NHS
Derbyshire Healthcare
NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY 1 OCTOBER 2024 TO COMMENCE AT 10.00AM
CONFERENCE ROOMS A&B, RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY, DE22 3LZ

	TIME	AGENDA	LED BY
1.	10:00	Chair's welcome, opening remarks, apologies and declarations of interest 1.1 Trust Vision and Values 1.2 Register of Interests 2024/25	Selina Ullah
PATIENT STORY			
2.	10.05	Patient Story *"From patient to practitioner. The importance of reasonable adjustments"*	Joe Thompson
STANDING ITEMS			
3.	10.30	Minutes of the Board of Directors meeting held on 2 July 2024	Selina Ullah
4.		Action Matrix and Matters Arising	
5.		Questions from members of the public	
6.	10.35	Chair's update	Selina Ullah
7.	10.45	Chief Executive's update	Mark Powell
OPERATIONAL PERFORMANCE, STRATEGIC PLANNING AND CORPORATE & QUALITY GOVERNANCE			
8.	10.55	Integrated Performance report to include Finance, People Performance and Quality	Vikki Ashton Taylor/ Tumi Banda/Rebecca Oakley/James Sabin
9.	11.20	Trust Strategy Progress update	Vikki Ashton Taylor
11.30 BREAK			
10.	11.40	Board Assurance Framework (BAF) update	Justine Fitzjohn
11.	11.50	Freedom to Speak Up Guardian Report (six-monthly)	Tam Howard
12.	12.00	Planning Update	Vikki Ashton Taylor/ Rebecca Oakley James Sabin
13.	12.10	Emergency Preparedness, Resilience and Response (EPRR) Core Standards	Vikki Ashton Taylor
BOARD COMMITTEE ASSURANCE			
14.	12.20	Board Committee Assurance Summaries	Committee Chairs
REPORTS FOR NOTING ON ASSURANCE FROM BOARD COMMITTEES			
15.	12.40	Audit and Risk Committee: ♦ Review of Standing Financial Instructions (SFI)	Geoff Lewins
16.		Finance and Performance Committee: ♦ Revised Terms of Reference	Tony Edwards
17.		People and Culture Committee: ♦ Workforce Plan Annual Review ♦ Flu and COVID Campaign 2024/25 ♦ Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)	Ralph Knibbs
18.		Quality and Safeguarding Committee: ♦ Safer Staffing Annual Review	Lynn Andrews
CLOSING BUSINESS			
19.	12.50	Consideration of any items affecting the Board Assurance Framework	Selina Ullah
20.		Meeting effectiveness	

FOR INFORMATION
Emergency Powers of the Chief Executive and Chair Report from the Council of Governors Meeting – 3 September 2024 Forward Plan 2024/25 Glossary of NHS Acronyms

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 on 5 November 2024 at 9.30am 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 *(until 31-Jul-2024)* 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).

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Tuesday, 2 July 2024

MEETING HELD IN PUBLIC

Commenced: 9.30am Closed: 12.30pm

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 (from DHcFT/2024/062)
	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	Director of People Organisational Development and Inclusion
	James Sabin	Director of Finance
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications and Engagement
	Jo Bradbury	Corporate Governance Officer
APOLOGIES	Geoff Lewins	Non-Executive Director
OBSERVERS	Dave Allen	Public Governor, Chesterfield (from DHcFT/2024/063)
	Sandra Austin	Equal Network Advisor
	Andrew Beaumont	Public Governor, Erewash

DHCFT/ 2024/057	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah, welcomed Board colleagues, Governors and observers to today's meeting. She went on to congratulation Rebecca Oakley, on her substantive appointment as Director of People, Organisational Development and Inclusion. Apologies were as stated. There were no declarations of interest.
DHCFT/ 2024/058	**MINUTES OF THE PREVIOUS BOARD OF DIRECTORS MEETING** The draft minutes of the previous meeting held on 7 May 2024 were accepted as a correct record of the meeting. There were no matters arising.
DHCFT/	**ACTION MATRIX AND MATTERS ARISING**

2024/059	Lynn Andrews, Non-Executive Director, pointed out that Action reference DHCFT/2024/046, Integrated Performance Report – Quality, increased oversight for patients clinically ready for discharge, was not fully complete and a further report is scheduled for the Quality and Safeguarding Committee on 16 July 2024. **Post-meeting note, Action Matrix corrected**. The Board reviewed the remaining closed and completed actions. There were no overdue actions.
DHCFT/ 2024/060	**QUESTIONS FROM MEMBERS OF THE PUBLIC** There were no public questions. However, Andrew Beaumont, Public Governor, Erewash, had submitted an advance question, which was: *"When a patient presents, is there a set of internationally accepted criteria (as there is for calculation of body mass index (BMI)) to decide whether to treat a patient within the hospital, or take the cheaper (riskier) option of 'in the community care'?"* Arun Chidambaram, Medical Director, thanked Andrew for the question and explained that there are two types of psychiatric classification, which are categorical (clearly either present or not) and dimensional (shades of grey, varying severity). The UK classification is ICD11 and the American classification is DSM5. It was noted that the Mental Health Act helps with the admission threshold: • Involuntary admission – there should be a mental disorder and associated risk, and the necessary treatment should only be possible to deliver in a hospital • Voluntary admission – the mental disorder should be of sufficient severity to require hospital admission.
DHCFT/ 2024/061	**CHAIR'S UPDATE** Selina provided the Board with her reflections on activity since the previous Board meeting on 7 May 2024 and drew attention to the points below: During a visit to the Beeches Perinatal Mental Health Services, Selina had been pleased to speak with some of the mums on the unit who were complimentary about their care and the environment. It was also encouraging to observe that the team had organised samosas and other foods for a patient to align with Eid celebrations and to reduce feelings of homesickness. Selina was happy to see the gym equipment at the Keddleston Unit was in working order as during a previous visit, some of the equipment was out of use. Selina was inspired by the passion and commitment of the team managers and colleagues and had enjoyed discussing predictions for the European cup finalists with patients. A visit to the Ashbourne Centre had provided the opportunity to meet with a group of preceptee Nurses, Selina was impressed by the diversity of the group, with representation from Cameroon, Ghana, Nigeria and Zimbabwe and affirmed the need to be responsive to differing needs of our workforce. The Reserves Day proved to be a very positive event and had highlighted the excellent partnership work between the Trust, the Armed Forces, University of Derby and Derbyshire Community Health Services (DCHS). The Board noted that there has been a steady increase in partnership working with DCHS and this has been further enhanced through regular meetings to review joint services, with Julie Houlder, Chair, DCHS.

	Selina informed there was openness and a genuine desire for collaborative working between the current Provider Chairs, including Prem Singh, University Hospitals of Derby and Burton (UHDB) and Mahmud Nawaz, Chesterfield Royal Hospital. She advised that all Chairs have been invited to meet at Kingsway in the near future. It was noted that following a visit to the new Making Room for Dignity (MRfD) facilities, the Carsington Unit at Kingsway, Dale Bywater, NHSE Regional Director, was very complimentary about the Trusts' vision for inpatient services and appreciated the complexity of the programme. Lynn asked for any reflections following the Integrated Care Board (ICB) system development meeting chaired for the first time by Kathy McLean, ICB Chair. It was noted that the emphasis had been on potential cost efficiencies and greater pace of delivery, in a climate of limited resources. Mark Powell, Chief Executive, had perceived a signalled intent to focus on integrated care and a challenge for providers to work collaboratively to provide the best care for patients. **RESOLVED: The Board of Directors considered the content of the Chair's update.**
DHCFT/ 2024/062	**<u>CHIEF EXECUTIVE'S UPDATE</u>** Mark's report provided an update on current local issues and national policy developments. The report was shorter than normal due to the pre-election period. Mark welcomed Rebecca Oakley, to her first Public Board meeting in her newly appointed role and then drew attention to the following: On behalf of the Board, Mark voiced his thoughts and condolences on the passing of Simon Stansfield, a long standing and highly valued member of the Crisis Resolution and Home Treatment Team in Chesterfield. It was noted that the Trust had observed a minute's silence on 27 June. Mark stated that the multi-agency discharge event (MADE) that took place across the Radbourne and Hartington units had impacted positively on the flow of patients, bed capacity and also resulted in improvements across the whole Adult Acute care pathway. The Board recognised the great work over the last 12-18 months, including significant interaction with service users, to develop the Memorandum of Understanding (MoU), between the Trust and Derbyshire Community Health Services (DCHS). The agreement clarifies the Neurodevelopmental (ND) services which are in scope, the operating arrangements, and the proposed structure to deliver a collaborative service across Derby and Derbyshire. Lynn thanked colleagues for their tremendous efforts and queried accountability for physical equipment, for example, defibrillators. Arun confirmed that both trusts will work closely on necessary safeguards. Deborah Good, Non-Executive Director, celebrated the great achievement of the Autism Assessment team, who were presented with the Great Autism Practice Award and heralded by the judges for having a profound impact on the community. Deborah went on to praise the infographic included in the report, which displayed impressive statistics on the different ways the Trust has supported local people during April and May. Tony Edwards, Deputy Trust Chair, pointed out that the waiting list for autism assessments remains extremely high and queried if the award might give leverage to secure additional funding. Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, explained that all capacity and funding is currently under review by the ICB and is expected to be commissioned differently. However, in order to capitalise on the success, it was agreed the

	award presented a good platform for the sharing of experience and business development opportunities, and this would be taken back to the team. Potentially, the team will receive additional contact and questions and it was noted they will need support. Mark added that he is to invite Amanda Pritchard, Chief Executive, NHS England, to visit the Trust to explore sources of national good practice. **RESOLVED: The Board of Directors:** **1. Scrutinised the report and noted the risks and actions being taken** **2. Approved the Neurodevelopmental service MoU with DCHS.**
DHCFT/ 2024/063	**<u>INTEGRATED PERFORMANCE REPORT (IPR)</u>** The IPR provided an update on key finance, performance and workforce measures at the end of May 2024. Executive Directors drew attention to the following areas and responded to questions: **<u>Operations</u>** Vikki highlighted two main points: • implementation of the Community Mental Health Living Well Programme and the data provided. It was noted that caseload sizes are reducing and referrals are managed better, which is increasing capacity to provide more care in the community along with reduced attendance at Accident and Emergency, and • inappropriate out of area (OoA) placements have significantly reduced in recent weeks. It was noted that substantial work has taken place, for example, following the MADE event, gatekeeping has improved to support patients into the most appropriate place. However, Vikki stressed that significant pressure remains on the Trust's Acute wards. The Board praised the incremental improvements and discussed how the progress can be consistently sustained. It was noted that the Trust is working with the system, representatives from the community, the ICB and social care, which has made the event qualitatively better, with increased ownership from stakeholders and Quality Improvement (QI) has been used as the driving force. Vikki pointed out that a number of actions have been identified which have been transposed into a Recovery Action Plan with set trajectories. Arun added that the Trust is benchmarking best practice with other trusts. Tony observed that it would be helpful for this work to be presented to the Finance and Performance Committee. **Action, Vikki Ashton Taylor**. Lynn pointed out the absence of caseload/capacity size and timescales on the data provided. Vikki agreed to take away the query and added that it takes time to embed the significant transformational change and the emphasis is to allow individual teams to be flexible. Thus, any issues can be reviewed immediately using QI methodology to make improvements. **Action, Vikki Ashton Taylor**. Tony probed the improved OoA and if the diminished reliance on contracted beds will result in cost savings, to which Vikki confirmed this is expected over time. However, the immediate focus is to relocate those currently placed outside of Derbyshire. It was noted that there are currently three individuals to be repatriated and the ambition is that the use of this mitigation will no longer be required. **<u>Quality</u>** Dave Mason, Interim Director of Nursing and Patient Experience, reported a 9% increase in compliments and that 100 plus teams are now enrolled to the electronic patient feedback platform. The reduction in formal complaints and gradual improvement in Care Plan reviews

was noted, along with a sustained increase in incident of violence, aggression and self-harm.

Ashiedu Joel, Non-Executive Director, asked Dave how the Trust is exploiting relationships with local authorities and housing stakeholders to expedite discharges. Vikki responded that the MADE event had cemented those critical relationships and there is strong engagement, including with Adult Social Care. Mark added that there is a system-wide discharge group, led by Dean Wallace, Chief Operating Officer, DCHS, at which Lee Doyle, Managing Director, Operations, is in attendance. It was agreed that there is an opportunity to share good practice and learning, which needs further exploration.

The Board noted that local authorities are currently in consultation on dementia services, which will impact bed occupancy and length of stay for adults and older adults.

Rebecca Oakley, Director of People, Organisational Development and Inclusion, drew attention to the increased Datix incidents, attributed to a small group of patients, and questioned if the Trust is taking sufficient action to reduce violence and aggression towards staff. Dave suggested that the increase is due to improved reporting and agreed that a deep dive would be beneficial. **Action, Dave Mason**.

People

Rebecca extended her thanks to April Saunders, Physical Health and Wellbeing Lead and Alex Dougall, Strategic Recruitment Lead, following the successful recruitment event held in Chesterfield on 8 June, which had increased appointments to the flexible workforce bank. In addition, the initiative to convert bank staff to substantive has resulted in 17 individuals joining wards, with an additional eight pending.

Improvements in appraisal and training compliance were noted, along with the imminent relaunch of the staff benefits programme.

Discussions then focused on the cost of agency doctors, the drive to build the medical bank and conversions to substantive members of the team, along with the dependence on agencies. It was noted that one CAMHS consultant has accepted a substantive post.

As there will be no inhouse Clinical Psychologist support for staff from August, Deborah was concerned about staff welfare. Rebecca confirmed that a monthly review of long-term absence cases is now a standing action to support early intervention and currently there are just five on the caseload.

Tony pointed out that appraisal compliance within Corporate Services remains below target. Rebecca confirmed there is a combination of reasons for this, ineffective handovers due to manager changes and ambiguity around the data.

Ashiedu was keen to know how these reasons are being addressed and the consequences when targets are not met. Rebecca agreed that improvement is needed with the emphasis on accountability. She added that data cleansing is underway. It was agreed that future reporting will include greater detail of the accountability, expectations and trajectories for appraisal compliance. **Action, Rebecca Oakley**.

Finance

James Sabin, Director of Finance, reported the year-to-date £1.9m deficit is on plan and that outline Cost Improvement Plans (CIP) have a larger proportion of recurrent schemes compared to last year. Improvements to Adult Acute Out of Area expenditure were noted, based on a reducing trajectory from 22 to zero beds by the end of March 2025.

James had no concerns in relation to capital and cash stability and highlighted the remaining risks discussed as part of the planning sign-off, including the challenges of the additional observation costs.

	In conclusion, James confirmed the Annual Accounts for 2023/24 have been signed off by the Audit and Risk Committee. Ralph Knibbs, Senior Independent Director, asked for clarification on the agency figures and James explained that the measure is a proportion of total pay and that 3.2% is the national target and the full year plan for the Trust is 3.7% of total expenditure. It was noted that under current VAT legislation, supply of medical services by certain registered health professionals is exempt from VAT, which represents a 20% saving. Mark highlighted that the Trust's agency volume and cost is significantly lower than spend across the system. Tony congratulated James and the team on the successful audit and alignment to plan and remarked that the biggest element is the CIP and the need to demonstrate that the schemes can be safely delivered as defined in the quality impact assessments (QIAs). James confirmed that six have been received and the Forensic and Rehabilitation assessments are awaited. **Action, Arun Chidambaram to contact medic group colleagues in the system to share Trust CIP plans for transparency**. The Board agreed it was difficult to agree the overall assurance level as there is considerable i progress, along with a good deal of challenge. The definitions and options were considered and areas of significant and limited assurance identified. The potential of a Balance Score Card was discussed as an alternative measure and it was suggested this could be explored within a Board Development Session. It was noted that the Board Committee Assurance Summaries also evidence the required governance. **RESOLVED: The Board of Directors:** **1. Recognised consistent progress was being made and embedded assurance and accepted limited assurance on the incremental performance improvements across the areas presented** **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/ 2024/064	**<u>FIT AND PROPER PERSON TEST (FPPT) DECLARATION</u>** Selina presented the Chair's declaration of Board members' compliance against the Fit and Proper Person Test Framework. The Board noted that accountability for taking all reasonable steps to ensure the FPPT is effectively implemented rests with Selina and that the Trust is fully compliant with this annual requirement. Selina drew attention to a technical issue, which has resulted in four members of the Board being covered under supervision waivers, whilst awaiting their enhanced Disclosure and Barring Service (DBS) clearance. **RESOLVED: The Board of Directors:** **1. Received 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. **Noted the compliance against the national Fit and Proper Person Test (FPPT) Framework.**
DHCFT/ 2024/065	**<u>IMPROVING THE WORKING LIVES OF DOCTORS IN TRAINING</u>**

	The report outlined the work that is underway to deliver the tasks set out in the open letter from NHS England, which calls upon trust Boards to take responsibility for the agenda to collectively improve the working and learning experience of doctors in training. Arun Chidambaram, Medical Director explained that the improvements are fully endorsed by Amanda Pritchard, Chief Executive, NHS England, Professor Sir Stephen Powis, National Medical Director, NHS England and Dr Navina Evans, CBE, Chief Workforce, Training and Education Officer, NHS England. It was noted that a task and finish group has discussed a workable plan and Arun proposed that the Trust's Guardian of Safe Working (GoSW), Karny Jawahar, Consultant is a natural fit as the group lead and this suggestion had been supported by the Quality and Safeguarding Committee. Ralph advocated the proposal and commented on the exceptional performance evidenced by Karny, to ensure the Trust is a front runner in terms of policy and process. Arun agreed that the Trust is very pro-active and gave examples of the pre-authorisation of study leave pay and promotion of junior doctors' wellbeing. Selina requested formal thanks to be sent on behalf of the Board in recognition of Karny's work. Tony pointed out that Karny is not an executive and how this might affect the group dynamics. However, Arun responded that much of the requirement is a duplication of Karny's current role. It was noted that overall accountability sits with Arun. **RESOLVED: The Board of Directors:** **1. Supported the proposed task and finish group to deliver on actions 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. Agreed on Karny as lead for the task and finish group, noting the alignment NHS England's planning guidance on strengthening the role of the GoSW.**
DHCFT/ 2024/066	**<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 highlighted that the Committee always has a very productive agenda and pointed out that although the formal CQC report for the April 2024 inspection had not yet been received, significant assurance had been accepted that the Trust is comprehensively addressing the concerns raised. **People and Culture Committee**: The Board noted the progress on the Making Room for Dignity (MRfD) recruitment and Ralph Knibbs emphasised the collaboration with the Finance and Performance and Quality and Safeguarding Committees to scrutinise this, along with the cultural transformation. The Leadership Development deep dive detailed that the accountability framework is built around the Trust Strategy and Ralph enthused at the potential benefits in support of the cultural transformation and the linked approach to Equality Diversity and Inclusion (EDI). Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, questioned the split assurance from the Health and Wellbeing deep dive, and it was noted that although there is a good range of benefits available, the Committee was not assured that people are aware or clear on how to access.

	Selina reflected on a recent conversation with Staff Governors, which had highlighted the challenges for some ward colleagues to find the time or headspace to take advantage of the offering. She suggested bite-sized sessions might be delivered on site. Lynn queried how the success of the leadership development offer is to be measured. Rebecca advised that the specific metrics are being considered and will be reflected in future reporting. The potential for a Balance Score Card was revisited, along with suitable metrics, including reduced turnover and grievances and improved appraisal compliance and the importance of the Trust setting its own standards, linking measures to the staff survey and ultimately the impact on patient experience. **Audit and Risk Committee**: In the absence of Geoff Lewins, Committee Chair, Deborah Good presented the summaries from the two meetings held in May and June. She highlighted the achievements of the Data and Security Team and recognised this is a high performing group, which has been reinforced by the internal auditors. Selina requested formal thanks be sent on behalf of the Board in recognition of the team's efforts. The Board noted the agreed significant assurance received on the processes to produce the annual report and accounts, along with the final Head of Internal Audit Opinion of significant assurance on the Annual Internal Audit. **Finance and Performance Committee**: Much of the subject matter had already been covered during the course of the meeting. However, Tony Edwards had been inspired by James' wider Estate's Strategy work. **Mental Health Act Committee**: Ashiedu Joel highlighted the Mental Health Act (MHA) Managers Report and the improved compliance for the reading of Community Treatment Order (CTO) rights, with the exception of remaining issues within three teams. It was noted that the Patient Experience Report had provided significant assurance that all complaints are investigated on an individual level, resulting in patients feeling safe. The Board discussed the pace and actions around the s132 reading of rights improvement programme and Arun advised a six to 12-month trajectory. Dave added that he is working with David Tucker, Managing Director, Operations, and Ward Managers to review the admissions process, to improve compliance. The Board was satisfied that it is within the Board Committees where much of the scrutiny and challenge takes place, which is an important part of the Trust's governance requirements. **RESOLVED: The Board of Directors noted the Board Committee Assurance Summaries.**
DHCFT/ 2024/067	**<u>REPORTS FOR NOTING ON ASSURANCE FROM BOARD COMMITTEES</u>** **<u>Quality and Safeguarding Committee</u>** <u>Learning From Deaths/Mortality Annual Report 2023/24</u>: Having noted that the Quality and Safeguarding Committee had no concerns with the report's findings, the Board accepted the Annual Mortality Report as assurance of the Trust's approach and agreed for the report to be published on the Trust's website as per national guidance. <u>Guardian of Safe Working (GoSW) Annual Report 2023/24</u>: This report provides data about the number of Junior Doctors in training in the Trust and details the arrangements made to ensure safe working within the new contract.

