated Body Annual Board Report 3
Section 1 – General: 3
Section 2a – Effective Appraisal 5
Section 2b – Appraisal Data 8
Section 3 – Recommendations to the GMC 8
Section 4 – Medical governance 9
Section 5 – Employment Checks 12
Section 6 – Summary of comments, and overall conclusion 12
Section 7 – Statement of Compliance: 14

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of Derbyshire Healthcare NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: the DHCFT will continue to discharge the role and responsibilities on behalf of the medical staff and will provide appropriate support to the Medical Appraisal Lead. Comments: Dr Chidambaram is the DHCFT Responsible Officer Action for next year: the DHCFT RO will continue to discharge the role and responsibilities on behalf of the medical staff and will provide appropriate support to the Medical Appraisal Lead

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: to secure an electronic platform to support appraisal processes. Comments: In the last year we have moved to L2P electronic platform for appraisal and job planning. This has been a very positive move. It has initially been very time consuming for the revalidation team to ensure all data is accurately transferred to the new system and past appraisals are available on the system. However, the benefits are significant and include ensuring we have clear and up to date data, transparency around the process of appraisal and a much easier to use system for medical staff than the previous format. Action for next year: Continue to embed the use of L2P across the medical body.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: an electronic platform will ease the process of ensuring all relevant doctors are connected to DHCFT and registered for appraisal. This will reduce the likelihood of revalidation referral requests due to issues with timings of appraisal. Comments: the medical appraisal lead accesses the GMC connect site regularly and can add new staff onto the L2P dashboard. This process is supported by the revalidation team. Action for next year: to continue with this process.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The policy will continue to be reviewed in line with DHCFT timeframes.

Comments: The medical appraisal policy was reviewed and ratified in 2023 and is available for staff on the DHCFT Intranet.

Action for next year: The policy will continue to be reviewed in line with DHCFT timeframes – next review date September 2026.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

> Actions from last year: Consideration to be given to peer review during future appraisal cycles.
>
> Comments: A peer review has not yet taken place due to the time implications of transferring to L2P and embedding this over the past 12 months.
>
> Action for next year: Consideration to be given to peer review during future appraisal cycles.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

> Action from last year: To continue with current arrangements as detailed below.
>
> Comments: Locums and short-term placement doctors are contacted by the medical appraisal lead and arrangements put in place for their appraisal as required. Agency locums may carry out their appraisal through their agency. Our Trust has developed a medical bank to reduce reliance on agency locums and will facilitate appraisals for colleagues employed longer term through Trust medical bank (primary employer). All medical staff have access to CPD, appraisal, revalidation, and governance.
>
> Action for next year: To continue with this arrangement.

Section 2a – Effective Appraisal

7. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: an electronic appraisal system will allow automated prompts and reminders to be sent to doctors to improve appraisal completion timeframes.

Comments: Quality of appraisals continues to be good and appraisals are carried out to a high standard. Completion of appraisals within required timeframes is an ongoing challenge. The move to L2P provides greater transparency about individual doctors appraisal status and allows targeted support to those doctors who are not in line with standards.

Action for next year: to continue to support all doctors to complete their appraisal in line with GMC standards with focused support for those who are not meeting required timescales.

8. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: To continue to ensure compliance with appraisal timeframes.

Comments: Doctors, whose appraisals have been delayed are aware of the requirements for appraisal and revalidation. Regular discussions are taking place with the RO and medical managers (via the Responsible Officer Advisory Group) to support these doctors to complete appraisal. This issue was also brought up in the Medical Senate (a forum for all the Trust employed doctors that is part of Trust governance) by the Responsible Officer with a clear message on individual professional accountability to ensure compliance with appraisal.

Action for next year: To continue to improve compliance with appraisal timeframes.

9. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: The Policy will be reviewed according to DHCFT timeframes.

Comments: The Medical Appraisal Policy was reviewed in 2023 with minor amendments.

Action for next year: The Policy will be reviewed according to DHCFT timeframes – next review September 2026.

10. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To continue to maintain adequately trained appraisers through training new appraisers in order to account for retirements and resignations. Comments: DHCFT has maintained appropriate numbers of appraisers. New doctors have joined the existing cohort following appropriate training. Action for next year: To continue to maintain adequately trained appraisers through training new appraisers in order to account for retirements and resignations.

11. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: We will continue to seek opportunities for feedback and peer review within the appraiser group as well as periodic refresher training. Comments: Medical appraisers receive support through informal group and individual discussion with peers and the appraisal lead. Action for next year: We will continue to seek opportunities for feedback and peer review within the appraiser group, development for appraisers as well as periodic refresher training.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

12. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: a quality assurance audit to be carried out

Comments: A full quality assurance audit has not been carried out this year due to the move to an electronic platform. The medical appraisal lead is carrying out an audit on a smaller number of appraisals to provide assurance on quality of documentation and reflections.

Action for next year: a quality assurance audit to be carried out

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2024	121
Total number of appraisals undertaken between 1 April 2023 and 31 March 2024	74
Total number of appraisals not undertaken between 1 April 2023 and 31 March 2024	30
Total number of agreed exceptions	17

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: To continue with regular liaison meetings.