	Lynn Andrews, Committee Chair, reported that the 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. **People and Culture Committee** Medical Appraisal and Revalidation in DHcFT Appraisal Year 2023/24: The Board received an update on medical appraisal and revalidation activity within the Trust during the 2023/24 medical appraisal cycle. Mark queried the number of doctors that have not completed an appraisal during the cycle. Arun explained that improvements have been made to the process through the implementation of the L2P platform, which allows greater transparency of the appraisal data for individual doctors and will help to improve compliance. Selina suggested it would be useful for future reporting to include information on the exceptions. The Board stressed that the level of compliance was not acceptable and that individuals must accept responsibility for meeting with the requirements and that this will be scrutinised by the relevant committees with additional oversight by the Responsible Officer Advisory Group. The assurance received by the People and Culture Committee was noted and the Board approved submission of the annual medical appraisal compliance report to NHS England.
DHCFT/ 2024/068	**IDENTIFICATION OF ANY ISSUES ARISING FROM THE MEETING FOR INCLUSION OR UPDATING IN THE BOARD ASSURANCE FRAMEWORK (BAF)** No issues were identified.
DHCFT/ 2024/069	**ANY OTHER BUSINESS** Selina announced that this was to be Ashiedu's last Board meeting as she was taking up a Non-Executive Director post with Nottinghamshire Healthcare NHS FT at the beginning of August. Ashiedu gave a poignant acclamation of her experience with DHcFT, dating back to 2019, and stated her delight at the evolution and status of the current Board, along with the significant achievements realised along the way. Ashiedu added that she is honoured and appreciative of the voice she has been afforded and is mindful of the power of advocacy this presents. On behalf of the Board, Selina thanked Ashiedu for her service, tenacity, probing and ability to view situations from an alternative perspective and wished her well for the future.
DHCFT/ 2024/070	**MEETING EFFECTIVENESS** The Chair invited feedback from the Board and also the observers. The meeting closed at 12.30pm.
The next meeting to be held in public session will be held in person on 3 September 2024 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby. **Post-meeting note, change of date - next meeting now 1 October 2024, at 10.00am.**	

ACTION MATRIX - BOARD OF DIRECTORS - OCTOBER 2024							
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
05-Mar-2024	DHCFT/ 2024/031	Position Statement - CQC Domains	Director of Nursing, Allied Health Professions, Quality and Patient Experience	To revise the CQC core standards reports and include forward trajectories for respective performance to meet CQC compliance.	~~01-Oct-2024~~ 05-Nov-2024	In review and new format to be presented at ~~Oct-2024~~ Nov-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	Psychological safety has been incorporated into the Leadership Strategy and is part of team development sessions. Further work is being developed around a bespoke psychological safety measurement at team level to be fed into the leadership assurance received at the People and Culture Committee.	Green
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.	Green
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).	Green
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.	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~~ 16-Jul-2024	Report presented to Quality and Safeguarding Committee 14-May-2024. Additional detail required, therefore a further report scheduled for 16-Jul-2024. Increased oversight now in place.	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.	01-Oct-2024	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. The first set of dates proposed by NHSE were for w/c 08-Jul issued at short notice and were unfortunately not suitable for the required key ICB Finance colleagues. Other dates are being progressed. Increased scrutiny now in place.	Green
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.	30-Jul-2024	Currently being worked on and expected agreement by the end of Jul-2024. The Contingency Plan is included with the MRfD update report for presentation at the People and Culture Committee 30-Jul-2024	Green
07-May-2024	DHCFT/2024/051	Board Assurance Framework	Director of Finance	Review Finance risks in context of deficit.	12-Jul-2024	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. Mark as complete. Awaiting feedback from Finance & Performance Committee on recent updates and changes. At present, remains one key finance BAF risk.	Green
07-May-2024	DHCFT/2024/052	Board Committee Assurance Summaries - Quality and Safeguarding - Patient and Carer	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	16-Jul-2024	Dave to oversee Patient and Carer Strategy through Quality and Safeguarding Committee. To be aligned with Trust Strategy Vikki leading development of the broader Trust strategy, which will be ready for November launch when it goes to Board.	Green
07-May-2024	DHCFT/2024/054	Assurance from the People and Culture Committee - Gender Pay	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.	Green
02-Jul-2024	DHCFT/2024/062	Chief Executive's Report	Deputy Chief Executive	Neuro-developmental Service Memorandum of Understanding (MoU) - to include clarity on ownership of accountability for equipment.	22-Jul-2024	The MoU is currently being updated by Libby Runcie and a specific line about equipment will be added.	Green
02-Jul-2024	DHCFT/2024/063	Integrated Performance Report (IPR) - Operations, MADE	Deputy Chief Executive and Chief Delivery Officer	Recovery Action Plan to underpin sustainability of the MADE to go through the Finance and Performance Committee	23-Jul-2024	Agenda item at Finance and Performance Committee 23-Jul-2024.	Green
02-Jul-2024	DHCFT/2024/063	Integrated Performance Report (IPR) - Operations, Living Well	Deputy Chief Executive and Chief Delivery Officer	Include caseload/capacity size and timescales on the data provided.	01-Oct-2024	Reporting now updated to include the requested information and will form part of the IPR going forward.	Green
02-Jul-2024	DHCFT/2024/063	Integrated Performance Report (IPR) - Quality	Interim Director of Nursing and Patient Experience	Increased Datix incidents. Deep dive to investigate if the Trust is taking sufficient action to reduce incidents of violence and aggression towards staff, attributed to a small group of patients.	14-Aug-2024	Escalated to Quality and Safeguarding Committee 14-Aug-2024	Green
02-Jul-2024	DHCFT/2024/063	Integrated Performance Report (IPR) - Finance, Cost Improvement Plans	Medical Director	Trust CIP plans to be shared with medic group colleagues in the system for transparency.	04-Sep-2024	Awaiting further CIP plans to be reviewed through QEIA process. Thereafter, plan to share at Medical Senate 4-Sep-2024.	Green

02-Jul-2024	DHCFT/2024/063	Integrated Performance Report (IPR) - People, Appraisal Compliance	Director of People, Organisational Development and Inclusion	Future reporting to include greater detail of accountability, expectations and trajectories for appraisal compliance.	01-Oct-2024	Included in the IPR from October onwards	Green
02-Jul-2024	DHCFT/2024/066	Board Committee Assurance Summaries - People and Culture	Director of People, Organisational Development and Inclusion	Future reporting to include specifics of how the impact of the leadership development offer is to be measured, accountability, expectations and trajectories.	01-Sep-2024	To be fed into People and Culture Committee as art of regular reporting on Leadership Development and included as appropriate within the IPR	Green

Key:	**Action Overdue**	RED		**0**	**0%**
	Action Ongoing/Update Required	AMBER		**0**	**0%**
	Resolved	GREEN		**17**	**94%**
	Agenda item for future meeting	YELLOW		**1**	**6%**
				18	**100%**

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 1 October 2024

Chair's Update

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 2 July 2024. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. On 10 July, I attended the staff network conference. The theme for the conference was 'Raising the bar, let's talk inclusion'. Guest speaker was Caroline Paige, the first transgender officer who served openly in the UK military for 16 years after transition – it was an inspiring story of courage, the importance of allies and personal tenacity. We have asked Caroline to return to do some further engagement with the Trust.
2. I also paid a visit to High Peak Community Mental Health Team and High Peak Neighbourhood Team with Mark Powell on 10 July. We heard about the challenges of providing a service in rural communities. We were pleased to hear about the steady progress being made with implementing Living Well.
3. On 12 July I met with Les Ralph, joint Chair of Equal. We discussed the stigma associated with mental health in BAME communities and the impact this has on early access to mental health services and what steps the Trust can take to improve engagement with our BAME communities.
4. On 17 July, I was pleased to host Kathy McLean, Chair of the Integrated Care Board (ICB) within the Joined-Up Care Derbyshire (JUCD Integrated Care System) at our Carsington Unit. She was impressed with the scale of the development and recognised the journey the Trust has been on in securing the finances with the support of ICS partners.
5. The Pharmacy team hosted a visit from the General Pharmaceutical Council (GPhC), the regulator of Pharmacists, Pharmacy Technicians and pharmacies on 24 July. We were pleased to host Gisela Abbam, Chair, Duncan Rudkin, Chief Executive and Dionne Spence, Chief Enforcement Officer and Deputy Registrar. This visit was at my invitation and Steve Jones, Chief Pharmacist, and his team provided a thought-provoking presentation on pharmacy in a mental healthcare provider trust and some of the challenges in the regulatory interfaces between primary and secondary care. The GPhC will be looking at the implications of the issues we raised and whether there needs to be any adjustments or changes to existing regulation. My thanks to Steve Jones and Arun Chidambaram for their work.
6. On 25 July I visited the Radbourne Unit. I enjoyed the time I spent with staff colleagues, student nurses and occupational therapists and patients on Wards 31, 32, 33, 34, 35 and 36. I received reassurance and assurance regarding the changes that are being put in place following CQC visits. The openness and confidence of junior colleagues and students particularly impressed me. They spoke of feeling empowered and listened to by team leaders and managers. I would like to thank Lisa Stanley, Manager and Kyle Dean, Team Leader for their time and who were mentioned by colleagues for their support and encouragement of staff.

7. On 6 August, Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, and I visited Peartree Health Centre and the health visiting and children's addiction services. The commitment and the dedication to serve their patients and service users was admirable. We spoke to the Health Visitors and Family Support Workers. They confirmed the rising need and associated risks in the communities they serve. My thanks to Danielle Nicholson, Deputy Area Service Manager, for taking us around and providing an informative update on the services.
8. I joined the Armed Forces staff network on 9 September. The work of the network has developed and much of it has been innovative with wider partnership and engagement from many stakeholders. The work and partnerships we have gained wider recognition and resulted in the joint leads, Gemma Saunders and Mel Dyke being shortlisted for two awards, Step into Health Award (NHS Confederation) and HSJ Award under the Military and Civilian Partnership category.
9. I met the Trust Library team on 10 September and learned about the work they do support individuals and services. We discussed how we can strengthen our approach to evidence-based decision making and the opportunity to commission research to support the board in delivering the Trust's new strategy.
10. I'm pleased to confirm that two of our consultants, Dr Rais Ahmed and Dr Subodh Dave, were shortlisted in two award categories in the APNA (Asian Professionals National Alliance) Awards. Dr Ahmed was shortlisted in the Mentoring and Coaching Champion category and Dr Dave for his work with Doctors in Distress in the working with the Voluntary Community Sector category.

Council of Governors

11. The Governor Nominations and Remuneration Committee was held on 24 July. The agenda included Non-Executive recruitment and also reappointment of a Non-Executive Director.
12. For some time now, the Governors have expressed interest in learning more about the Integrated Care System. On 31 July, our Governors joined other governors from the Joined-Up Care Derbyshire system. Our Governor presence was strong and the event provided an opportunity to hear from ICS Chair, Kathy McLean and Richard Wright, ICS Non-Executive Member Lead on Patient and Public Engagement as well as from other governors.
13. On 5 August, I held a virtual governors coffee session followed by a face to face catch up with Governors on 6 August.
14. The Governance Committee met on 6 August, chaired by David Charnock and are due to meet again on 15 October. The Committee received plans for the Annual Members' meeting, which was held on 26 September, feedback from the engagement activities, including recent quality visits, Governors' annual effectiveness survey and Governor training and development, as well an update on the new Trust Strategy.
15. I had my bi- monthly meeting with Lead Governor and Deputy Governor Susan Ryan and Hazel Parkin on 16 September. These meetings are mutually beneficial and ensure our ability to share and resolve matters quickly and ensure robust governance.
16. The Council of Governors meeting took place on 3 September. It was chaired by Tony Edwards, Deputy Chair. The Governors received the Annual Report and Audited Accounts for 2023/24. This is a statutory function of the Council of Governors as is the approval of Non-Executive Director (NED) reappointments. The Governors approved Deborah Good's second term, following a successful 360-degree appraisal. Deborah chairs the Mental Health Act Committee and is Board lead on sustainability and carers. Her second term of three years commences in March 2025.

17. I had my catch-up with the staff Governors on 10 September. These meetings provide an invaluable temperature check on how the Trust feels from a colleague perspective and how corporate communication and priorities are received by colleagues.

18. The next Council of Governors meeting will then be on 5 November. The next Governance Committee takes place on 15 October 2024.

Board of Directors

19. On 16 July, an extraordinary Remuneration and Appointment Committee was held to discuss some board changes.

20. On 17 July, the Board engaged with primary care colleagues to understand the Derbyshire Primary Care Model, we reflected on the implications to the development of the Trust Strategy. We received an update on equality, diversity and inclusion (EDI) and EDI priorities.

21. A further Board Development session was held on 18 September. The Board reflected on the Darzi review, which focuses on a need to shift the way the NHS currently operates if the NHS is to survive for future generations, the current model is not working and is not sustainable. The Secretary of State has distilled this down to three big shifts the NHS needs to make. These are: a shift from treatment to prevention, a shift from acute to community and a shift from analogue to digital.

22. I have also continued to meet with all NEDs individually on a quarterly basis. In the last quarter I have met with Deborah Good, Tony Edwards, Ashiedu Joel, Ralph Knibbs and Lynn Andrews. We use these quarterly meetings to review progress against their objectives, any developmental needs and to discuss any issues of mutual interest.

System Collaboration and Working

23. On 15 July, I paid a visit to incontinence services with Julie Houlder, Chair at Derbyshire Community Health Services (DCHS) Foundation NHS Trust 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. We are arranging reciprocal visits to Derbyshire Healthcare Services for Julie.

24. The Derbyshire CEOs and Chairs met with Kathy McLean, ICS Chair and Chris Clayton, ICS CEO on 31 July, to discuss post-election messages for the NHS from the newly elected Government.

25. On 2 September, Mark Powell, Chief Executive, and I met online with Chris Clayton and Kathy McLean. We discussed mutual priorities and areas of concern.

26. 10 September Chairs and CEOs catchup – DCHS and our Trust held a four-way meeting with Julie Holder, DCHS Chair and Tracy Allen CEO, DCHS to discuss areas of concern and synergy between our two organisations. Mark and I also said goodbye to Tracy Allen, as it was her last day with the NHS after a long and successful career. The experience and wisdom that Tracy bought to the system will be sorely missed by all.

27. I attended the JUCD chairs and Local Authority Leads meeting with ICB Chair, Kathy McLean on 23 September. We discussed areas of challenge being experienced by individual trusts and our current priorities. The four themes of our discussions included - our people and creating a sense of belonging, Children and 0-19 services, health inequalities and emergency services/flow. There was broad agreement that there was value in further exploring these themes.

Regulators, NHS Providers and NHS Confederation and others

28. I attend fortnightly briefings from NHS England for the Midlands region, which has been essential to understand the challenges and expectations of provider Trusts, for example the changing environment and drivers of the new Government.

29. 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.

30. On 3 July, as a Trustee of NHS Providers, I attend the NHS Providers Board meeting in London. The agenda covered the NHS Providers Strategy and work plan and the changing environment with a potentially new Government.

31. On 29 July, the NHS Confederation Chairs Group met and we were briefed on the new Government's early priorities and expectations of the NHS.

32. On 22 August I attended NHS Confederation's Patient Public Reference Group which is gathering best practice on initiatives to address disproportionate outcomes for BAME patients in mental health services. Our emerging work with the Patient and Carers Race Equality Framework (PCREF) will assist in this space.

33. On 4 September, I attended the NHS Providers Board meeting online.

34. On 11 September, I was very generously hosted by David Sallah, Chair of Birmingham Community Health Trust and members of his executive team. The team shared their journey in establishing and leading the Birmingham Community Providers Collaborative and how they were able to establish multidisciplinary community neighbourhood hubs, using the Sure Centre estate infrastructure which the Local Authority transferred to the Trust. They also shared their work on major transformation programmes, including developing commercial work to fund their community provision.

35. The Trust was well represented at the APNA Conference held on 13 and 14 September. I also took part as a panel member.

The conference was stimulating and offered a safe space for colleagues to learn and share experience, knowledge and expertise.

36. On 23 September the NHS Confederation Chairs Group met online. The focus was on prevention, and we heard from PWC and their work on the future of how we care for ourselves. We also heard from Bedfordshire ICB and the work they have embarked on in addressing health inequalities using a bottom–up approach, community led research and community engagement supported by strong visible leadership from the Integrated Care Board and Integrated Care Partnership.

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 with 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 – 1 October 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. 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

New Government

A new Government is in place since the Board of Directors last met in public, following the general election that took place on 4 July. All MPs across Derby and Derbyshire now represent Labour.

Early messages from the new Government confirm there is no new money available, alongside an expectation to deliver current financial plans. An independent investigation into NHS performance has been commissioned, with a particular focus on assessing patient access to healthcare, the quality of healthcare being provided and the overall performance of the health system. The review, being undertaken by Professor Ara Darzi, reporting in September 2024 (see below).

The new Chancellor has announced the launch of a multi-year spending review, and an autumn budget on 30 October.

The King's Speech outlined priorities for the coming year, with key health announcements, including a new Mental Health Bill, alongside a number of reforms to mental health services. We are also now implementing the public sector pay award, which was announced in August.

In July, I wrote to all Derby and Derbyshire MPs, many of whom were newly elected, to provide an update on the Trust's activities and priorities. I have also made an open offer for all local MPs to visit the Trust's new facilities in Derby and/or Chesterfield, and I am pleased to confirm that several MPs have already planned to visit the Trust.

Lord Darzi Review

Lord Ara Darzi has published his initial report into the issues facing the NHS. This will shape the development of a new 10-year plan for the NHS, which is due next year. The report highlights key issues, including a lack of funding and capital investment, alongside increased demand for services and high levels of regulation.

Themes in the report include:

- The importance of engaging staff and empowering patients
- Shifting care closer to home and adapting services to meet the needs of people with long-term conditions
- Embracing new multi-disciplinary models of care that bring together primary, community and mental health services

- Driving productivity in hospitals; improving flow, reducing waiting times and better operational management
- Technology is key to unlocking productivity
- The role of the NHS in contributing to the nation's prosperity
- Clarification of roles and accountabilities, ensuring the right balance of management resources and strengthening key processes such as capital approvals.

The report outlines the positive difference staff make to patients every day, and how staff engagement will be central for moving these priorities for the NHS forward. There is also significant alignment to the priorities outlined in our new Trust Strategy, which we will consider more over the coming weeks.

The findings of the Darzi report will inform a new 10-year plan for the NHS. As part of this plan, Wes Streeting, Secretary of State for Health and Social Care, has outlined his commitment to three 'big shifts':

- From hospital to community care.
- From analogue to digital.
- From treating sickness to preventing it.

I will continue to keep colleagues updated on these national developments over the coming months.

GP Partners Contractual Strike Action

The outcome of a ballot by the British Medical Association (BMA), confirmed that from Thursday, 1 August, GP Partners would be taking action short of a strike. This means that some GP Partners are now 'working to rule' and only delivering core contractual requirements, for an indefinite period of time.

The impact of this action on our services remains unclear but will be monitored on an ongoing basis to ensure there is no negative effect on flow through and accessing our services. While there may be some disruption to services, practices will remain open as usual and patients can make requests by phone, online or by walking in.

The Trust is monitoring the situation alongside system partners and through our local incident management approach.

Covid Inquiry

The first of many reports looking at how the UK responded to the COVID-19 pandemic was released in July, which highlighted inadequate pandemic planning at a national level. Lessons learned will inform our emergency preparedness, resilience and response (EPRR) processes.

Review of Community Mental Health

As required in the 2024/25 planning guidance, Joined Up Care Derbyshire (JUCD, the Derby and Derbyshire Integrated Care Board – ICB) has commenced its local review to ensure there are clear policies in place to meet the needs of people in Derbyshire with severe mental health illness. To support the review, NHS England has recently issued guidance on intensive and assertive community mental health treatment which outlines that the reviews should be used as an opportunity to reflect on the community provision in place for people with severe and relapsing mental illness, and in particular the specific actions services need to take to ensure people are receiving and engaging in the care they need.

The guidance is based on learning from the incident in Nottingham last year, with safety as the pivotal consideration.

For example, it has been made clear that 'Did Not Attends' (DNA) should not be used as a reason for discharge from care for this vulnerable patient group and JUCD has carried out a rapid check of existing service polices and practice to ensure they are clear on this issue.

Although the review is being led by JUCD, they are working closely with us and other partners and will involve patients who have lived experience of using these services, to ensure that learning is as open and honest as possible and can inform improvements to local services. The deadline for submission of the review template is 30 September. Our submission identifies several gaps in service provision that will need to be discussed in more detail with the ICB.

National Recommendations for NHSE

Following the CQC's publication of the final part of its special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust (NHFT), Wes Streeting, Health and Social Care Secretary, has called for the review's recommendations to be implemented across the country, including the following recommendations to NHS England:

- Ensuring that **providers' boards fully understand their role in the oversight** of the needs of patients who have serious mental illness and who find it difficult to engage with services. This includes **developing local services in partnership with others** to provide intensive support to prevent this cohort of patients from falling through the gaps.
- **Ensuring every provider and commissioner in England undertakes a review of the model of care in place for patients with complex psychosis** who typically services struggle to engage and who present with high risk (see above)
- Within the next 12 months, **providing evidence-based guidance setting out the national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia**. Within three months of its publication, ensuring every provider and commissioner develops and delivers an action plan to achieve these.

As well as implementation of these recommendations, the CQC has begun work to look in detail at the standard of care in community mental health across the country to fully understand the gaps in the quality of care, patient safety, public safety, and staff experience in community mental health services. They are also working with NHSE to improve data on the quality and safety of community mental health services.

As outlined above, NHSE have issued guidance on intensive and assertive community mental health treatment. We also expect new waiting times data to be released in the autumn and national focus on reducing long waits.

NHS Providers – Guide for Good Governance in the NHS

The first chapter of the above guide *Effective boards: why boards?* has been recently revised to provide further support for Trust leaders. The guide is available on the NHS Providers website www.nhsproviders.org/topics/governance/a-guide-to-good-governance-in-the-nhs..

Mental Health 111

Access to crisis mental health support is now available via NHS 111, as part of a national development to make it easier for people to contact their local mental health helpline team, without having to remember or search for a helpline number.

This update includes our local Derbyshire Mental Health Helpline and Support Service, which can now be accessed by calling 111 and selecting the 'mental health option', option 2.

The support offered by the helpline remains unchanged, with the team providing urgent mental health support to local people. GPs and other primary care professionals will continue to refer all non-crisis mental health referrals through the usual routes.

Regional and Local Context

Joined Up Care Derbyshire (JUCD) newsletters.

Bi-monthly JUCD newsletters provide important updates on health and care developments around the City and County, I would recommend subscribing here where you can also view past copies.

Mental Health, Learning Disabilities and Autism Delivery Board

As part of a review of the role of the system delivery boards, I have stood down as Chair of the Mental Health, Learning Disabilities and Autism Delivery Board and it will now be chaired by Professor Dean Howells, Chief Nurse at JUCD. Vikki Ashton Taylor, our Deputy Chief Executive and Chief Delivery Officer, will be Vice-Chair, ensuring that the Trust continues to be involved in developing solutions collaboratively, an example of this is our involvement in the new three-year Mental Health Inpatient Strategic Plan that aims to bring together all the key projects – and partners – that are focused on the improvement of these services. These strategic aims will be complemented by the opening of our new acute inpatient facilities in Chesterfield and Derby in the months ahead.

Response to Derbyshire County Council's consultation on the proposed redesign of residential care and day opportunities for older people (adult care)

The Trust has recently contributed to the ICB response to the above consultation, which has been shared with the Board and our Governors.

Our Trust and Staff

National Oversight Framework (NOF) Change of Segmentation

From Quarter 1 of 2024/25, the Trust has been placed into NOF Segment 3. This is based on the ICB's assessment of the Trust's delivery against the performance measures set out in the NOF and, within Joined Up Care Derbyshire, is the same rating as University Hospitals of Derby and Burton and the overall system rating. The Trust was previously in Segment 2 (the default segment unless the criteria for moving into another segment are met).

We are clearly disappointed with this decision but given the significant challenges the Trust is facing, we accept the requirement for additional support and oversight from the ICB and NHS England.

In practical terms, mandated support will see future review meetings jointly chaired between the ICB and NHSE and held more frequently. An important factor in this process will be to jointly agree the exit criteria and improvement plan against the areas flagged around quality, operational and financial performance.

The NOF is being refreshed and a new version will be published shortly so we await what that would mean in the current context.

Annual Staff Awards

Nominations for the **HEARTS Awards** have been coming in, with entries welcomed from partners and/or members of the public. There are various categories available for the achievements of Trust staff to be recognised. The nomination form, accessed via the Trust website, remained open until Friday, 13 September, and our Awards event is taking place on 20 November 2024.

Staff Engagement

I have continued to get out and about to see our colleagues and service users at the following sites:

9 July – Bayheath House, Chesterfield

10 July – High Peak Neighbourhood Team, Corbar View

11 July – Hartington Unit, Chesterfield

2 August – Radbourne Unit, Derby

17 September – Century House, Long Eaton

17 September – Killamarsh Team, Sheffield

24 September – Cubley Court, Kingsway

Engagement activities

- **Derby and Derbyshire Deaf Mental Health Forum visit**

The Derby and Derbyshire Deaf Mental Health Forum visited Kingsway in July to tour the Carsington Unit and Kingfisher House. The group offered real insight into the expectations and requirements of deaf service users and constructively challenged us in many areas of the new builds.

This included prior experiences of inpatient intercom systems without video functionally, flashing alarms and vibrating beds.

- **Derby Caribbean Carnival**

The Trust's Engagement team participated in the Derby Caribbean Carnival in July, which is annually organised by the Derby West Indian Community Association. The team had some valuable conservations about improving access to mental health services, our new healthcare facilities and recruitment. This included promotion of the Trust's upcoming job's fair in October, with secondary school teachers and Junior Doctors taking an interest in attending.

NHS Birthday

The NHS celebrated its 76th birthday on 5 July. Colleagues joined the celebrations by taking part in Park Runs, wearing blue and we also celebrated the **League of Friends Summer Fayre** on 6 July. Sunday, 7 July, was the fourth annual **Thank You Day**. I know we receive many messages of thanks for the support we offer to people and their families each day and I took the opportunity to reflect this by saying a huge thank you to every person who works for and supports the Trust for all they do.

Recent Achievements

Congratulations to:

- **Ben Milward**, Lead Nurse for the Crisis Resolution and Home Treatment Team, who was July's DEED of the month winner. Ben was celebrated for the support he provided to an individual wanting to settle into community life after struggling with their mental health

- **Leah Stead**, Registered Nurse on Ward 35 at the Radbourne Unit, who was June's DEED of the month winner. Leah was nominated for "showing perseverance, determination, and dedication" when locating a patient who had left the unit. Leah ensured this patient returned to the unit safely and did so in a calm and methodical way. Thank you and well done, Leah!
- **Vicky Swinard, Administration and Secretarial Support Manager at the Radbourne Unit who (alongside wider admin colleagues at the Unit)** won 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
- **Dr Subodh Dave and Dr Rais Ahmed** who were both been shortlisted in this year's APNA (Asian Professionals National Alliance) Awards. The awards celebrate Asian colleagues and those who support equality, diversity, and inclusion work to break through the glass ceiling and visibly make a difference to the NHS and its diverse workforce.

  Subodh was shortlisted in the **Outstanding Contribution in the Voluntary or Charity Sector category** for his achievements carried out as Trustee of Doctors in Distress to help raise awareness on suicides in healthcare. Rais Ahmed was also shortlisted for an award under the **Mentoring and Coaching Champion category** for his contributions towards his workforce, improving training, development and financial outcomes for staff and the Trust as a whole. Best of luck to both nominees who find out if they have won at an award's ceremony taking place later in September
- The **Icare programme team** who have been shortlisted for two awards. This includes a national HPMA Excellence in People Award for supporting the emotional, educational and wellbeing needs of newly employed Healthcare Support Workers (HCSWs) and a national Nursing Time's Workforce for the team's innovative efforts to support HCSWs of all disciplines, who work with people that access mental health services. Good luck to the team for both awards
- **Lynne Woodroffe** Specialist Dementia Support Worker at Derbyshire Healthcare NHS Foundation Trust, who was presented with a Chief Nursing Officer Award for providing compassionate and person-centred care to dementia patients, particularly for supporting a patient who was declining in health
- **Toby Marandure** who has been shortlisted in the national BAME Health and Care Awards for his efforts to deliver strong leadership and mentoring, as well as addressing health inequalities to improve health outcomes for patients
- **Sue Earnshaw**, Area Service Manager for our 0-19 Service, and **Vicky Hulland**, CAMHS Trainee Advanced Clinical Practitioner, who have both recently been named as Queen's Nurses by the Queen's Nursing Institute. Only a small number of community nurses are chosen each year for this honour, so this is a fantastic achievement which recognises their contribution to both patient care and the nursing profession. Congratulations to Sue and Vicky on being selected
- Our **joint NHS Armed Forces Community Staff Network** (alongside Derbyshire Community Health Services) and its co-chairs, Gemma Saunders and Mel Dyke, who have been shortlisted in the Military and Civilian Partnership category at the HSJ Awards for their efforts to enhance opportunities for the Armed Forces community. Thank you to Gemma Saunders, who left the Trust this summer.

Wider News

The **Derby Drug and Alcohol Recovery Service** has put together a digital pack to promote its work, including information for service users, explaining what the service provides and how to access it, which can be downloaded by GPs and given to patients in place of having physical paper leaflets in waiting rooms.

A second digital leaflet is also now available for professionals and details the services available and how to refer a service user. Two videos have been designed to appeal to the public with a quiz format and simple details of the service and how to find out more or how to self-refer. As well as being sent out to all the GP surgeries in the city, there are plans to send the videos out to other places, including universities and council offices, to try to extend our reach.

Our **South Derbyshire CAMHS team** hosted a peer-led review of the service – and received very positive initial feedback. The team welcomed CAMHS professionals from across the country for a QNCC (Quality Network for Community CAMHS) peer review, which looked at several key areas including referral and assessment, quality of care and partnership working.

While the full report won't be published for a while, the informal feedback from the review team was very positive about the level of participation by experts by experience through all elements of the service; there was particular praise for the CAMHS Advisory Board, which holds senior leaders to account over service developments, while the CAMHS Participation team has been asked to present at a QNCC event in October.

The review team was also complimentary about the environment at Temple House, where multiple teams are based together, and about the day service and the activities it offers. Well done to everyone involved.

In June we held a **Jobs Fair** in Chesterfield, promoting opportunities to join the Trust in the new Making Room for Dignity facilities in Derby and Chesterfield. More than 200 people registered to attend the event and I'm pleased to hear there was a high level of interest in working for Derbyshire Healthcare. A further event is scheduled to take place in Derby during October.

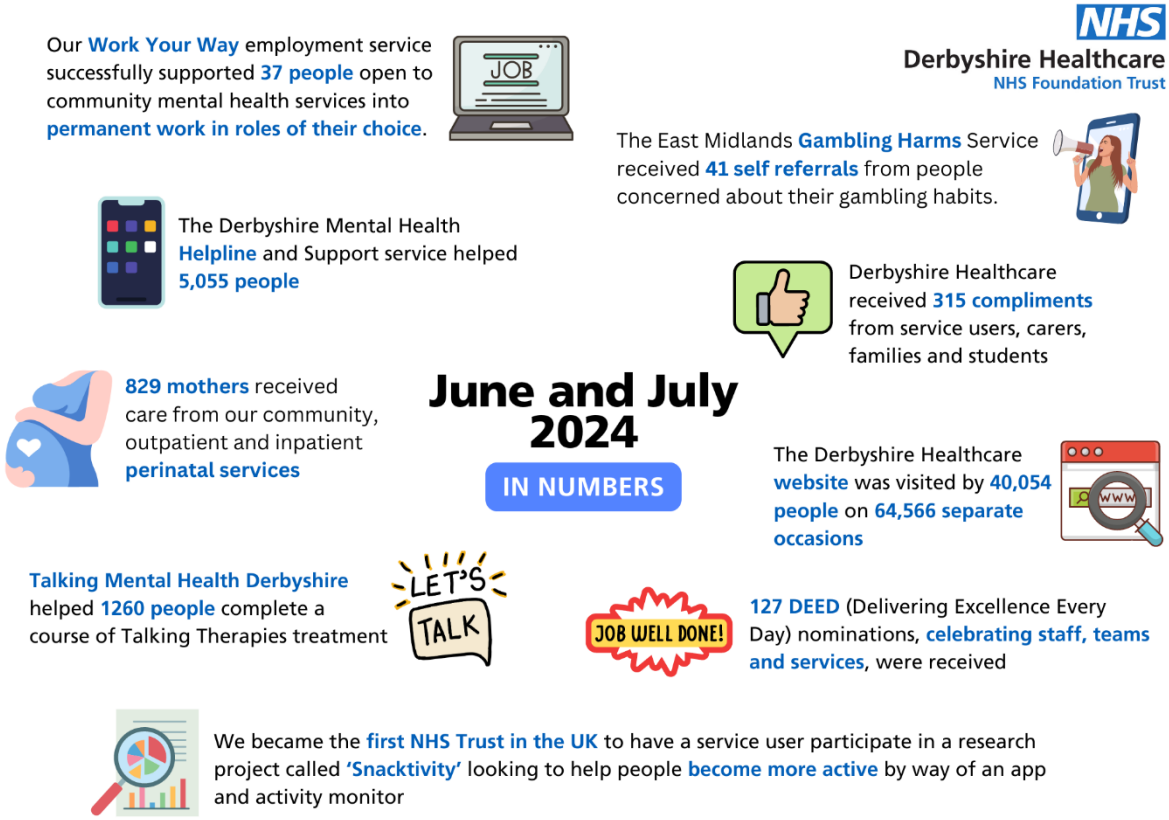
Raising Awareness

South Asian Heritage Month took place between 18 July to 17 August, with the theme this year being, 'Free to be me'. I enjoyed reading about the experiences of South Asian colleagues within the Trust, including Drs Sowmya Maiya, Abbas Ramji, Rais Ahmed and Arun Chidambaram.

Given the theme and our approach to recognising South Asian Heritage Month this year, I also wrote a short blog that talked about my own South Asian (Anglo Indian) heritage and why this is an important month for me.

We have also recently recognised and provided information on International Non-Binary People's Day, Carers Week, Pride Month, Men's Health Week, World Breastfeeding Week and Disability Awareness Month.

Trust Activity



Developing our new Trust Strategy

Engagement sessions have continued over recent months, focused on the development of a new Trust Strategy. Starting in February 2024, colleagues, governors, and patient/carer/ service user representatives have discussed various topics including the Trust's vision, values, culture, brand identity and strategic priorities. All feedback has been collated and analysed and made a direct role on the development of the new Trust Strategy. Following feedback, a new Personal Accountability Framework has also been developed.

A draft of the completed Strategy document is currently being finalised before it is shared for final comments during September/October. This will also provide an opportunity to engage with partners and voluntary and community sector organisations about the new Trust Strategy, which we were unable to do earlier in the year as planned, due to the pre-election guidance that was in place ahead of the general election.

Following these final steps in engagement, the Trust Strategy will be taken to the Trust's Board of Directors meeting in November.

Board of Directors and Council of Governors

Board Changes

I am pleased to confirm that Tumi Banda (pictured) has been appointed as the Trust's substantive Director of Nursing, AHPs, Quality and Patient Experience, following a recent national recruitment process.

Tumi commenced in post on Monday, 16 September 2024. Tumi was previously the Trust's Interim Director of Nursing and Patient Experience in 2022/23 and he joins the Trust from his current role as Interim Director of Nursing at Essex Partnership University NHS Foundation Trust. I am very much looking forward to Tumi joining the Trust and Executive Team.

I would like to take this opportunity to say thank you to Dave Mason, who has been the Trust's Interim Director of Nursing and Patient Experience between October 2023 and August 2024. Dave joined the Trust at a time of change and has helped provide much needed stability and leadership.

Thank you also to Michelle Bateman, Executive Director of Nursing, AHPs and Quality at DCHS, who provided short term Executive Director of Nursing cover for five weeks, bridging the gap between Dave and Tumi's leadership.

Following the departure of Ashiedu Joel, the Trust is currently working in partnership with Nottinghamshire Healthcare NHS FT, to recruit to the Non-Executive Director vacancy.

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

Risks and Assurances

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

Feedback from staff, people who use our services and members of the public is being reported into the Board.

Consultation

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

Governance or Legal Issues

This report describes emerging issues that may become a legal or contractual requirement for the Trust, and potentially impact on our regulatory licences.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

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

Recommendations

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

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

Integrated Performance Report (IPR)

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 August 2024. The report focuses on key finance, performance, and workforce measures.

Executive Summary

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

Operational Performance

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

Most challenging areas

- Waiting times for adult autistic spectrum disorder assessment – **demand continues to outstrip capacity**, resulting in increasing waits of two years plus. However, the excellent work by the team has resulted in greater volume of assessments being completed which is starting to make a positive difference
- Community paediatric waiting times remain high – **pathway issues and high levels of demand**
- NHS Talking Therapies waiting times from first to second treatment are increasing
- 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, with the prevalence of dementia predicted to increase significantly by the end of the decade**
- Inappropriate out of area placements and inpatient bed occupancy. **The inappropriate out of area positions for acute and psychiatric intensive care unit (PICU) have both reduced in recent months, following a sustained period of being significantly high**.

Most improved areas

- The number of adult autistic spectrum disorder assessments completed each month has increased significantly for the last 12 months and **after five months of the annual target has been exceeded by 24%**
- The psychological services waiting list continues to reduce significantly
- Significant improvements to the Child and Adolescent Mental Health Service (CAMHS) waiting times have been sustained
- NHS Talking Therapies six-week referral to treatment has significantly improved and **the target has been achieved** for the past five months
- The NHS long-term plan targets for dementia diagnosis, perinatal access, and community mental health access were all achieved once more
- The individual placement and support service continues to support increasing numbers of people into employment.

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.

Regional comparison

- NHS Derby and Derbyshire Integrated Care Board (ICB) is performing favourably against a number of long-term plan targets to which the Trust contributes, when compared with other ICBs in the region: dementia diagnosis, children and young people contacts, adult community mental health contacts and perinatal access. Inappropriate out of area placements remain challenging, with Derby and Derbyshire having the second highest level in the region.

Finance

At the end of August, the year to date (YTD) position is a deficit of £3.8m which is on plan.

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

Current financial risks to deliver the planned deficit:

- 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 patient with complex needs
- Management of agency expenditure within budget
- Management of any new emerging cost pressures.

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.

Following the planned, stepped increase in the savings target from July, YTD efficiencies are behind plan by £0.4m. Work continues in progressing sign-off of the project initiation documents (PIDs) and quality and equality impact assessments (QEIAs).

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 £3.1m which is above plan by £0.3m. This includes £1.1m of additional costs to support a patient with complex needs, which ceases at the beginning of September. Excluding this additional support, agency expenditure would be below plan by £0.9m.

Business as usual agency expenditure (excluding the patient with complex needs and zonal observations) has been reducing from August 2023 but started to increase back up throughout May, June and July. However, there has been an improvement again in August.

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 August, remains at 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

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. In addition to this, the plan also included a further six block beds for part of the financial year.

At the end of August, total expenditure is £3.6m which is £0.7m above plan.

Capital Expenditure

Capital expenditure at the end of August is slightly below plan by £0.2m.

It is important to note that the BAU plan includes the 5% planning assumption, which will need to be managed down in year. The capital plan for 2024/25 also includes £4.8m of national funded capital in relation to the Making Room for Dignity Programme.

Cash

Cash at the end of August is at £21.1m (£21.0m last month) which is below plan by £4.9m. This is due to the phasing of payments year to date related to the Making Room for Dignity Programme, with cash forecast to hit the plan of £19.1m at the end of the financial year.

People

Annual appraisals

Appraisal compliance continues to remain high at 88.26% against a target of 90%. However, there has been a slight decrease in compliance during the month of August. Low compliance continues to remain a particular challenge within Corporate Services and efforts continue to address both appraisals that are out of date and those coming up for renewal.

Annual turnover

Overall turnover continues to remain in line with national and regional comparators and has remained below the Trust's 12% upper tolerance for the last two months.

Compulsory training

Overall, the 85% target has been achieved for the last 24 months. Operational Services are currently 92% compliant and Corporate Services is at 87%, both maintaining the same compliance since the last reporting period. Whilst overall compliance of the 20 individual training elements remains high, there has been a challenge with one mandatory training element which is below target. However, it is an improved picture compared to the reporting period when two training elements where below target. Plans remain in place to work towards bringing the outstanding training element back within target.

Staff absence

The annual sickness absence rate is running at 6.16% and compared to the same period last year it is 0.03% higher. Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by surgery and other musculoskeletal problems. One of the key factors for the increase in overall sickness absence, is an increase in short-term sickness, which is unusual for this time of year. Cold, Cough, Flu is the fourth highest reason for absence and other trusts in the region have also noted an unusual increase in short time absence.

Proportion of posts filled

At the end of August, 88% 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 and continues to fall following a temporary increase in agency usage 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 81% (a decrease of 1% since the last reporting period) and management supervision at 84% (no change since the last reporting period). Following the audit of supervision processes, the Trust is now following up on the recommendations which will help 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

The number of compliments recorded between May and August 2024 range from a high of 181 to a low of 74. In relation to patient feedback, there are over 100 teams (including sub-teams) that are live on the Electronic Patient Survey platform, with over 700 patient feedback responses across the teams received to date. This is currently undergoing an evaluation which will be presented in September to the Trust Leadership Committee with recommendations in relation to what resource will be required to ensure the sustainability of the project.

Complaints

From 1 April 2024, to resolve matters at the earliest opportunity the Trust has implemented a new process to resolve complaints categorised as “quick resolution” within 10 working days via a Service Manager, with responses being provided directly to the complainant either verbally, in person, by email or by letter. If it is not possible to resolve the concern like this, a “closer look investigation” is commissioned with a timeframe of 40 or 60 working days to resolve.

Owing to complaints now being re-categorised as quick resolution and closer look, it is not possible to compare any data prior to April 2024. This will be resumed in the next report. In August 2024, there have been 11 quick resolution complaints and 19 closer look complaints received by the Trust.

Clinically ready for discharge (CRD)

The proportion of service users meeting the criteria of clinically ready for discharge (CRD) has continued on a downward trajectory that has reduced from 12% to 9% between May and August 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’s Strategic Integrated Flow Lead chairs a weekly meeting designed to improve flow, which includes social care and Voluntary, Community and Social Enterprise stakeholders.

The System priorities identified from the Discharge Planning Implementation Group are to achieve continuity and coordination of care, reduce avoidable length of stay and improve flow and access to local beds.

Employment and settled accommodation

Patients open to the Trust in settled accommodation has remained static at 49% between May and August 2024 and the number of patients open to employment has continued to remain between 12% and 13% 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 increased from 72 to 80 (11%) and continues in line with common cause variation and under the mean of 90. It should be noted that the medication incidents reported are largely of low-level harm.

The number of falls recorded between May and August 2024 has decreased by 46% from 46 to 22.

The Number of Datix incidents occurring recorded as moderate at catastrophic harm have decreased by 32% between May and August 2024 from 76 to 52 incidents.

Analysis suggests that this is due to a sustained number of incidents routinely reported by staff and sustained reporting of incidents recorded as “self-harm” and physical assault from patients to staff and patient to patient. Incidents of prone restraint have decreased from 17 to seven between May and August 2024 and is now below the Trust target of 12 incidents. The number of patients secluded between May and August 2024 has decreased by 21% from 24 to 11 episodes. This is in line with common cause variation and continues below the mean of 19. Physical restraints have also decreased by 56% from 121 to 54 incidents between May and August 2024.

A pattern of repeated incidents involving a small group of patients continues to be seen and is consistent with anecdotal reports from staff that acuity on the inpatient wards is high and this is most prevalent on the female acute wards. This is being reviewed within the Trust Reducing Restrictive Practice group.

Strategic Considerations	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care.	X
2) We will ensure that the Trust is a **great place to work** by 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 are 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 (see appendix 2)
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 & Inclusion**
	Tumi Banda **Director of Nursing, Allied Health Professionals, Quality and Patient Experience**
Report prepared by:	**Peter Henson** **Head of Performance**
	Rachel Leyland **Deputy Director of Finance**
	Liam Carrier **Interim Deputy Director of People & Inclusion**
	Joseph Thompson **Assistant Director of Clinical Professional Practice**

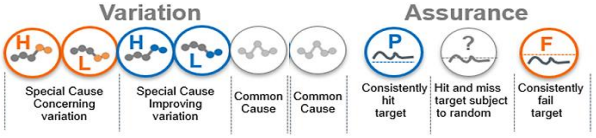
Performance Summary	
Areas of Improvement	**Areas of Challenge**
Operations	
• Adult ASD assessments completed • Psychological services waiting times continue to reduce and the number of people waiting has dropped significantly • CAMHS waiting times continue to reduce • NHS Talking Therapies six-week referral to treatment has significantly improved.	• Adult ASD assessment waiting times – to date over 200 people have been waiting over two years • Community paediatric waiting times continue to prove challenging • NHS Talking Therapies waiting times from first to second treatment • Memory Assessment Service waiting times – around 24 weeks • Inappropriate out of area placements • Inpatient bed occupancy levels and length of stay remain high.
Finance	
• Adult acute out of area expenditure increased in July and August but is starting to reduce again • Agency expenditure usage has started to reduce again, 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	
• Compulsory training • Annual turnover.	• Staff absence • Bank staff use • Agency staff use • Annual appraisals • Supervision.
Quality	
• Reduction in number of falls • Care plan reviews, gradual improvement continues • Reduction in restrictive interventions • Sustained reduction in proportion of patients meeting the criteria of clinically ready for discharge • Friends and family test feedback remains positive.	• Incidents of moderate to catastrophic harm remains high • Care hours per patient day • New Complaints resolution framework.