Comments: The Responsible Officer has regular, documented meetings with the GMC Employment Liaison officer. Fitness to practice issues and thresholds of referral are discussed and noted.

Action for next year: To continue with regular liaison meetings.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: To continue with high levels of compliance.

Comments: All revalidation recommendations have been made within appropriate timeframes.

When deferral recommendations are made, this is discussed in Responsible Officer Advisory Group to ensure that Clinical Directors, Appraisal Lead and the Responsible Officer are able to clearly provide the rationale for the recommendation. An exceptional case of non-engagement recommendation was made with advice and input from Practitioner Performance Advice Service and GMC Employee liaison advisor. The clinician was also provided with information through a series of meetings.

Action for next year: To continue with high levels of compliance.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: to continue with and develop the approach below.

Comments: Quality Improvement activity is undertaken across services and by individuals to look at their own practice. Feedback is given about complaints and serious incidents. There is a drive within DHCFT to make data accessible to clinicians to support improved care and outcomes.

Action for next year: To look further at the use of data to inform individual doctors practice and comparison amongst groups of doctors.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: to continue with and develop the approach below.

Comments: Individual doctors and the Appraisal Lead are able to link in with the Patient Experience Team for details of any complaints or serious incidents involving them.

Action for next year: to continue with and develop this approach

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: To continue and develop the approach below.

Comments: Processes are in place involving the Patient Experience Team to review concerns. The RO is in regular contact with the GMC Liaison Officer to discuss any concerns. The Medical Disciplinary Policy has been extensively revised and ratified by the People and Culture Committee.

Action for next year: To continue and develop this approach.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Action from last year:

Comments: Formal disciplinary matters are reported to People and Culture Committee along with other professions. This report has narrative on numbers, type (conduct & capability) and breakdown of protected characteristics.

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Action for next year: Produce an annual report to People and Culture committee from the activity in Responsible Officer Advisory Group.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Action from last year: Comments: Most of the doctors who work in our Trust work exclusively for the organisation and declare any other links in their appraisal. Agency Locums are connected to their respective Agency Locum Ros. Derbyshire Healthcare NHS Foundation Trust RO has made contact with the ROs of all the agencies linked to locums. We are able to email Agency Locum Ros and the person with governance responsibility, when there is a need to share concerns. Action for next year: Continue with the above plan

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Comments: We seek advice from Practitioner Performance Advisory Service who provide neutral and independent advice. The input from Employment Relations experts is outsourced to a neighbouring organisation – Derbyshire Community Health Trust – when discussing concerns, they are not always aware of protected characteristics. This offers some level of assurance against bias and discrimination. We adopt a similar process in Responsible Officer Advisory Group, where the concerns are discussed anonymously (though it is not possible to fully anonymise in an organisation of our profile).

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

We continue to implement Just Culture pilot with GMC which focusses on informal resolution (when appropriate) to address bias and discrimination.

Action for next year: Continue to ensure that processes are fair

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:

Comments: Pre-employment checks are completed by Medical HR team focussing on registration, qualifications, DBS checks. Section 12 status and Approved Clinician Status was included as part of pre-employment check. We have access to the national database for Section 12 status and Approved Clinician status.

Action for next year:

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report**

We have strengthened the data visibility in appraisals and medical governance in several areas.

- **Actions still outstanding**

Quality assurance audit for appraisal planned for next year

Peer review (deferred this year due to transition to an electronic platform)

- **Current Issues**

Number of deferral requests in this cycle – managed robustly in Responsible Officer Advisory Group.

- **New Actions: Once we fully embed the adoption of electronic platform, this year, we will focus on quality improvement next year.**

Overall conclusion:

We have strengthened data visibility, governance of appraisal process and the governance of concerns about doctors.

Section 7 – Statement of Compliance:

The Board of DHCFT has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _

Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

© NHS England 2023
Publication reference: PR1844

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 2 July 2024

Report from the Council of Governors meeting

The Council of Governors has met once since the last report, on 7 May 2024. The meeting was conducted as a hybrid meeting.

Matters arising

Governors received a response from the Deputy Chief Executive/Chief Delivery Officer regarding the concern raised that Triangle of Care carers champions were not getting protected time to enable them to carry out the role. Governors requested that an update be given at the September Council of Governors meeting.

Chief Executive's update

The Chief Executive's update focused on:

- Operational and finance plan 2024/25
- Care Quality Commission (CQC)
- Making Room for Dignity programme
- Development of the new Trust strategy
- New services.

Report From Governors Nominations and Remuneration Committee – 26 April 2024

The Director of Corporate Affairs and Trust Secretary presented an overview of the matters discussed at the last Governors Nominations and Remuneration Committee which focused on:

- The appraisals for the Trust Chair and the Non-Executive Directors (NEDs)
- A proposal for the re-appointment of Geoff Lewins, NED
- A proposal for the re-appointment of the Trust Chair
- Several year-end governance reports.

The Council of Governors approved the:

- Re-appointment of Geoff Lewins, as Non-Executive Director and Chair of the Audit and Risk Committee, for a further 12 months from 1 December 2024
- Re-appointment of Selina Ullah, Trust Chair for a second, three-year term of office from 14 September 2024
- Five Chair objectives as set out in the report
- Committee's revised Terms of Reference.

Council of Governors Annual Effectiveness Survey

The Council of Governors approved the recommendation that the survey is undertaken in September 2024.

Staff Survey Results

The Human Resources and Organisational Development Project Lead presented the staff survey results which shows the current position of the Trust for the 2023 NHS staff survey.

Non-Executive Directors (NED) Report

Ashiedu Joel and Ralph Knibbs (NEDs) presented their overview reports on their role and activities at the Trust.

Escalation Items to the Council of Governors from the Governance Committee

Governors received responses to two holding to account questions to the NEDs around the wait times for memory assessments; and the role and involvement of the Allied Health Professions (AHP) workforce. 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.

Governance Committee Report

The Co-Chair of the Governance Committee presented a report of the meeting held on 16 April 2024. The Council of Governors approved the governor statement for the Quality Account which was included in the report.

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). The Action Plan is aligned to the key objectives for members' engagement in the Membership Strategy 2021-2024. It was agreed that the Action Plan will be reviewed by the Governance Committee in June.

RECOMMENDATION

The Trust Board is asked to note the summary report from the Council of Governors meeting held on 7 May 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
AOVPN	AlwaysOn VPD (secure network access)
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
BPD	Borderline Personality Disorder
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
CD-LIN	Controlled Drug Local Intelligence Network
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CP	Child Protection
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CPRG	Clinical Professional Reference Group
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQRG	Care Quality Review Group
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
CSPR	Child Safeguarding Practice Review
CTO	Community Treatment Order
CTR	Care and Treatment Review
D	
DAR	Divisional Assurance Review
DASP	Drug and Alcohol Strategic Partnership
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
DHR	Domestic Homicide Review
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
EbE	Expert by Experience
ECT	Enhanced Care Team
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHCP	Education, Health and Care Plan
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
EPRR	Emergency Preparedness, Resilience and Response
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)

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HFMA	Healthcare Financial Management Association
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
Icare	Increase Confidence, Attract, Retain, Educate
ICB	Integrated Care Board
ICM	Insertable Cardiac Monitor
ICO	Information Commissioner's Office
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
IMT&R	Information Management, Technology and Records
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPS	Individual Placement and Support
IPT	Interpersonal Psychotherapy
IRHTT	In-reach Home Treatment Team
IRT	Incident Review Tool
J	
JDF	Junior Doctor Forum
JLNC	Joint Local Negotiating Committee
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
LADO	Local Authority Designated Officer
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LeDeR	Learning Disabilities Mortality Review
LFPSE	Learn from Patient Safety Events

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
LWSTO	Living Well Short-Term Offer
M	
MADE	Multi-agency Discharge Event
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors
MARS	Mutually Agreed Resignation Scheme
MAS	Memory Assessment Service
MASH	Multi-Agency Safeguarding Hub
MAST	Management and Supervision Tool
MAU	Medical Assessment Unit
MBU	Mother and Baby Unit
MCA	Mental Capacity Act
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MFA	Multi-Factor Authentication
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
MHRA	Medical and Healthcare products Regulatory Agency
MHRT	Mental Health Review Tribunal
MHSDS	Mental Health Services Data Set
MMC	Medicines Management Committee
MoU	Memorandum of Understanding
MPAC	Multi Professional Approved Clinician
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSP	Medicines Safety and Practice
MSU	Medium Secure Unit
N	
NCRS	National Cancer Registration Service
NED	Non-Executive Director
NETS	National Educational Training Survey
NHS	National Health Service
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NPS	National Probation Service
NQB	National Quality Board
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
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
PMH	Perinatal Mental Health
PMLD	Profound and Multiple Disability
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPT	Partnership and Pathway Team
PQN	Perinatal Quality Network
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
PSQG	Patient Safety and Quality Group
Q	
QAG	Quality Assurance Group
QASI	Quality Assurance Serious Incidents
Q&SC	Quality and Safeguarding Committee
QEIA	Quality and Equality Impact Assessment

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
SAR	Safeguarding Adult Review
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
SIG	Serious Incident Group
SID	Senior Independent Director
SIDS	Sudden Infant Death Syndrome
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
SOC	Strategic Options Case
SOF	Single Operating Framework
SPOA or SPA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
SSQD	Specialised Services Quality Dashboards
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
TIC	Trauma Informed Care
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
VFM	Value For Money
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

June 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**	**21-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
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/MD	Safer Staffing Annual Review (prior to publishing on website, following assurance at QSC)			X			
DPODI	Workforce Plan Annual Review (prior to publishing on website, following assurance at PCC)			X			
QUALITY GOVERNANCE							
EXEC	Update on CQC Domains (following 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	
MD	Improving the Working Lives of Doctors in Training		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	Standing Financial Instructions Policy and Procedures (Jul 2024)		Deferred to Sep-2024	X			