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			7	4	7	10	9
1b	Waiting list - older adult CMHT - average wait to be seen			1	4	1	2	1
2a	Waiting list - adult CMHT SPOA - number waiting			732		747	959	853
2b	Waiting list - older people CMHT SPOA - number waiting			69		19	123	71
2c	Older people mental health 4 week referral to treatment			94%		12%	95%	53%
2d	Adult mental health 4 week referral to treatment			98%		2%	94%	48%
2e	Waiting list - ASD assessment - average wait to be seen			58		65	73	69
2f	Waiting list - ASD assessment - number waiting at month end			1,803		2055	2326	2191
2g	ASD assessments			84	26	22	73	47
3a	Waiting list - psychology - average wait to be seen			19		10	52	31
3b	Waiting list - psychology - number waiting at month end			491		636	786	711
4a	Waiting list - CAMHS - average wait to be seen			14		14	21	17
4b	Waiting list - CAMHS - number waiting at month end			277		314	469	392
5a	Waiting list - community paediatrics - average wait to be seen			46		32	38	35
5b	Waiting list - community paediatrics - no. waiting at month end			2,433		2214	2567	2390
B1	3 day follow-up			85%	80%	78%	95%	87%
D1	Community Mental Health Access (2 plus contacts)			11,970	11,899	10637	11471	11054
E1	Children & Young People Mental Health Access (1 plus contact)			3,485		3093	3279	3186
E4	Children & Young People Eating Disorder Waiting Time - Routine			94%	95%			
E5	Children & Young People Eating Disorder Waiting Time - Urgent			n/a	95%			
G3	Early intervention 14 day referral to treatment - complete			100%	60%	65%	105%	85%
G3	Early intervention 14 day referral to treatment - incomplete			94%	60%	55%	120%	87%
H0	IAPT 6 week referral to treatment			87%	75%	53%	72%	62%
H1	IAPT 18 week referral to treatment			100%	95%	98%	101%	99%
H2	IAPT 1st to 2nd Treatment over 90 Days			38%	10%	13%	36%	25%
H7	IAPT patients completing treatment who move to recovery			48%	50%	43%	60%	51%
I1	Individual Placement and Support Access			335	343	130	482	306
K2	Total inappropriate out of area bed days			2,175	0	1,514	2,689	2,101
K2	Average patients out of area per day - adult acute			9	0	2	18	10
K2	Patients placed out of area - adult acute			16	0	5	29	17
K2	Average patients out of area per day - PICU			16	0	11	23	17
K2	Patients placed out of area - PICU			25	0	21	35	28
L1	Perinatal Rolling 12 Months Access			11.0%	10%	6%	8%	7%
L2	Perinatal Access Year to Date			550	1,070	249	818	534
N4	Data quality maturity index			98%	95%	98%	99%	98%

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

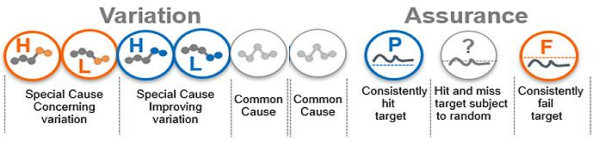
B. People

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Annual appraisals			89%	90%	79%	84%	81%
2	Annual turnover			12%	8-12%	12%	13%	12%
3	Compulsory training			91%	85%	88%	90%	89%
4	Staff absence			6%	5%	5%	8%	6%
5	Clinical supervision			84%	95%	75%	80%	77%
6	Management supervision			82%	95%	72%	78%	75%
7	Filled posts			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	No. of compliments received			109.0	119.0	71.9	189.2	130.5
2	No. of formal complaints received ("quick resolution")			12.0		8.5	52.3	30.4
3	No. of formal complaints received ("closer look")			19.0		0.0	30.3	15.0
4	Proportion of patients clinically ready for discharge			0.1	0.0	0.1	0.1	0.1
5	Proportion of patients on CPA >12 months who have had their care plan reviewed			0.7	1.0	0.6	0.7	0.6
6	Patients who have their employment status recorded as "in employment"			0.1		0.1	0.1	0.1
7	Patients who have their accommodation status recorded as "settled"			0.5		0.3	0.5	0.4
8	Number of medication incidents			80		59	114	87
9	No. of incidents of moderate to catastrophic actual harm			57	48	28	78	53
10	No. of incidents requiring Duty of Candour			0	1	0	3	1
11	No. of incidents involving prone restraint			9	12	0	24	11
12	No. of incidents involving physical restraint			76	46	31	123	77
13	No. of new episodes of patients held in seclusion			9	14	4	31	18
14	No. of falls on inpatient wards			26	30	9	58	34

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

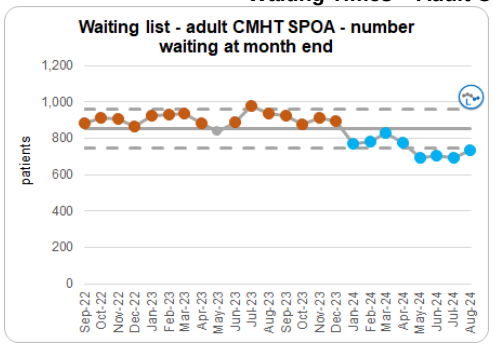
[1]The rating symbols were designed by NHS Improvement

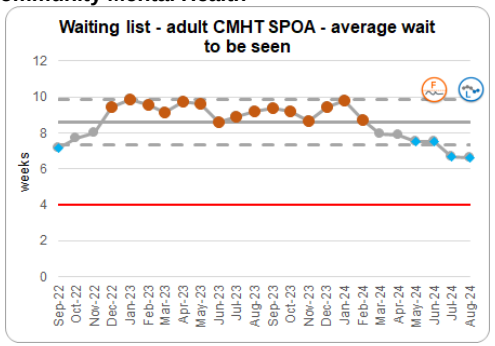
Derbyshire Healthcare
NHS Foundation Trust

Operations

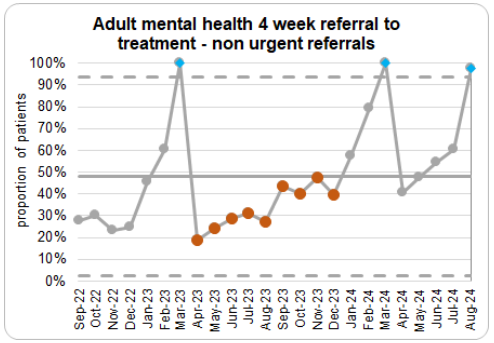
Operational Performance

Waiting Times – Adult Community Mental Health





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



Currently this is an internal measure:

- Four-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 average wait to be seen continues to reduce is currently just over six weeks. It is possible that a national standard for 4-week referral to treatment for non-urgent referrals will be introduced at some point, although currently no standard has been set. NHSE are expected to start publishing national 4-week referral to treatment data from this Autumn.

Recovery action plan

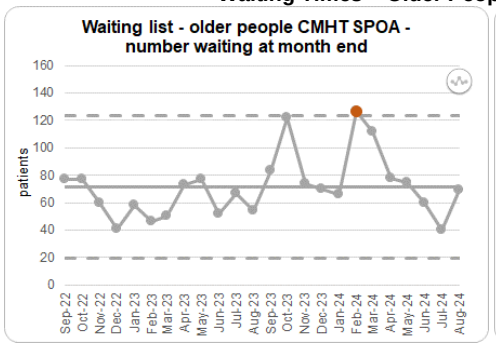
The Adults of Working Age Community Mental Health Services division have developed a productivity plan and associated recovery action plan. To address the waiting lists, reducing numbers waiting and length of time waiting, there is a focus on productivity within all parts of the service pathway to ensure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

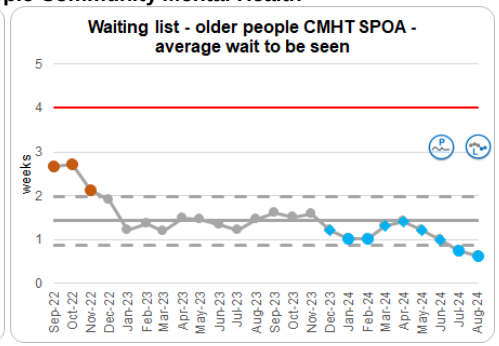
- Targeted messaging – accountability, back to basics, getting it right
- Setting expectations – number of contacts; caseload numbers vs productivity
- Consistent use of the Employee Improvement Policy and Procedure
- Quality improvement approach to outpatient caseload management
- Optimised caseloads within the long-term offer
- Increased compliance with 4-week referral to treatment
- Positive impact of the Living Well transformation once complete – see the following 2 pages.

By when we will have recovered the position

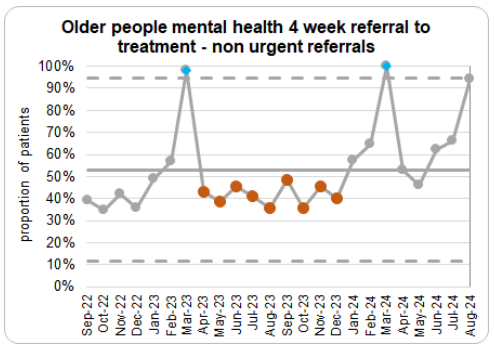
The plan is expected to have positively impacted on waiting times by the end of October 2024 and this can be seen in the reduction over the last 4 months, which is a statistically significant reduction.

Waiting Times – Older People Community Mental Health





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



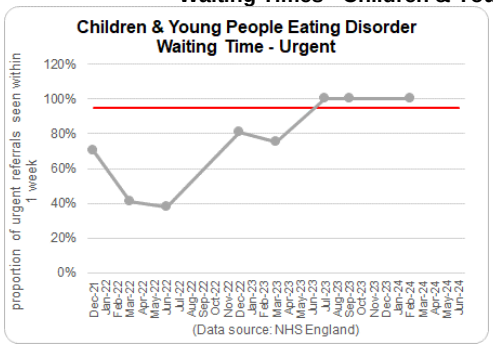
Summary

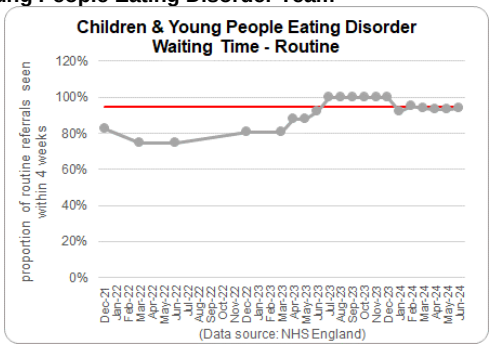
Whilst there are wait times for assessment in most areas, these are being managed and there is flow through the service. The two areas of concern remain as Derby City and South Derbyshire owing to vacancy factor. There has been some positive recruitment into the South Derbyshire team and as new recruits come online, the wait times will reduce.

<u>Dementia Assessment Pathway</u>

This work remains ongoing, with further engagement with Primary Care underway.

Waiting Times - Children & Young People Eating Disorder Team





Summary

Where urgent referral numbers are very low NHS England suppress the data. However, internal analysis indicates that the Trust's Child & Adolescent (C&YP) Eating Disorder Service is generally achieving around 100% for both standards. The Division internally monitors the C&YP Eating Disorder Service waits from first to second contact: 2023/24 quarter 1 - 11 days, quarter 2 - four days, quarter 3 - four days, and quarter 4 – eight days. 2024/25 quarter 1 – two days, quarter 2 to date – three days.

Operational Performance

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.

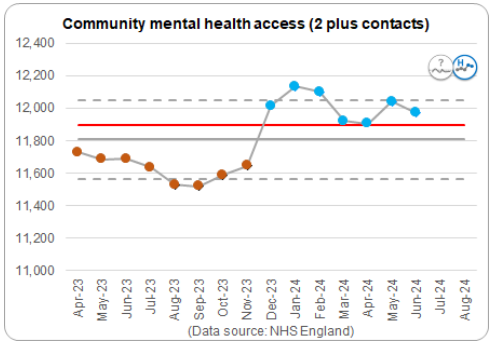
The new services went live during 2023/24:

- 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 the 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.

Community mental health access 2 plus contacts (NHS long term plan target)



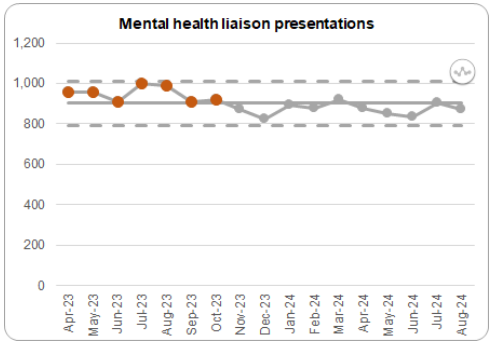
Summary

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.

For financial year 2023/24 the year-end target was increased to 11,899 and for the last 4 months the target was exceeded.

For financial year 2024/25 NHSE have published data up to June, which demonstrates that year to date the target level of activity has been sustained each month.

Mental health liaison presentations

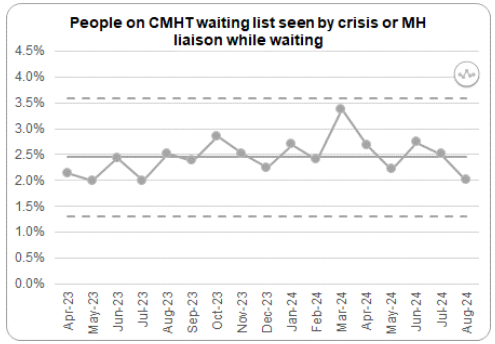


Summary

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 continue to demonstrate a reduction in presentations in recent months.

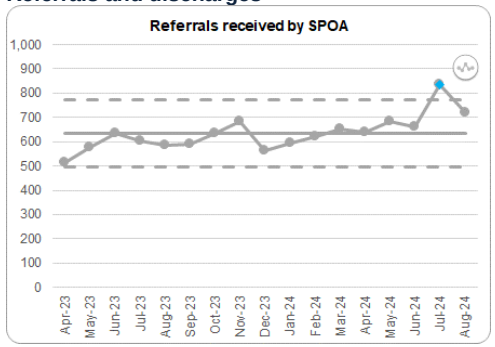
People on the community mental health team waiting list who have been seen by crisis services or mental health liaison while waiting

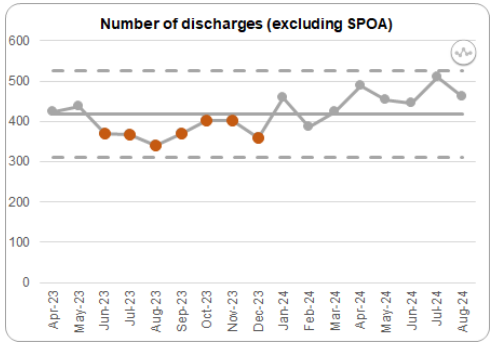


Summary

People who are waiting to be seen by community mental health teams should be seen sooner, therefore we would be expect the number of people needing to access crisis services whilst waiting to decrease, reducing demand on secondary services.

Referrals and discharges





Summary

The volume of referrals received has been steadily increasing since December 2023. The volume of discharges has also been increasing over time since December 2023.

Operational Performance

https://livingwellderbyshire.org.uk/

Caseload sizes

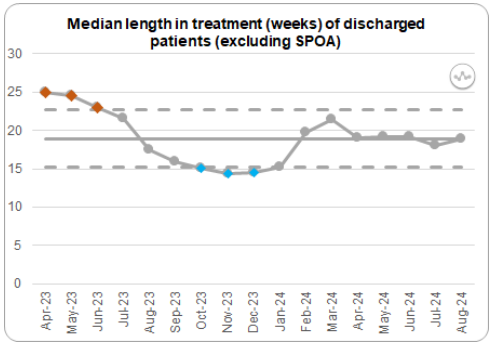
Over time you would expect to see long term offer caseloads reducing, and short-term offer caseloads increasing. The right hand 3 columns give the proportion of caseload that is long term offer in each team:

STO & LTO caseloads		Proportion of caseload that is long term offer							
Team	Caseload	Apr-23	Oct-23	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Movement
CHESTERFIELD	556	99.6%	95.9%	75.0%	72.1%	79.0%	72.8%	75.0%	
HIGH PEAK	214	97.2%	70.3%	53.7%	54.5%	53.4%	53.4%	53.7%	
AMBER VALLEY	473	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	99.8%	
EREWASH	416	100.0%	99.7%	91.1%	89.1%	90.2%	88.4%	88.7%	
SOUTH DERBYSHIRE	298	100.0%	100.0%	92.9%	89.4%	85.4%	80.1%	80.5%	
DERBY CITY B	335	93.0%	72.1%	56.7%	57.8%	66.4%	60.4%	65.1%	
DERBY CITY C	390	91.1%	73.8%	61.2%	59.5%	67.0%	58.4%	59.7%	
Grand Total	**2682**	**97.4%**	**88.7%**	**76.8%**	**75.6%**	**79.6%**	**75.4%**	**77.0%**	

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. This pattern is also starting to appear in Erewash and South Derbyshire.

NB Bolsover, Killamarsh, North & South Dales are excluded from this table, as those teams only hold long term offer caseloads and so will always be 100%. Their short-term offer caseloads are held elsewhere.

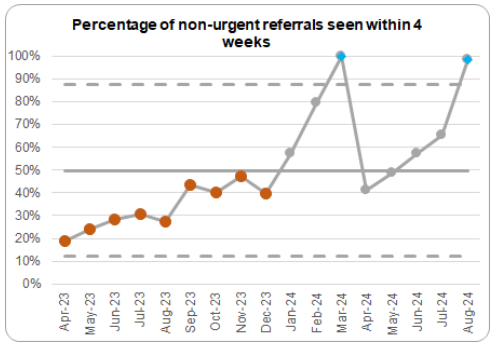
Length in treatment



Summary

Discharges would be expected to increase and length in treatment to reduce, owing to the short-term offer throughput offering a 12-week service. The flow of people through the service would ensure there is capacity to support people in a timely manner.

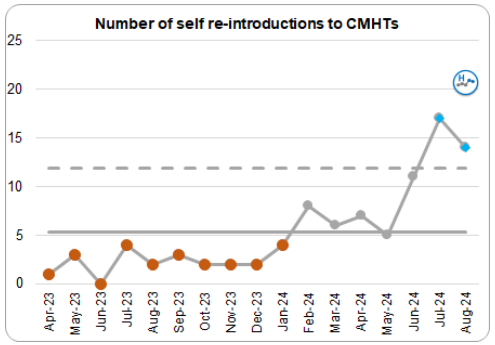
Community mental health team 4-week referral to treatment



Summary

NB Four-week referral to treatment performance is based on referral to second contact of patients who had their second contact in the month. The data does not show patients who are currently waiting for their second contact.

Self re-introductions to community mental health services

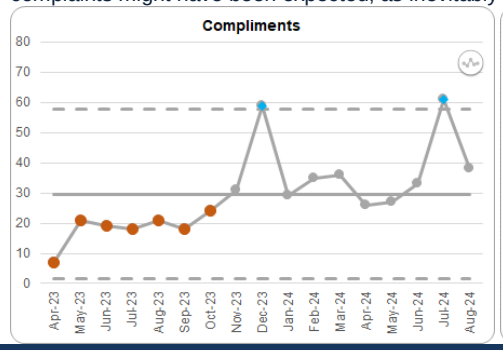


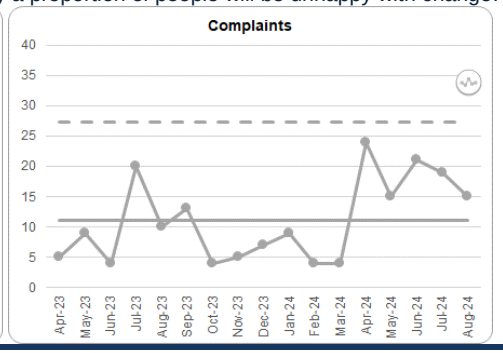
Summary

The Living Well Service enables people to readily access services up two years following discharge from a previous spell of treatment. The number of self-reintroductions would be expected to increase over time, through the provision of easier access to services, and is also expected to reduce demand on primary care. The facility to self-reintroduce will be increased during phase 2 of the Living Well transformation.

Complaints versus compliments

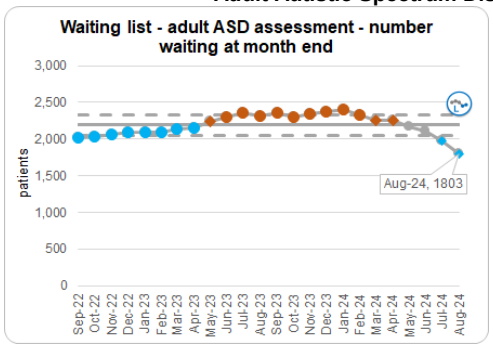
Oversight of complaints and concerns will continue, to ensure the service offer is meeting the needs of people accessing their services during and beyond the transformation period. Initially an increase in complaints might have been expected, as inevitably a proportion of people will be unhappy with change.

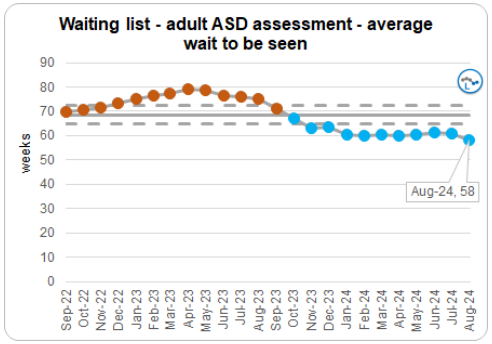


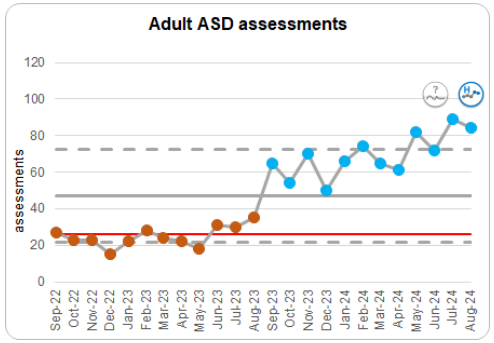


Operational Performance

Adult Autistic Spectrum Disorder Assessment Service







Summary
The number of completed assessments per month has remained high and after five months the full year contractual target of 312 assessments has been exceeded by 24%. Demand for the service continues to outstrip capacity (contracted to undertake 26 assessments per month but receiving around 78 referrals per month this calendar year to date).

Ongoing actions to optimise productivity within current resources

- Clinical efficacies: the review of clinical processes to increase the number of ASD assessments completed has continued to result in a significant and sustained increase in assessments completed, with no reported loss of quality or service user satisfaction.
- Ongoing support of individuals on the diagnostic pathway remains in place. Whilst this does not reduce diagnosis waiting times, it informs people of options available to them and improves the service user experience.
- Ongoing enhanced support for individuals pre and post diagnosis to improve their experience and understanding, and support with management of anxiety, reducing the risk of urgent need to access services. Earlier awareness can be raised through signposting from the support services to the specialist teams.
- There is work in progress re future commissioning and contracts regarding adult ASD assessment services

ADHD
Ongoing gap in adult ADHD services. We ae continuing to work this through with commissioners to establish a proposal to go out to tender for 'Right to Choose' with scope to consider what a more thorough service offer including treatment and intervention needs to look like for phase 2 and on release of funds from the current provider.

Adult Neurodevelopmental Division (ND)

Summary of inpatient admissions

The end of August position for adult inpatients: 32 in total (one below trajectory)

- 14 ICB beds (four below trajectory)
- 18 Provider Collaborative beds (three above trajectory)

Key priorities for Quarter 2 and Quarter 3

Short Break Pre- Engagement Consultation
The ICB have begun the DCHS short breaks pre-engagement consultation. This service sits within ND and as such ND are supporting this consultation period.

Patient Flow and Avoiding Inappropriate admissions

- The Short-Term Intervention Team (STIT) SDF funded team that provides wrap around support has been funding until March 2025. Meetings in place to look at beyond 25.
- Hillside unit (Derbyshire ATU) has been temporarily closed (August). Consultation process swill follow in due course.
- Long waits for psychiatry are improving with additional clinics in place and successful recruitment. The waiting list has been reduced by 45% between March and August 2024 (128 down to 70).
- Outpatient clinics within community are running for nursing and physiotherapy- Pilot projects which will be reviewed as QI.

JUCD ND transformational Programme
ND are currently in the process of remapping the ND priorities and vision for 2025-2029 as part of the ND delivery group. Coproduction and engagement will support this new programme of work.

ND governance
In line with the ND integration, a new governance structure has been approved. The aligned governance structure ensures there is robust clinical and operational governance across the integrated division that meets the requirements of both host organisations (DHcFT and DCHS).

Success
Annual Health Check project is being presented at the NHSE regional transformation meeting and the Allied Health Professionals conference.

Operational Performance

Psychology & Psychological Therapies

Introduction
The Division has maintained its excellent reputation in the region for being a fantastic place for psychologists to work and remains the employer of choice. We continue to have around 6% vacancy.

Engagement:
We had our engagement hour in August. They remain well attended, although this was the lowest number to date (likely due to holidays). The anonymous shared space highlighted two issues this month, which were responded to during the engagement session. In relation to freedom to speak up, in the last quarter we have had 0 issues raised. We are pleased to have started engaging with our new NED link.

Workforce update highlights:
Sickness & morale: Sickness within the division reduced further to 2.4% in August 2024. We are working hard to maintain this through supporting staff where possible. Morale appears to be team dependent and remains variable. We have one ongoing investigation and no new ones this month.

Trainees: New intake of trainee clinical psychologists starting in September. Within the employing trusts DHCFT is now a popular choice with 16 trainees across three x year groups.

LD psychology in the North of the county: The referrals into psychology are to open on 2nd October. Within 12 months we have successfully recruited and built a psychological service that is now offering care and treatment. The lack of one electronic patient record continues to cause challenges clinically.

TMHD: See separate report; six-week treatment target achieved and being maintained. Reductions in treatment required. Decision not to bid as part of new procurement process has impacted on staff, their wellbeing and morale. RTW interview and IPRs are areas needing support so as to maintain previously high levels of compliance.

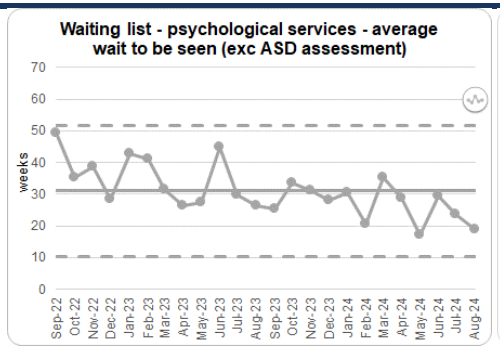
Business Unit:
The Division is keen to develop a business unit to offer specific psychological services (mainly assessment) as an income generating scheme. A paper was prepared for ELT to consider this idea in principle before building a business case.

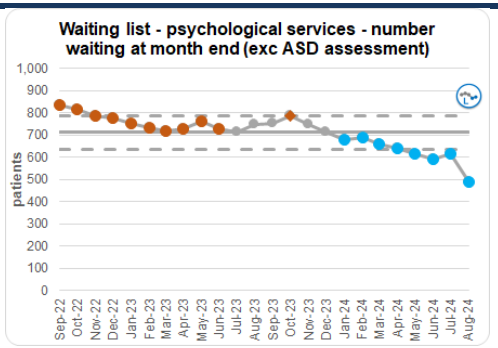
Friends & Family Test:
Friends and Family Test, where reported, continues to show excellent feedback. In the last 12 months:

- Adults of working age psychology received 30 returns showing 86% positive feedback. The less positive feedback due to waiting times.
- Cognitive Behavioural Therapy & psychodynamic therapy received 29 responses and 100% were positive
- NHS Talking Therapies received 1,759 responses and 98% were positive.
- South & Dales Older Adult Psychology received 3 responses and 100% were positive

Trust wide staff wellbeing:
Wellbeing remains a priority for all teams. However, the loss of the in-house service provision of psychological support has impacted or coincided with increased numbers of requests for psychological support from staff teams and individuals. Psychologists embedded in teams are starting to offer RP in line with trauma informed developments and good practice where there is capacity.

Data:
There does remain a challenge with gaining accurate data re job role, expectation, head count and training. We are working with the Training & Development team and ESR colleagues to rectify this. It remains an ongoing issue. We also have a challenge with accurate productivity data.





Waiting lists and referrals:
Overall, there has been sustained reduction in the number of people waiting for psychological input from 55 weeks to around 19 weeks. This has been achieved through a series of quality improvement projects, delivery of a new psychological group as well as focused work on trying to support our longest waiters.

Key Performance Indicators:
Clinical and managerial supervision remain high at 92% and 93% respectively. Annual appraisal completion has dropped this month and stands at 85%. Return to work interviews in August were required by 37 people and 18 received them – a figure of 48.6%. This is a focus for improvement.

Finance:
Financially, we remain within budget, have no unfunded posts or roles, agency or bank. We are now making plans for the CIP 2025/26. The plan will be complete by December and ready to implement from 1 April 2025. TMHD has a separate plan discussed in recent ELT papers.

Mandatory training:
All areas of mandatory training for the division are above requirement at 90% or higher with the exception of basic life support/ resuscitation which is at 69% (a rise from last month). This is being addressed through supervision and monthly governance meetings but one of the challenges is booking this training. The overall divisional performance on mandatory training is 93%. There remain issues with data accuracy in relation to job specific training.

Increasing psychological awareness:

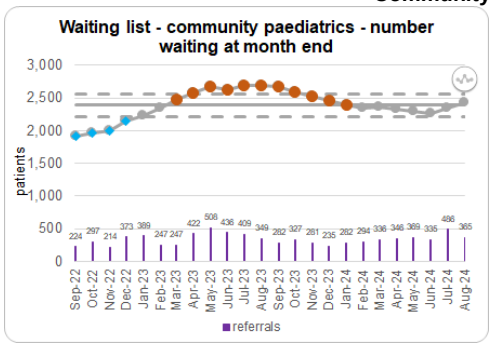
- Bite size psychological teaching sessions continues to have good attendance with a range of topics being delivered.
- The trauma informed animation is now ready and will form part of all trauma-related training in the coming months. It will be made available to all staff in September.
- We continue to support colleagues through provision of reflective practice, debrief and supervision.

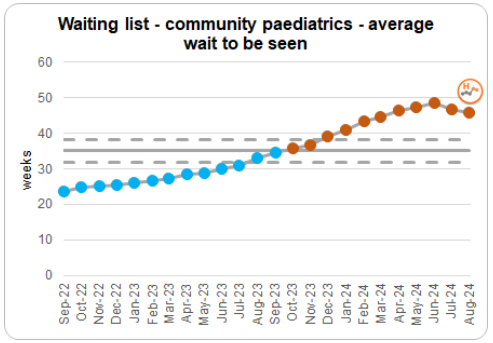
Productivity:
Productivity remains a focus for all teams. We have shared expectations around job planning and delivery with managers and this will start to filter into teams with some impact. Accurate data is still a challenge.

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

Operational Performance

Community Paediatrics





Summary
At the end of August 2024 there were 2,214 children waiting to be seen and the average wait time was 46 weeks, with an additional 1,800 children & young people waiting to be triaged. Whilst referrals continue to rise we have maintained progress with our internal review of processes, job plans etc. which enabled us to increase the number of assessments in 23/24 by 34% compared to 22/23.

Internal factors:
- Ongoing difficulty in discharging children under NICE guidance and shared care agreements in relation to medication for ADHD – specialist nursing team caseloads continue to expand causing problems with flow from the community paediatrics service.

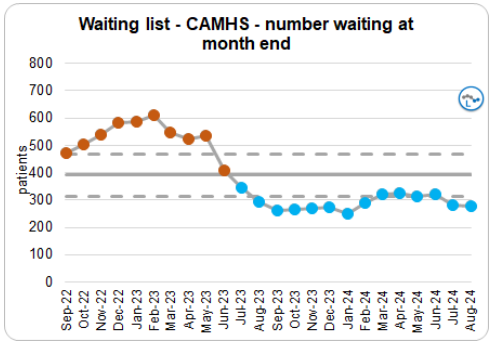
External factors contributing to increased demand on Community Paediatricians:
- Since March 2021 the volume of referrals received has remained above a level that the service can cope with, and this higher level of demand has persisted to date.
- ASD/ADHD demand for specialist assessment increased by 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.
- Ongoing ADHD supply issues continue to impact on demand and management of cases needing to be expedited.

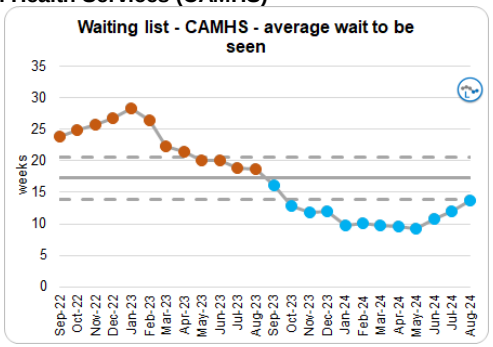
Actions:
- Deputy Area Service Manager is continuing to lead on transformation work for the CYP neurodevelopmental pathway.
- Ongoing senior leadership attendance at system neurodevelopmental meetings to highlight risks and increase Local Authority, Education and Primary Care accountability for the increasing demand.

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.

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)



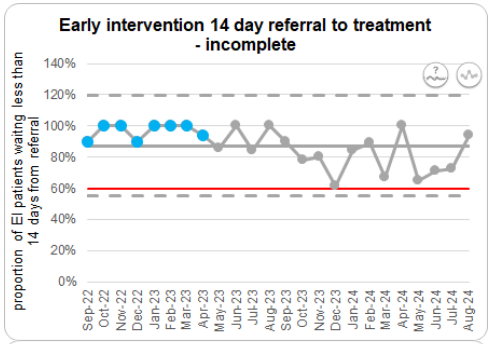


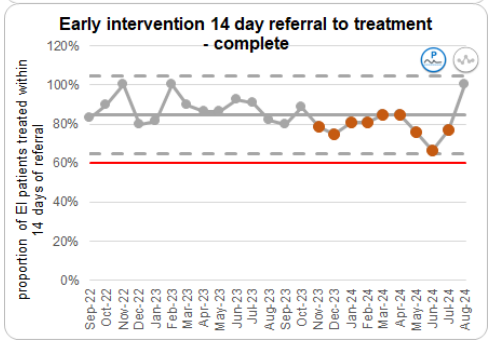
Summary
At the end of August 2024, 277 children were waiting to be seen and the average wait time was 14 weeks, an increase from 9 weeks. The average wait is now more accurately reflected. Priority assessments remain to be seen within 4-6 weeks and routine assessments up to 20 weeks, however this is 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.
- A business case was worked up with the ICB to access long term plan children & young people (CYP) services transformation money for 2024/25. This is now in the final stages of being transacted.
- Waits and CAMHS performance oversight in COAT and reported to Trust Leadership Team. Also oversight at the CYP Mental Health Board.
- Escalation via the ICB Fragile Services Committee – monthly updates provided.

Recovery timescales:
Average wait is below 18 weeks however a national target of 4 weeks is being requested by the system. This would require new investment as outlined in the business case above, and would take 2-3 years to fully implement.

Operational Performance

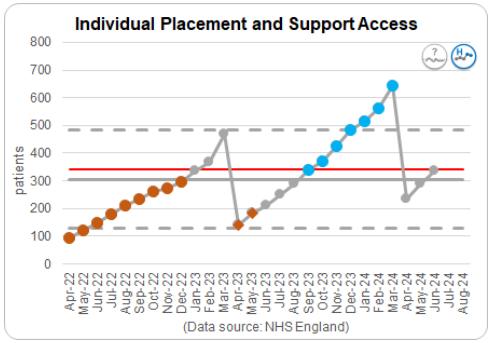




Summary

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

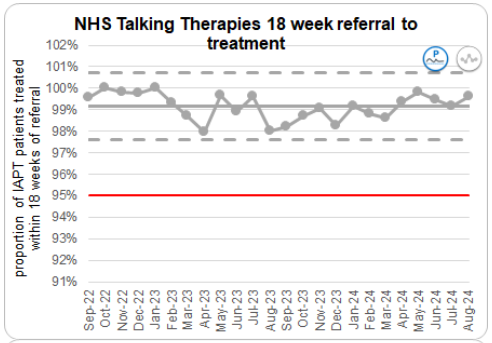
The service continues to be extremely responsive and has consistently achieved or exceeded the national 14-day referral to treatment standard of 60% or more people on the waiting list to have been waiting no more than 2 weeks to be seen.

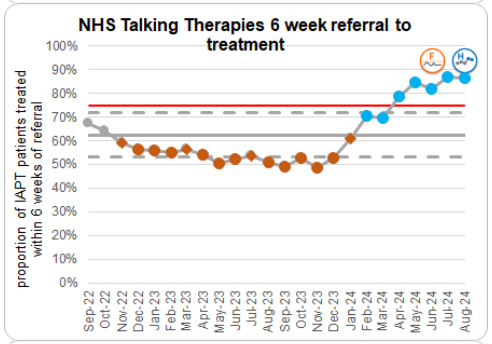


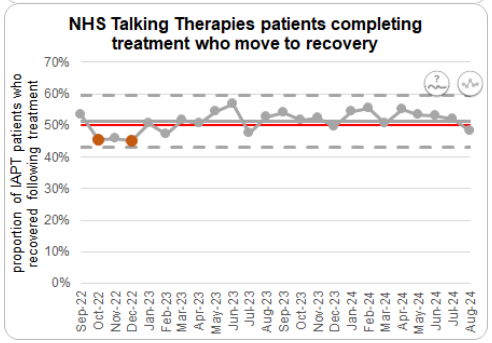
Summary

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 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, in the first three months a significant number of people have been supported to access the service, almost double compared with the previous year.

NHS Talking Therapies

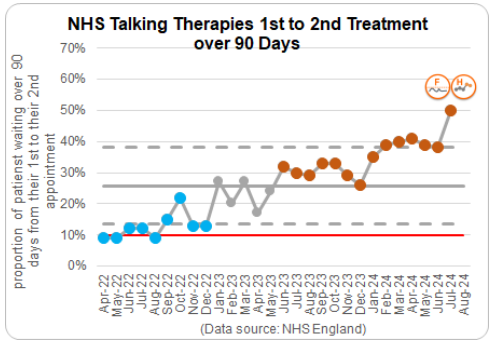






Summary

- 18-week referral to treatment performance continues to exceed the 95% target.
- The 6-week wait for referral to assessment/ 1st treatment has exceeded target for 5 months in a row.
- Recovery rates dipped slightly under target in August 24 but year to date the target has been exceeded. Reliable improvement achieved 72% (7% above target) and reliable recovery achieved 49% (against a target of 48%).



Summary

1st to 2nd treatment over 90 days continues to be high, this is for those reaching the top of wait lists and as such will not be impacted by the closure to referrals for a period of time. Further work continues on managing access and productivity, however commissioner requests to reduce activity and completed treatments, coupled with a reduction in income, make this more challenging.

Actions

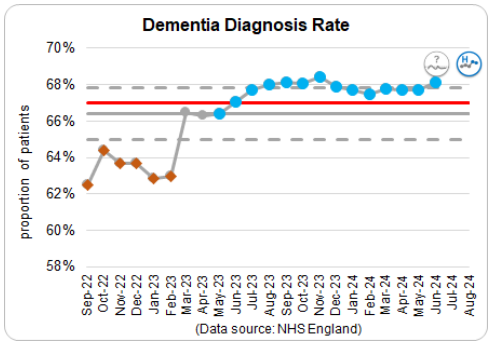
- Referrals paused for eight weeks.
- Reset of the acceptance criteria to reduce levels of risk are now in place reducing numbers entering treatment. This has significantly increased the levels of triage required, which we are addressing with support from clinicians.
- We have worked with sub-contractors to negotiate reductions in activity as requested by commissioners.
- Now working on exit strategy and plans up to the 30 June 2025 in preparation for a single or lead provider to manage the contract going forwards.
- Mutual aid is being negotiated with other providers who may have capacity to take clients from our waiting lists.
- To reduce Trust costs there will be no recruitment into Talking Therapies up to the end of the contract, further impacting capacity.

By when we will have recovered the position

- Whilst referrals have not returned to pre closure levels during August, we expect them to increase month on month. This position will exacerbate the position and we will need to work with the Trust and Commissioners on how we manage an increase in demand and reduction in capacity.

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. NB this is national data and the August position is yet to be published by NHSE.

Regional Comparison May 2024

Dementia diagnosis rate

Organisation Name	Measure Value STR	Target STR.
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	72.6%	66.7%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	70.3%	66.7%
NHS DERBY AND DERBYSHIRE ICB	67.7%	66.7%
NHS LINCOLNSHIRE ICB	66.7%	66.7%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	65.2%	66.7%
NHS NORTHAMPTONSHIRE ICB	64.4%	66.7%
NHS BLACK COUNTRY ICB	64.2%	66.7%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	61.2%	66.7%
NHS BIRMINGHAM AND SOLIHULL ICB	60.7%	66.7%
NHS COVENTRY AND WARWICKSHIRE ICB	57.4%	66.7%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	53.8%	66.7%

NHS Derby & Derbyshire ICB has the 3rd highest diagnosis rate in the region, with performance exceeding the long-term plan trajectory target.

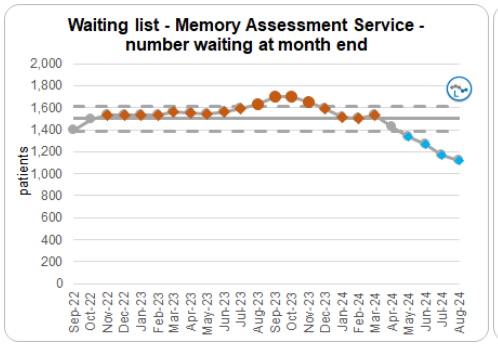
Dementia Diagnosis Benchmarking Data

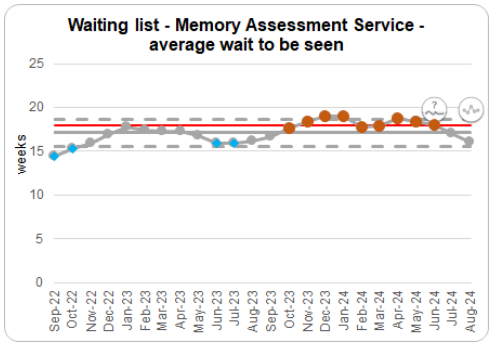
Org Type	Code	Diagnosis rate
National	England	65.2
ICB	QF7	75.6
ICB	QOP	74.4
ICB	QNC	73.5
ICB	QWE	72.6
ICB	QT1	70.7
ICB	QKK	70.1
ICB	QUY	69.6
ICB	QWO	69.6
ICB	QE1	68.9
ICB	QHG	68.7
ICB	QHM	68.5
ICB	QJ2	68.3
ICB	QNQ	67.9
ICB	QYG	67.7
ICB	QJM	67.6
ICB	QMJ	67.4
ICB	QXU	67
ICB	QH8	66.7
ICB	QRV	65.2
ICB	QK1	65
ICB	QPM	64.9
ICB	QR1	64.8
ICB	QM7	64.6
ICB	QUA	64.6
ICB	QNX	62.8
ICB	QU9	62.5
ICB	QMM	61.7
ICB	QRL	61.7
ICB	QMF	61.4
ICB	QOC	61.3
ICB	QHL	60.9
ICB	QOX	60.8
ICB	QJG	60.5
ICB	QUE	60.5
ICB	QT6	60.3
ICB	QKS	60.1
ICB	QOQ	59.6
ICB	QJK	58.5
ICB	QVV	58.1
ICB	QWU	57.5
ICB	QSL	55.3
ICB	QGH	54.5

Primary Care Dementia Data - NHS England Digital

The diagnosis rate in Derby & Derbyshire continues to compare very favourably with other areas nationally.

Dementia Diagnosis Waiting Times





Summary

At the end of August 2024 there were 1,120 people on the waiting list, with an average wait of 16 weeks, which includes people currently waiting as well as those who were assessed in month. Wait times for initial assessment have reduced to approximately 24 weeks with a few outliers. The wait time from assessment to diagnosis has increased, more so in the north of the county due to challenges around diagnostic capacity. We are working with the medical workforce within memory assessment services (MAS) on a plan to manage this and ensure parity.

Reasons for underperformance

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

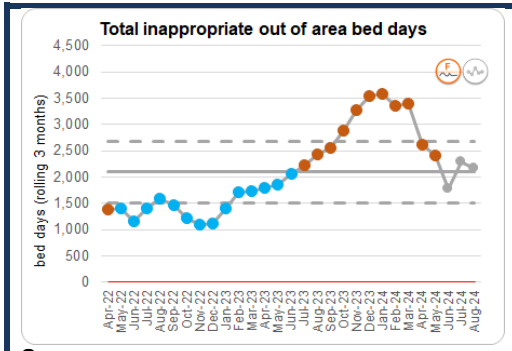
Action plan

- Completion of quality improvement project to maximise and make best use of current resource, to ensure maximum capacity and quality of current provision. The focus currently being on the medical workforce and diagnostic capacity.
- MAS 24 has now been fully absorbed into the CMHT Care Homes Project.
- Reducing the DNA rate.
- Dementia assessment pathway work remains ongoing, with further engagement with Primary Care underway. Weekly emails to staff with individual performance data to ensure individual accountability for service provision.
- Regular monitoring of wait times and data cleansing.
- Continued focus on staff wellbeing and support.
- Complex case/ under 55 pathway review
- Medical workforce review

By when we will have recovered the position

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

Operational Performance



Summary

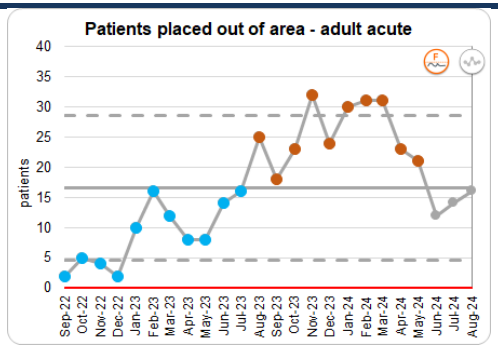
The national measure up to the end of 2023/24 gave a combination of inappropriate out of area adult acute placements and psychiatric intensive care unit placements, calculated on a rolling three-month basis. From April 2024 NHS England are changing to measuring the number of placements at month end, so the chart uses internal data from that point. From internal data, at the end of August 24 there were seven adult acute and 16 PICU patients in inappropriate out of area placements. NB these figures exclude placements where continuity of care principles have been put in place, which are classed as appropriate placements.

Reasons for underperformance

There is an ongoing high level of demand for acute and PICU beds, which has persisted for several years. Capacity and demand methodology continues to indicate that to meet adult acute daily bed demand most of the time, there would need to be 160-170 beds (65th to 85th percentile). This demand was factored into the bid for the new wards in 2021, but unfortunately could not be accommodated owing to the limited financial envelope. Adult acute wards continue to operate at around 100% capacity. However, leave beds are utilised where safe to do so.

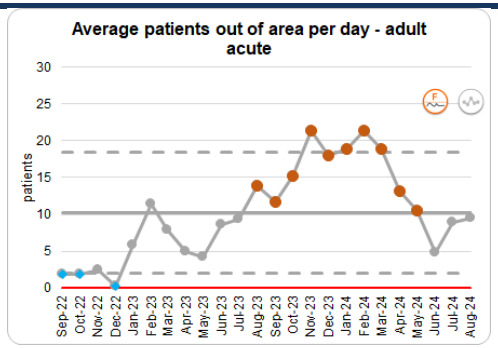
The level of acuity remains persistently high, resulting in the need for PICU beds and represented by the increase in adult acute admissions under the Mental Health Act, which account for 69% of all admissions. The level of acuity may also result in people taking longer to recover.

There are no PICU beds in Derbyshire at this time and therefore all patients placed in PICU are placed in out of area beds.



Recovery action plan

- A comprehensive recovery action plan has been developed and is being implemented.
- Continuity of care principles have been achieved for 6 female beds at mill lodge and 12 male beds at Sherwood Lodge.
- Step down beds to help with discharge flow and crisis house beds are being utilised to help avoid admissions where safe to do so.
- The crisis teams continue to work with higher than usual caseloads in an attempt to avoid admissions to hospital wherever possible and appropriate.
- Fiona White and Dr Rais Ahmed continue in their current roles to support the improved flow of patients into and out of hospital.
- 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.
- Liaison with the ICB regarding commissioning of inpatient services for people living in High Peak
- Flow structure to be implemented to provide a multi-agency response to the admission and discharge challenges.
- Implementation of community based Clozaril initiation, avoiding the need for admission to hospital.
- Gatekeeping function and purposeful admission to comply with the crisis fidelity model. Fully implemented.

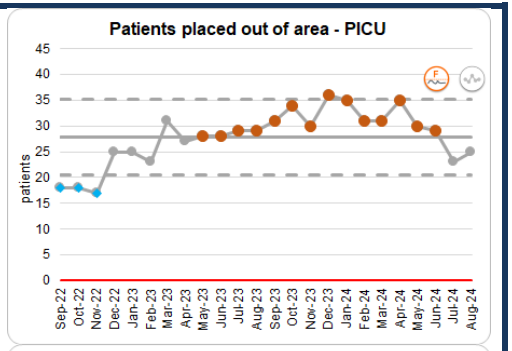


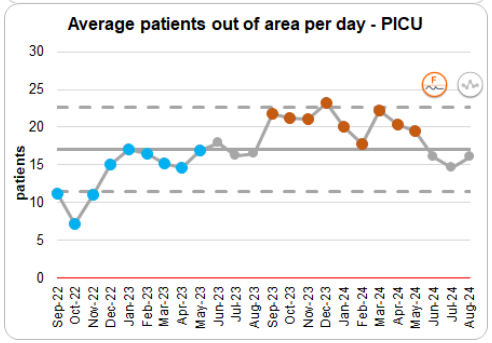
Recovery action plan (cont.)

- 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 2024. This consists of one vehicle staffed by a paramedic and a mental health nurse.
- To implement MAST in CMHTs ensuring focused input to those at greatest need and at greatest risk of admission.
- Cascade a communication to staff seeking a focus/support to improve flow and reduce inappropriate out of area placements.
- Cascade specific communication to medics
- Review, refine and cascade OPEL differentiated actions.
- Develop and implement criteria led discharge guidance.
- Challenge and confirm process incorporated into review of out of area patients.
- Automatic multi-disciplinary review of patients identified as “extended length of stay”.
- Estimated discharge date established during admission process and discharge planning to start at point of admission
- 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

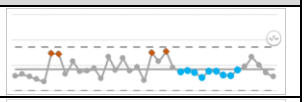
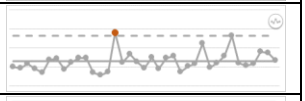
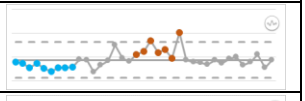
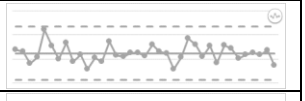
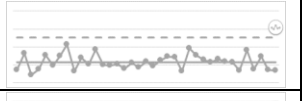
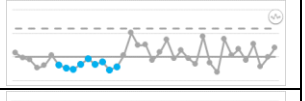
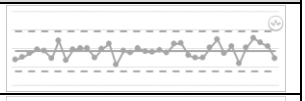
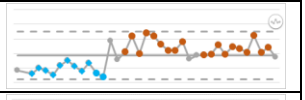
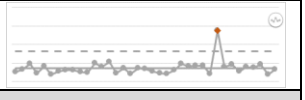
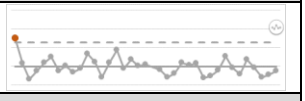
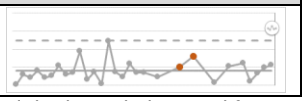
There is no local PICU provision, so anyone needing psychiatric intensive care must be placed out of area, however, work continues on the provision in Derbyshire of a new build male PICU and an enhanced care ward for females.

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.

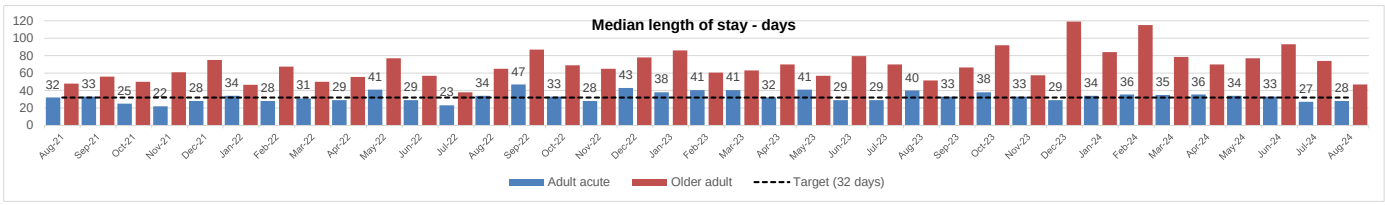
Operational Performance

Occupancy & length of stay (days)

Clinical area	Beds	Bed occupancy Aug-24	Average duration of stay to date (days) of current inpatients	Average length of stay (days) Aug-24 discharged	Change versus previous month discharged	Change over time – average length of stay of discharged inpatients
Adult Acute						
Morton	20	98%	37	28	↘	
Pleasley	21	95%	97	68	↘	
Tansley	21	99%	46	44	↗	
Ward 33	20	82%	101	37	↘	
Ward 34	20	108%	65	34	↘	
Ward 35	20	90%	81	69	↗	
Ward 36	21	104%	54	42	↗	
Older People						
Cubley Female	18	48%	82	73	↘	
Cubley Male	18	65%	58	87	↘	
Tissington	18	87%	94	64	↗	
Perinatal						
The Beeches	6	67%	49	37	↗	
Rehabilitation						
Cherry Tree Close	23	90%	315	551	↗	

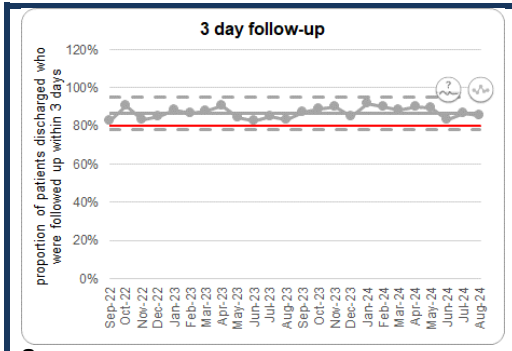
Explanatory note: where occupancy is over 100% this means that patients are on periods of trial home leave and their beds are being used for new admissions while they are at home. Leave beds used are predominantly safe planned leave, so leave would normally be extended, where safe to do so, to prevent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

Although the mean average has been used as the measure nationally for many years and so is also used above, the median average is a more appropriate measure as it is a better measure of central tendency. Using the median the length of stay of discharged patients was as follows:



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

Operational Performance

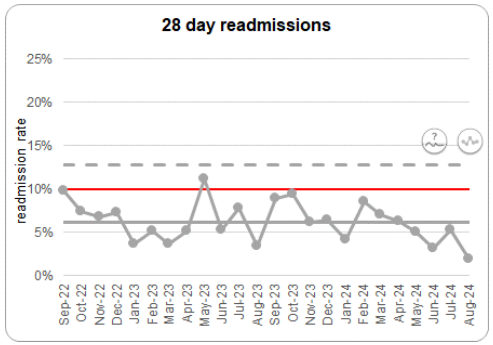


Summary

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

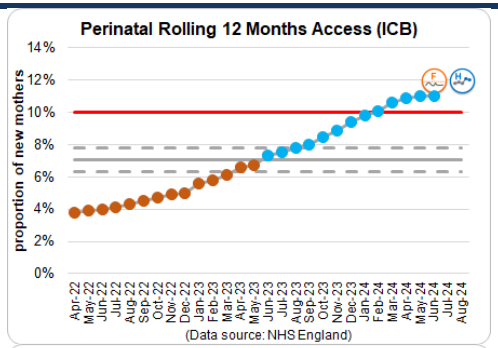
Actions

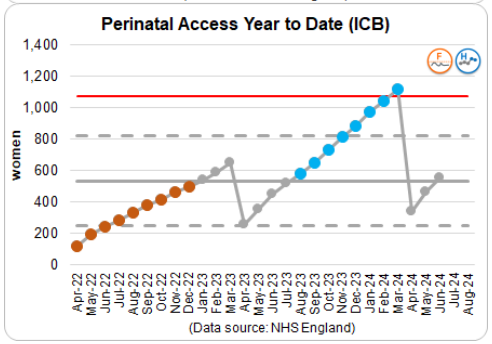
- Regular audit of follow-ups to ensure improved accuracy of reporting.
- Completion of breach reports for any follow-ups that were not achieved to enable learning from breaches.



Summary

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

Year to date activity levels are exceeding levels seen in previous years. There is a consistent, demonstratable demand for the service. The self-referral process is now embedded, and community outreach work continues, with the aim to improve parity of access. Referrals into the maternal mental health service (MMHS) have reduced during this time period. Local data indicates that since April 24 initial assessments have been below the monthly target. This is a result of reduced capacity within the service owing to vacancies and staff sickness. Did not attend (DNA) rates have also increased in this period.

Actions needed to maintain target

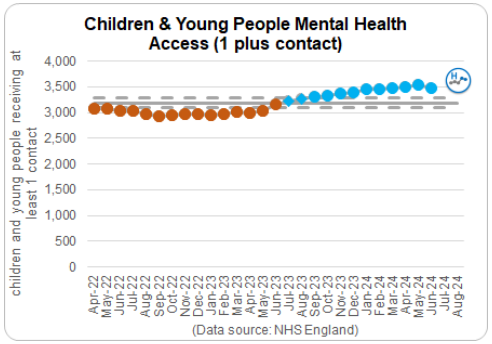
- Community nurse (CPN) posts have now been recruited into. Psychology posts to be recruited.
- Agreed CPN job plans and target caseloads to be maintained.
- Service to continue strategic direction to address health inequalities and potential barriers to access.
- Waiting list action plan in place and waiting well offer in place to support patients while waiting.
- DNA action plan
- MMHS to increase capacity to assess.

Regional comparison May 24

Perinatal access – rolling 12 months

Organisation Name	Measure Value STR	LTP Trajectory STR	LTP Trajectory Percentag..
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	890	501	177%
NHS NORTHAMPTONSHIRE ICB	1,165	905	128%
NHS DERBY AND DERBYSHIRE ICB	1,180	1,111	106%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	1,290	1,298	99%
NHS BLACK COUNTRY ICB	1,560	1,585	98%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	750	781	96%
NHS LINCOLNSHIRE ICB	690	742	93%
NHS COVENTRY AND WARWICKSHIRE ICB	960	1,045	92%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	1,085	1,259	86%
NHS BIRMINGHAM AND SOLIHULL ICB	1,670	1,953	85%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	960	1,215	82%

NHS Derby & Derbyshire ICB was the 3rd highest performing in the region, with activity exceeding long-term plan trajectory.



Summary

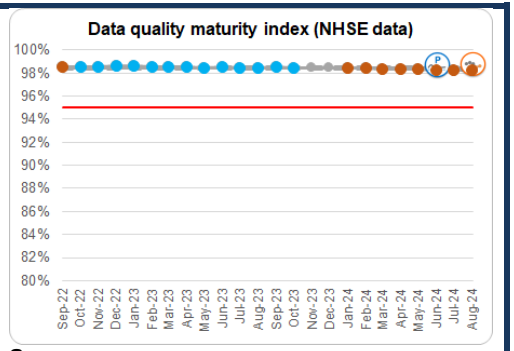
Performance was significantly high in the last 10 months of 2023/24. Awaiting publication of 2024/5 data by NHSE.

Regional comparison May 2024

C&YP access 1 plus contact

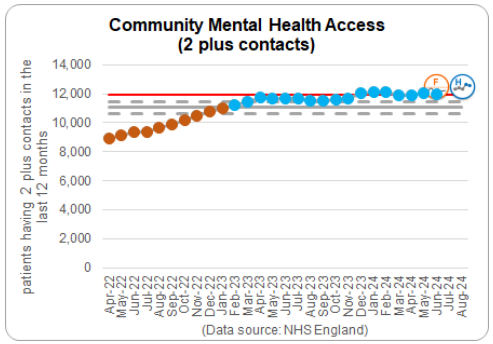
Organisation Name	Measure Value STR	LTP Trajectory STR	LTP Trajectory Percentag..
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	18,880	14,553	130%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	19,760	16,124	123%
NHS NORTHAMPTONSHIRE ICB	10,050	9,600	105%
NHS DERBY AND DERBYSHIRE ICB	14,115	14,463	98%
NHS COVENTRY AND WARWICKSHIRE ICB	11,900	12,972	92%
NHS BLACK COUNTRY ICB	16,910	20,240	84%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	14,360	17,273	83%
NHS LINCOLNSHIRE ICB	8,740	11,829	74%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	8,745	11,865	74%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	5,840	8,341	70%
NHS BIRMINGHAM AND SOLIHULL ICB	14,280	24,834	57%

NHS Derby & Derbyshire ICB was the 4th highest performing in the region, with activity slightly below long-term plan trajectory.



Summary

The level of data quality is consistently high.



Summary

NHSE have published data for the current financial year 2024/25 up to June, which demonstrates that the target level activity has been sustained each month so far.

Regional comparison May 2024

Community mental health 2 plus contacts

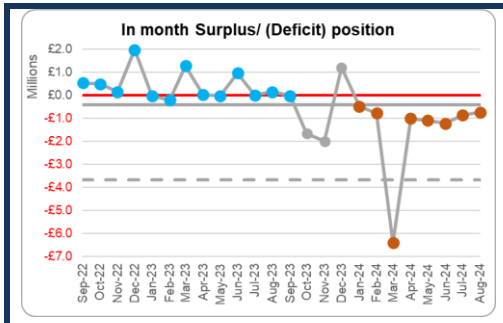
Organisation Name	Measure Value STR	LTP Trajectory STR	LTP Trajectory Percentag..
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	13,050	6,449	202%
NHS BIRMINGHAM AND SOLIHULL ICB	23,815	22,715	105%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	12,680	12,678	100%
NHS DERBY AND DERBYSHIRE ICB	11,920	11,899	100%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	8,065	8,184	99%
NHS NORTHAMPTONSHIRE ICB	10,215	10,870	94%
NHS LINCOLNSHIRE ICB	7,255	7,941	91%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	14,895	17,035	87%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	4,250	4,984	85%
NHS COVENTRY AND WARWICKSHIRE ICB	6,955	8,521	82%
NHS BLACK COUNTRY ICB	13,515	16,864	80%

NHS Derby & Derbyshire ICB was the 4th highest performing in the region, with activity achieving the long-term plan trajectory.

Derbyshire Healthcare
NHS Foundation Trust

Finance

Financial Performance

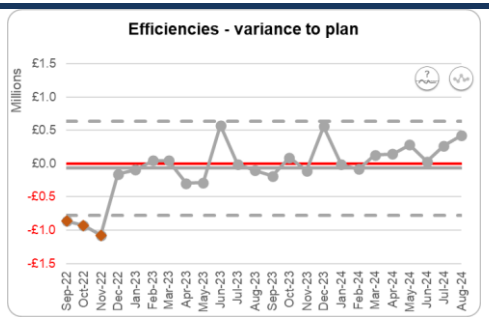


Summary
At the end of August, the position is a deficit of £3.8m which is on plan.
The forecast position remains in line with the plan submission of £6.4m deficit.

Current risks to deliver the planned deficit:

- Delivery of efficiencies in full
- Management of Adult Acute out of area expenditure to reducing trajectory
- Management of in-patient expenditure to budget
- Additional costs of complex patient
- Management of agency expenditure within budget
- Management of any new cost pressures

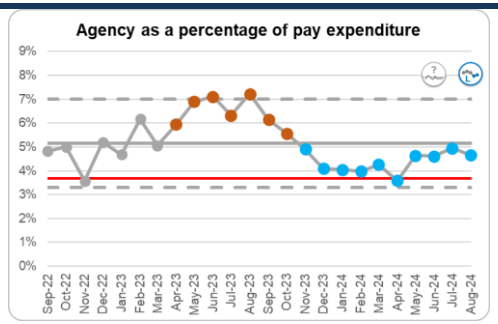
The Board Assurance Framework (BAF) risk *that the Trust fails to deliver its revenue and capital financial plans for 2024/25,* remains rated as EXTREME due to the financial risks above.



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.

Following the planned stepped increase in the target from July, YTD efficiencies are behind plan by £0.4m. Work continues in progressing sign-off of the PIDs and QEIAs.

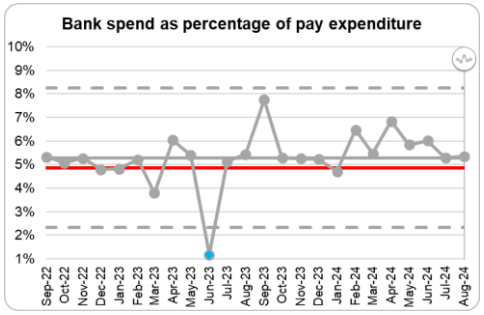
The Efficiency Programme Delivery Group, held fortnightly, continuous to oversee progress of the required savings.



Summary
Agency expenditure YTD totals £3.1m which is above plan by £0.3m. This includes £1.1m of additional costs to support a complex patient, which ceases at the beginning of September. The forecast agency expenditure of £6.0m is below plan by £0.3m.

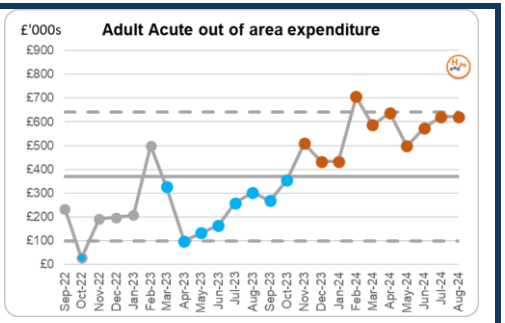
The two highest areas of agency usage continue to relate to consultants and nursing staff. The agency expenditure as a proportion of total pay for August is 4.6%.

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 £4.1m, which is above plan by £0.6m.

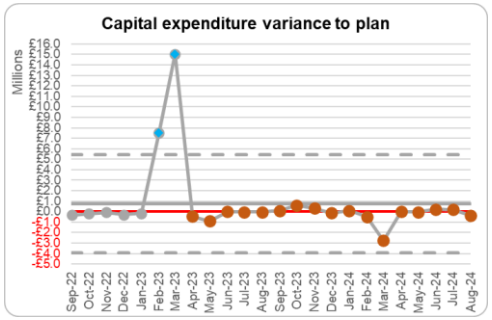
Some of the additional staff on the wards in relation to CQC actions are through bank use, where the plan was set against agency.



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. In addition to this the plan also included a further six block beds for part of the financial year.

At the end of August total expenditure is £3.6m which is £0.7m above plan.

Financial Performance

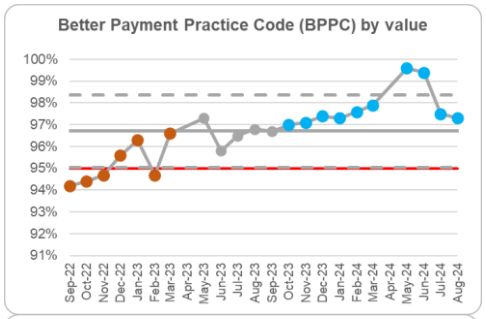


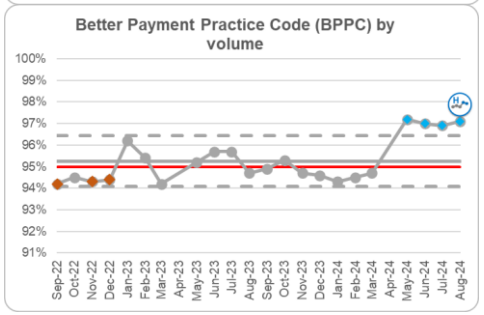
Summary
Capital expenditure at the end of August is slightly below plan by £0.2m.

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.



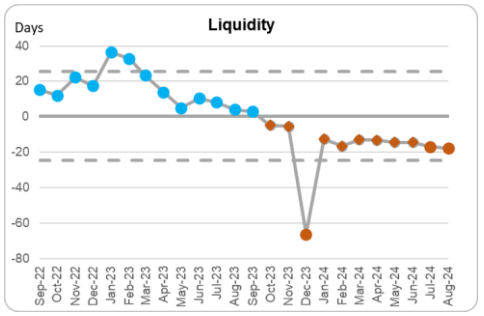


Summary
The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices.

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

Summary
Cash at the end of August is at £21.1m (£21.0m last month) which is below plan by £4.9m.

This is due to the phasing of payments year to date related to the Making Room for Dignity Programme, with cash forecast to hit the plan of £19.1m at the end of the financial year.

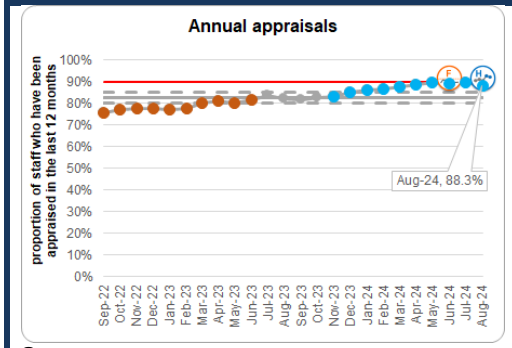


Summary
The chart above shows the liquidity levels over the last two years. Liquidity levels were high in 2021/22, however in 2022/23 the liquidity reduced until the last quarter due to the timing of cash receipts related to the centrally funded capital schemes for the eradication of dorms. The Public Dividend Capital (PDC) drawdown requests caught up in January 2024 which increased the level back up. Drawdown requests are transacted monthly which has stabilised liquidity levels during 2024/25.

Derbyshire Healthcare
NHS Foundation Trust

People

People Performance



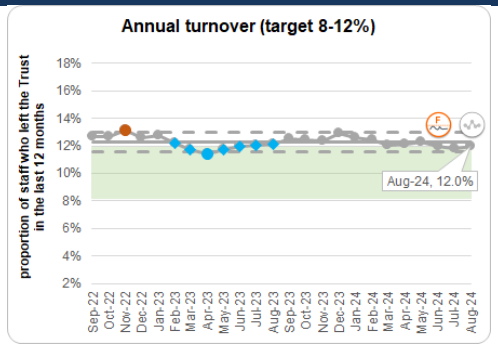
Summary
Overall, performance has dipped very slightly below target. Operational Services are currently at 89% and Corporate Services at 84%, against the target of 90%.

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 remain a challenge and despite seeing an increase in the previous reporting period, compliance has decreased from 87% to 84%.

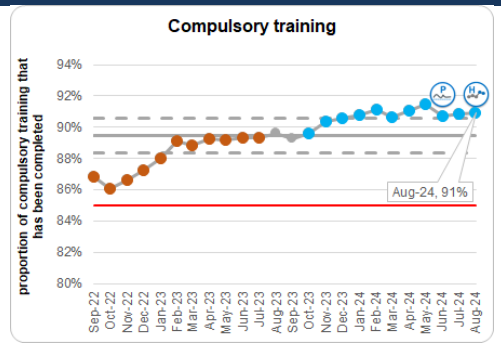
Business Imp & Tran	100%
Corporate Central	96.43%
Estates + Facilities	78.77%
Finance Services	100%
Med Edu & CRD	81.05%
Nursing + Quality	70.21%
Ops Support	96.23%
People + Inclusion	90.91%



Summary
Overall turnover has been around 12% for the last 12 months and 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 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. One of the key components of the review was the Trusts salary sacrifice schemes. The scheme was re-launched in August 2024 and is proving extremely popular with our colleagues.
- The Trust continues to run a vacancy control panel to monitor all recruitment activity.

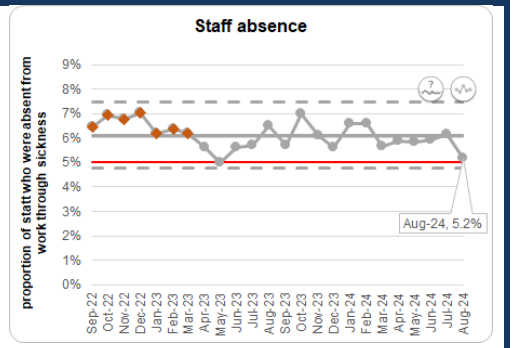


Summary
Overall, the 85% compliance target has been achieved for the last 24 months. Operational Services are currently 92% compliant and Corporate Services are 87%.

Actions
Whilst overall compliance of the 20 training elements remains high, there have been challenge with one mandatory training element remaining below target, however this is an improved position compared to two training competencies below target during the last reporting period. 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
The monthly sickness absence rate has fallen significantly during August where we have seen a reduction in both short term sickness and long-term sickness absence cases. The annual sickness absence rate remains a challenge running at 6.16% and compared to the same period last year it remains 0.03% higher.

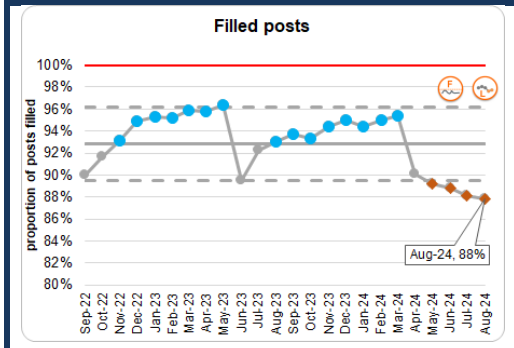
Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by surgery and other musculoskeletal problems. One of the key factors for the increase in overall sickness absence, is an increase in short term sickness which is unusual for this time of year. Cold, Cough, Flu is the fourth highest reason for absence and other Trusts in the region have also noted an unusual increase in short time absence.

Long-term sickness absence represents 56% of all sickness absence and short-term represents 44%.

Actions:

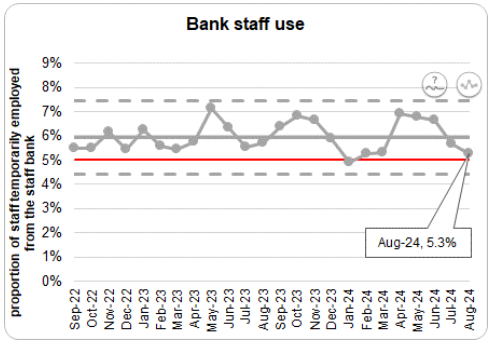
- A review continues to take place with a view to ensure early intervention takes place at an earlier stage.
- All long-term absences are reviewed each month with the Director of People, Organisational Development and Inclusion and the Employee Relations to ensure a supportive and robust approach continues to be taken to managing all absences.

People Performance

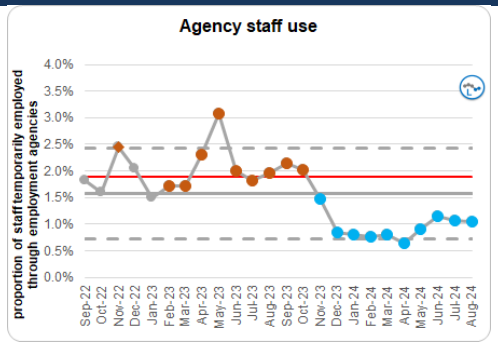


Summary
At the end of August 2024, 88% of posts overall were filled. New investment released from April 2024 onwards has created brand new vacancies.

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

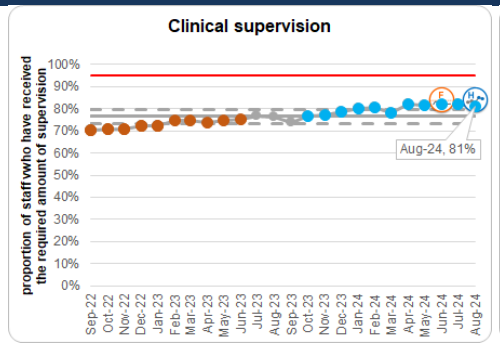


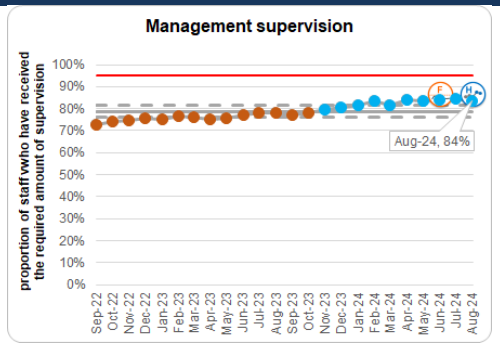
Summary
The proportion of staff employed from the bank ranges from 4-7% per month. Bank staff are predominantly employed on inpatient wards. Reasons for temporary staffing include cover for vacancies, sickness and maternity leave, and for increased levels of observations.



Summary
Agency usage has reduced significantly over recent months and continues to fall following a temporary increase in agency usage 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 81% 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 62% and clinical: 84% versus 31%).

Actions
In Operational Services a review of progress takes place at operational meetings and via weekly reporting to senior operational management for ongoing monitoring and action.

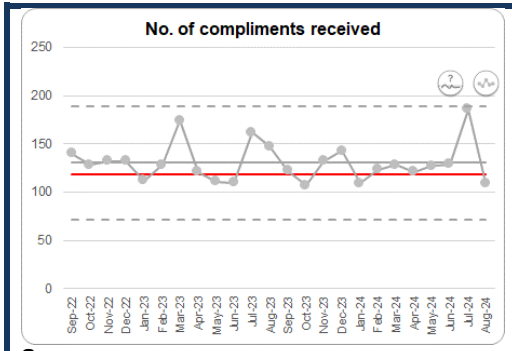
Following the audit of supervision processes, the Trust is now following up on the recommendations which will help towards achieving its target for both clinical and non-clinical supervision.

The recommendations include:
- 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.

Derbyshire Healthcare
NHS Foundation Trust

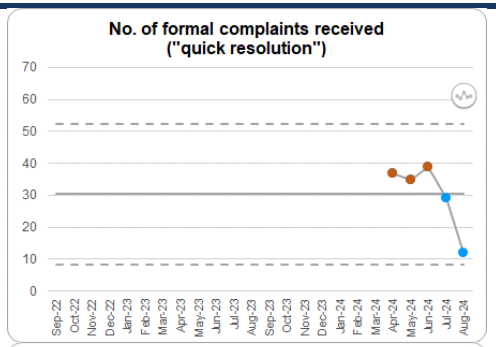
Quality

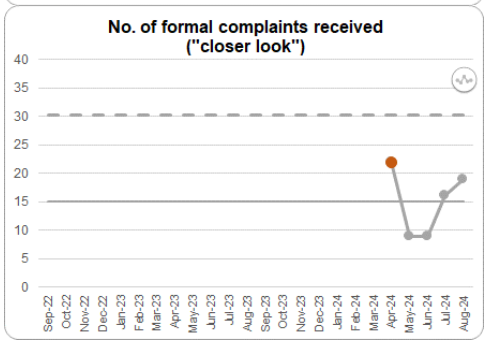
Quality Performance



Summary
The number of compliments recorded between May and August 2024 range from a high of 181 to a low of 74.

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 700 patient feedback responses across the teams received to date. This is currently undergoing an evaluation which will be presented in September to the trust leadership committee with recommendations in relation to what resource will be required to ensure 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.

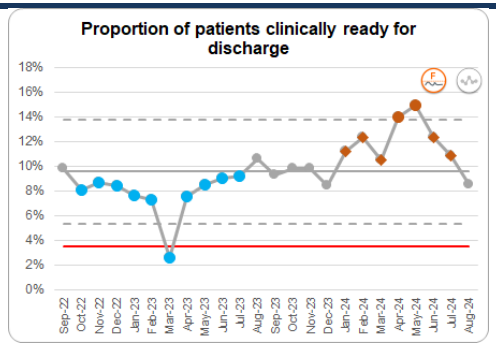




Summary
From 1 April 2024, to resolve matters at the earliest opportunity the Trust have implemented a new process to resolve complaints categorised as "quick resolution" within 10 working days via a Service Manager with responses being provided directly to the complainant either verbally, in person, by email or by letter. If it is not possible to resolve the concern like this a "closer look investigation" is commissioned with a timeframe of 40 or 60 working days to resolve it.

Owing to complaints now being recategorised as quick resolution and closer look, it is not possible to compare and data prior to April 2024. This will be resumed in the next report. As of August 2024, there have been 11 quick resolution complaints and 19 closer look complaints received by the Trust.

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

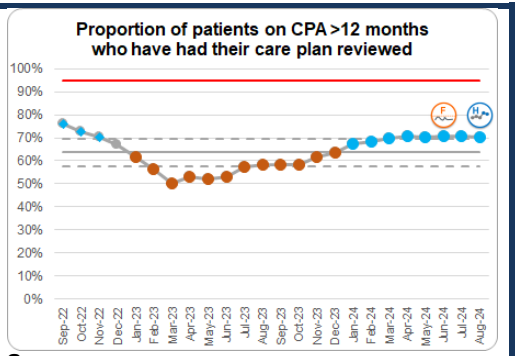


Summary
The proportion of service users meeting the criteria of clinically ready for discharge (CRD) has continued on a downward trajectory that has reduced from 12% to 9% between May and August 2024.

Key issues
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.

Escalation processes and partnership support

- An Adult CRD meeting is held three times a week, which social care services.
- A Strategic Integrated Flow Lead attends the weekly system wide Pathways Operations Group, system wide, weekly Discharge Planning Implementation Group and monthly Strategic Discharge Group.
- A Discharge Tracking Tool as requested by NHS England has been in progress since July 2024, reviewing all adult admissions and onward referrals, allocations and barriers to discharge. This tool will be used to monitor timescales, escalations and identify themes.
- The System priorities identified from the Discharge Planning Implementation Group are to achieve continuity and coordination of care, reduce avoidable length of stay and improve flow and access to local beds.

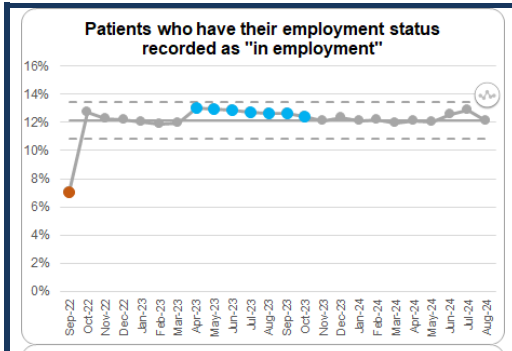


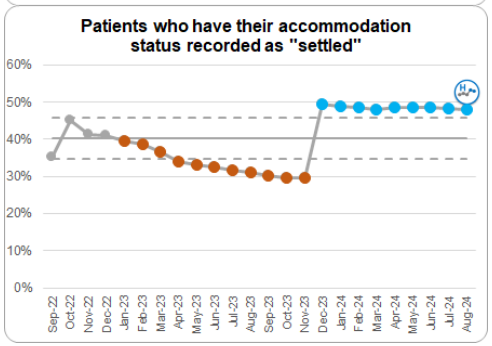
Summary
The current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months is 71%. The trust Target is 95% compliance.

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 is monitored via the monthly Fundamentals of Care meeting, (in Inpatients, the Clinical Reference group) and the Divisional Clinical Operational Assurance Team (COAT) meetings.
- The Community Mental Health team (CMHT) had a target to achieve 85% compliance by April 2024 and the current care plan compliance is 87% as of August 2024. As of September 2024, it has been requested that this target is increased to 100%. The Trust Digital practice team sent out "quick user guides" to services and offer drop-in sessions to support staff in inputting information correctly but have stated there is no way to prevent staff creating the care plans in a incorrect way which is not picked up by the algorithm.
- 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 led by the trust medical director which is now expected to start in October 2024 following a further delay due to changes of staff.

Quality Performance



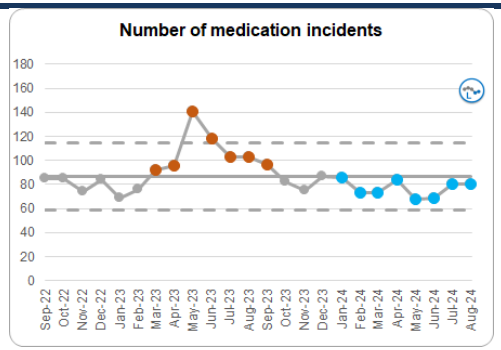


Summary

Patients open to the Trust in settled accommodation has remained static at 49% between May and August 2024 and the number of patients open to employment has continued to remain between 12 and 13 percent 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.

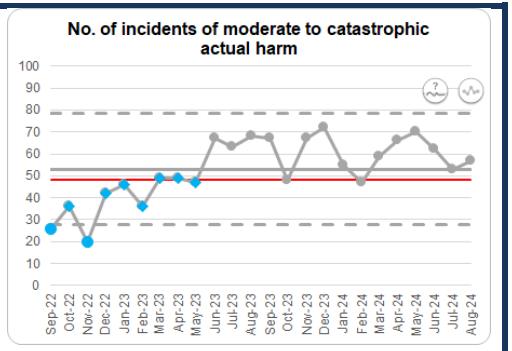


Summary

The number of medication incidents between March and May 2024 has increased from 72 to 80 (11%) and continues in line with common cause variation and under the Mean of 90. 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 could be influencing incidents not going over 90 since January 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 demonstrate the number of DATIX incidents recorded as moderate or catastrophic harm. The number of incidents decreased by 32% between May and August 2024 from 76 to 52 incidents.

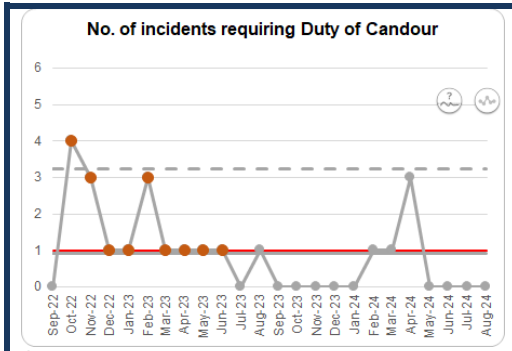
Analysis suggests that this is due to an sustained number of incidents routinely reported by staff and sustained reporting of incidents recorded as “self-harm” and physical assault from patients to staff and patient to patient.

A pattern of a high number of repeated incidents involving to a small group of patients continues to be seen and is consistent with 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 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
Duty of Candour remains within expected thresholds with no cases between May and August which required duty of candour disclosure.

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

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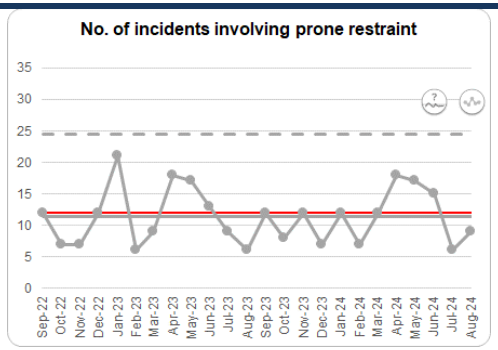
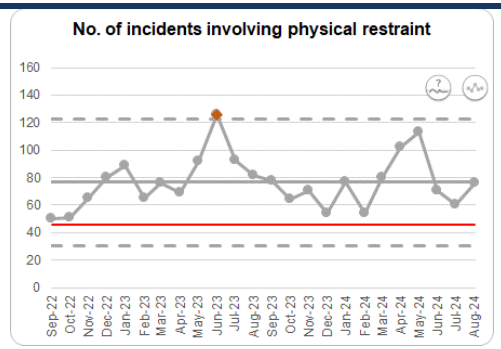
Action
Training around accurately reporting DoC continues within clinical teams and the Family Liaison Officer with support from the patient safety team review each DoC incident as they occur and request support from the HoN team as required.



Summary
Incidents of prone restraint have decreased from 17 to 7 incidents between May and August 2024. This is in below the Trust target of 12 incidents.

The reduction in prone restraint was expected as the number in May was attributed to an unwell individual who required multiple interventions and numbers have reduced in line but this person recovering.

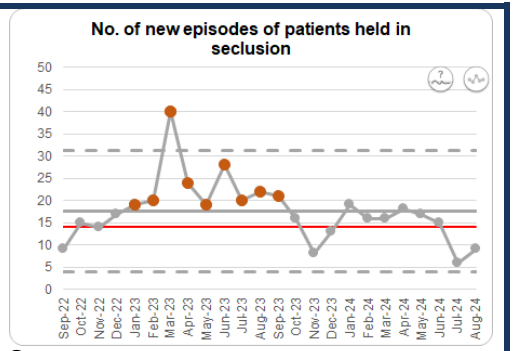
Action
The Positive and Safe Support Team PSST have introduced training around alternative injection sites in April 2024 and the clinical lead from the Trust Health Protection unit has developed a training package on giving deltoid injections to support staff confidence and this is expected to start in June 2024. These are now live and over 90 staff have expressed an interest in the deltoid injection training. These interventions are expected to reduce the need for prone restraint.



Summary
Physical restraints have decreased by 56% from 121 to 54 incidents between May and August 2024. The female acute wards and older adult wards continue to have most incidents attributed to them. The decrease in episodes of physical restraint is attributed to a reduction in self-harm incidents and a correlating reduction in staff intervention required to prevent individuals harming themselves.

The high number in May was due to an increase in physical restraint due to repeated incidents on the perinatal ward due to an unwell individual which is unusual for this area and as expected incidents have reduced following the individual's recovery. Incidents involving physical restraint are continuously reviewed within the Reducing Restrictive Practice group and the Trust Positive and Safe Support team continue to offer extra training sessions to improve training availability for staff.

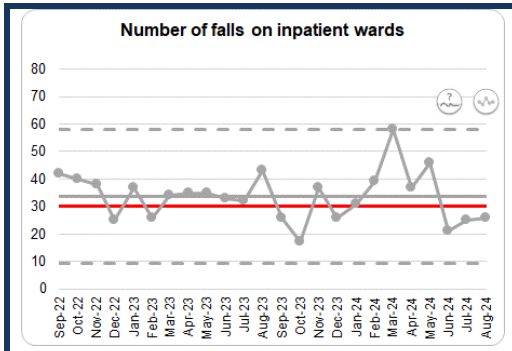
Action
The Trust Positive and Safe Support team continues to offer supplementary training sessions to improve training availability for staff and compliance with positive and safe training is currently at 72% for teamwork and 83% for breakaway training. The slower than anticipated increase in compliance 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 Practise group. Compliance is expected to increase monthly and the PSST team expect to get both breakaway and teamwork training to 85% by October 2024 due to the increase in staff who require training.



Summary
Seclusions between May and August 2024 have decreased by 21% from 24 to 11 episodes of seclusion. 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 was expected in June 2024 however due to delays links due to a change in staff, this is now expected to be complete by October 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 May and August 2024 has decreased by 46% from 46 to 22. The higher numbers in May were due to several repeated incidents attributed to a small group of patients with challenging conditions. Following these patients being discharged to more appropriate environments, the number of falls has reduced as expected.

It should also be noted that 95% of the falls recorded over this period were categorised as minor or insignificant meaning that no harm came to the individuals involved. This is very similar to the previous report (96%)

Actions

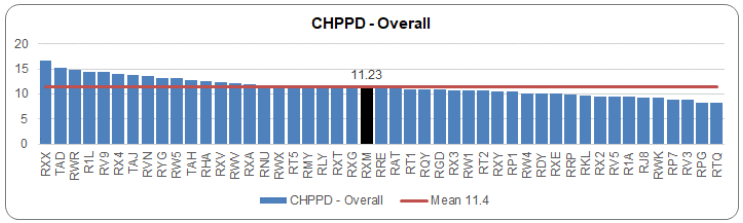
- The patients identified as high risk of falling are discussed in the biweekly falls prevention meeting all have fall prevention care plans in place and a dedicated falls prevention Physiotherapist returned following a long absence in April 2024.

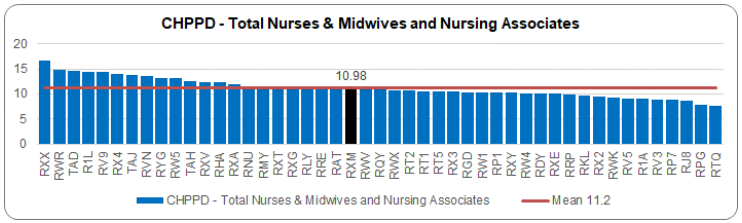
- The number of falls reported is monitored via the Falls Lead Occupational Therapist, Head of Nursing and Clinical Matron and learning from the bi-weekly falls prevention meeting is reviewed in the monthly Divisional COAT meeting.

Care Hours per Patient Day (CHPPD)

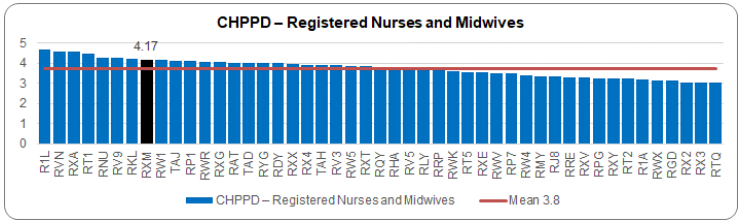
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying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

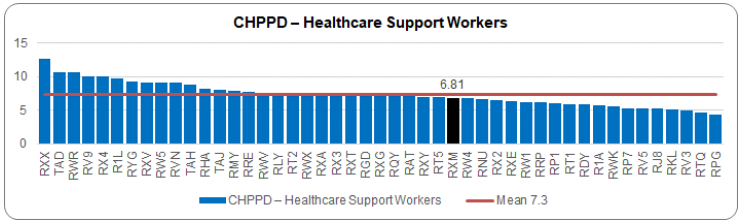
The charts below indicate that the Trust's CHPPD overall achieved 11.23 hours, which was slightly below average when benchmarked against other mental health trusts in the country (11.4). For total nurses and nursing associates the Trust achieved 10.98 hours against the national average of 11.2 hours:





For registered nurses the Trust achieved 4.17 hours against the national average of 3.8 hours. For healthcare support workers the Trust achieved 6.81 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:

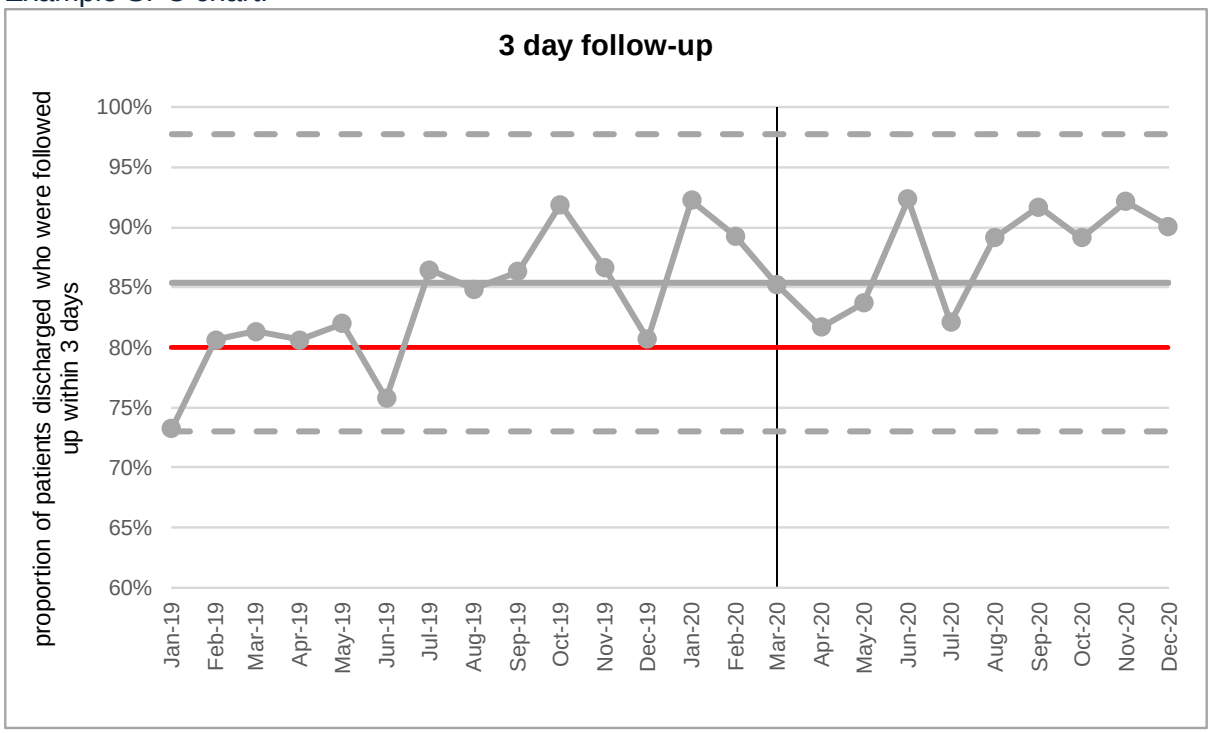
Trust Code	Total Responses	Total Eligible	Percentage Positive	Percentage Negative	Mode of Collection							
					Mode SMS	Mode Electronic Discharge	Mode Electronic Home	Mode Paper Discharge	Mode Paper Home	Mode Telephone	Mode Online	Mode Other
	22,773	**895,903**	**85%**	**8%**	**2,669**	**1,456**	**425**	**5,411**	**1,449**	**833**	**8,710**	**1,820**
	22,233	**884,232**	**85%**	**8%**	**2,617**	**1,330**	**425**	**5,321**	**1,445**	**833**	**8,600**	**1,662**
	22,763	**883,819**	**-**	**-**	**2,342**	**1,456**	**425**	**5,133**	**1,449**	**833**	**8,455**	**1,656**
RCU	6	1,049	100%	0%	0	0	0	0	2	0	4	0
RR7	10	220	100%	0%	0	0	0	10	0	0	0	0
R8B8U	5	5	100%	0%	0	0	0	0	0	0	5	0
RYK	11	2,098	100%	0%	0	0	0	0	0	0	0	0
O2F3D	63	269	100%	0%	0	0	0	63	0	0	0	0
R0B	123	1,806	98%	0%	0	0	0	86	0	0	37	0
TAH	52	3,932	98%	0%	0	0	0	52	0	0	0	0
NNF	156	2,955	97%	3%	0	0	0	23	4	0	98	0
TAJ	221	18,326	96%	3%	0	0	0	0	0	0	0	4
NQL	84	3,685	95%	1%	0	0	0	0	0	0	0	0
RXL	82	1,466	95%	1%	1	0	0	38	0	0	43	0
RX3	1,326	153,778	94%	2%	108	331	0	785	0	0	102	*
RW4	665	21,085	94%	2%	0	318	0	107	0	0	240	*
R1C	274	2,012	93%	3%	0	0	134	65	0	0	75	60
RXG	409	13,344	92%	4%	1	0	0	178	0	0	230	0
RDY	341	6,933	92%	4%	0	0	44	0	107	0	190	0
RWV	386	6,103	92%	3%	0	0	0	0	120	2	264	0
RP7	524	5,216	91%	2%	15	0	59	0	0	0	450	0
RRE	279	25,935	91%	4%	0	0	0	0	0	0	258	0
R1L	88	16,100	91%	5%	*	*	*	*	*	*	*	*
RV9	307	5,376	91%	3%	0	0	0	307	0	0	0	*
RXX	429	34,457	91%	3%	14	56	0	27	0	0	332	0
TAF	229	1,629	90%	3%	0	0	6	0	0	0	223	483
RXV	523	35,683	89%	7%	0	0	0	0	0	0	0	21
RT2	1,408	12,265	89%	2%	229	0	0	780	0	68	331	1
RRP	632	9,341	89%	4%	0	0	0	632	0	0	0	0
TAD	9	10,076	89%	0%	0	0	0	3	6	0	0	0
RT1	246	2,827	89%	3%	22	53	0	0	88	0	82	523
RXA	777	13,341	89%	6%	770	0	0	7	0	0	0	0
RTF	26	1,896	88%	8%	26	0	0	0	0	0	0	0
RW5	1,294	47,888	88%	7%	0	0	0	0	0	304	990	0
RWX	662	12,745	88%	5%	0	59	0	22	0	0	581	0
RV5	364	39,893	88%	3%	0	0	0	108	0	0	256	0
RXY	596	14,837	88%	4%	0	0	0	576	0	0	20	0
RXM	403	18,305	87%	6%	0	0	0	162	0	0	241	0
RXT	367	19,674	87%	6%	0	0	0	321	0	0	46	0
RQY	756	22,760	87%	7%	165	418	0	0	0	0	0	0
RXE	469	19,470	87%	7%	313	0	0	156	0	0	0	*
RY6	45	1,056	87%	4%	1	0	0	0	0	0	44	0
RGD	188	7,678	86%	4%	0	0	0	0	43	0	145	221
RTQ	190	3,934	86%	6%	0	0	0	0	0	0	190	11
R1F	24	2,432	83%	4%	0	0	0	0	18	0	6	1
NMJ	126	2,134	83%	9%	0	126	0	0	0	0	0	0
RV3	414	26,535	82%	8%	0	0	0	131	0	0	283	173
RVN	452	6,390	82%	6%	1	0	0	111	268	0	72	0
RX2	530	13,361	82%	9%	0	0	0	0	0	0	530	0
RLY	126	13,755	82%	9%	2	0	0	0	18	0	105	0
RP1	244	8,351	82%	11%	0	0	134	0	99	0	11	0
RWK	600	33,774	81%	8%	53	17	0	30	0	440	0	0
RX4	203	35,553	81%	9%	0	0	0	39	0	0	0	0
RMY	483	29,058	81%	13%	0	0	0	0	0	0	0	0
RHA	174	15,626	80%	7%	17	0	0	0	155	0	2	0
RT5	397	12,091	80%	12%	275	6	0	0	0	9	107	0
RKL	239	10,819	79%	15%	0	0	0	114	0	0	125	31
NR5	107	2,129	79%	11%	52	0	0	0	0	0	12	0
RPG	894	15,029	78%	8%	277	47	48	164	164	0	190	*
RWR	712	12,688	77%	11%	*	*	*	*	*	*	*	0
RNK	50	2,735	76%	16%	*	*	*	*	*	*	*	43
RW1	1,157	11,261	75%	15%	0	25	0	36	357	10	729	84
RQ3	104	30	68%	7%	0	0	0	0	0	0	104	*
RAT	702	8,620	27%	61%	0	0	0	0	0	0	702	0

Data source: NHS England » Friends and Family Test data

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



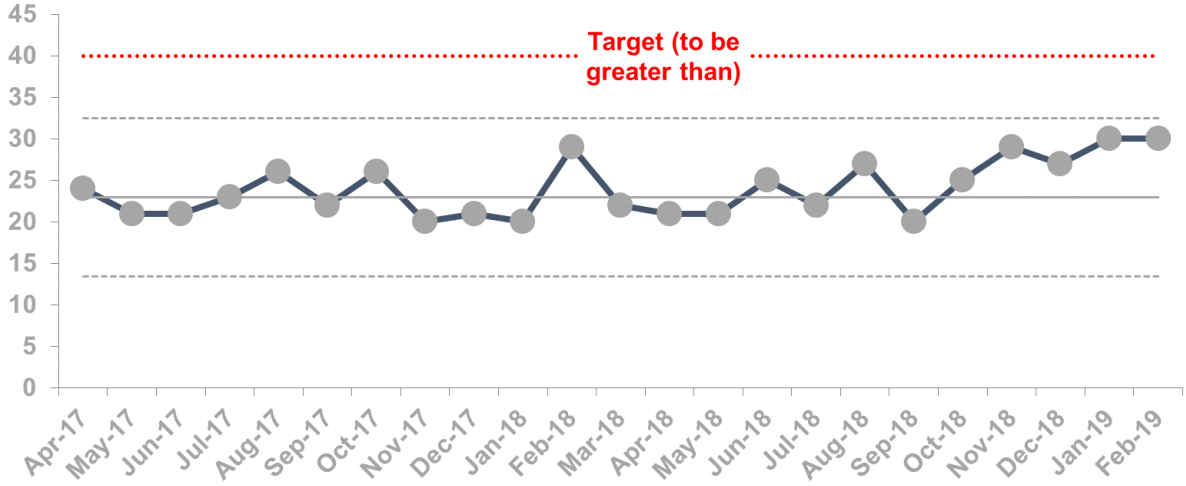
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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

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

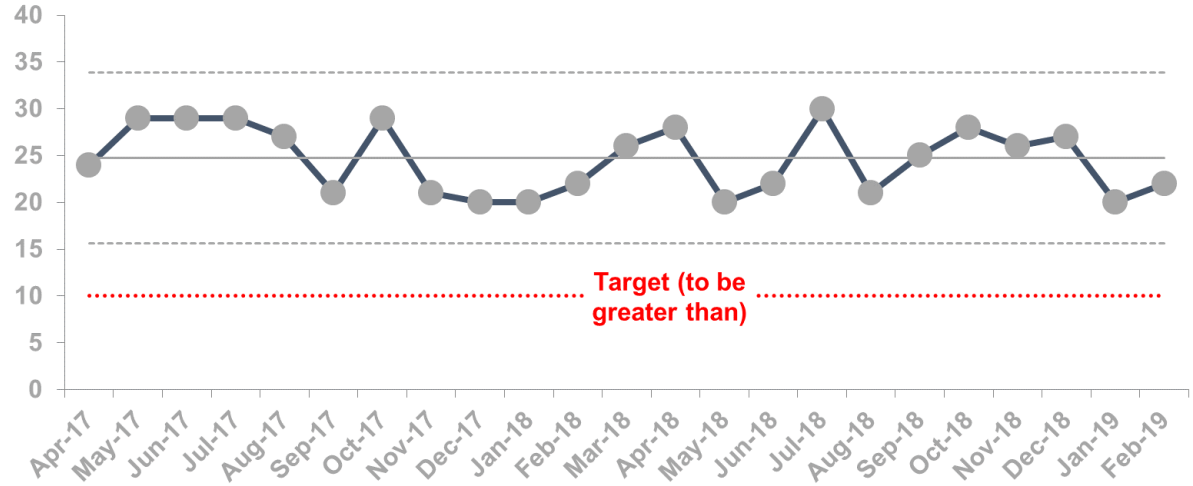
Things to look out for:

1. A process that is not working



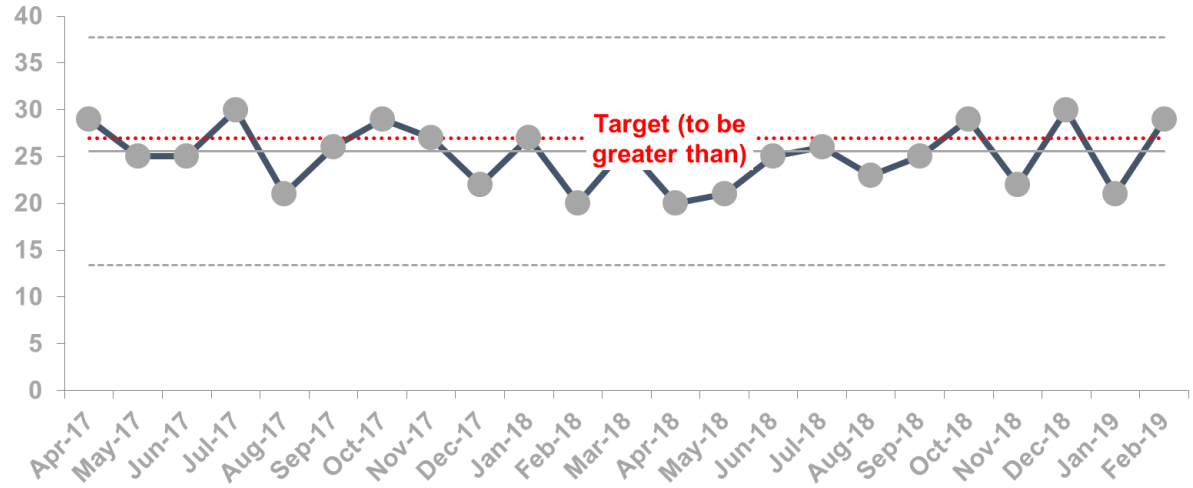
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process



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

3. An unreliable system

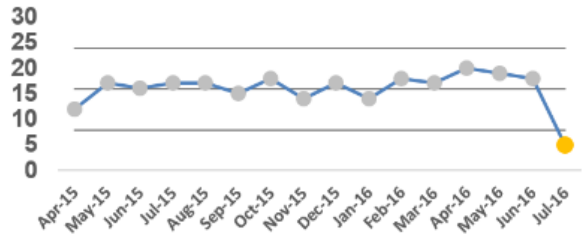
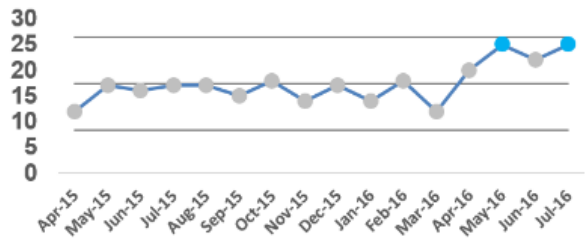
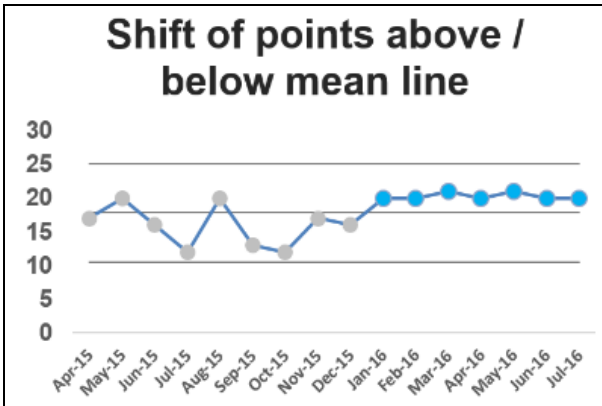


In this example the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

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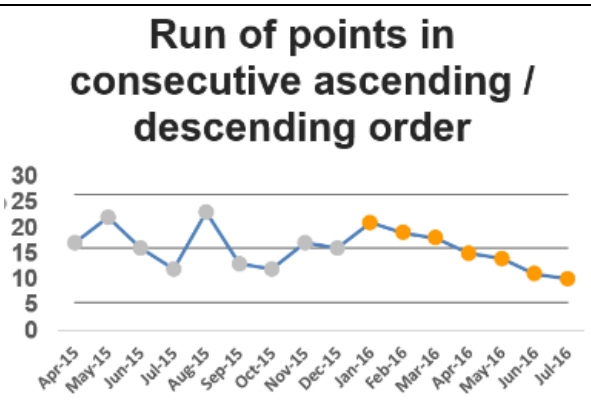
<td> 
</td>
</tr>
<tr>
<td>A run of 7 points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 16 that has proven to be effective.</td>
<td>A run of 7 points in consecutive ascending or descending order is significant.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

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 – 1 October 2024

Trust Strategy Progress Update 2022–2025: Quarter 1 2024/25

Purpose of Report

To provide the Board with an update on progress in delivering the priority actions identified in the Trust Strategy for delivery during quarter 1, 2024/25.

Executive Summary

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

The attached appendices set out progress in delivering the priority actions identified in the Trust Strategy for delivery during quarter 1, 2024/25 quarter 1. There were no specific priority actions due for delivery in Q1, 2024/25, however, a number of priority actions have been delivered ahead of schedule including:

- **Develop a consistent approach to people centred leadership** – the Leadership Development Strategy and approach has been finalised. A senior leadership programme has now been commissioned. In addition, a number of ongoing leadership programmes are on offer to colleagues and bespoke team development is in place. Assurance will continue to be fed into the People and Culture Committee on progress and delivery
- **Be a compassionate and inclusive organisation where staff feel they belong, thrive and are valued** – there are strengthened organisational communication and engagement channels to colleagues, including the introduction of a face-to-face leadership forum. The Staff Survey 2023 measures indicate improvements across our key engagement and belonging measures. Bespoke team development programmes arranged where there have been areas of concern or development needed for the team to move to a more compassionate and inclusive approach. Independent review of Michelle Cox lessons learnt has been completed and recommendations feed into the EDI steering group to strengthen our approach on bullying and discrimination.

The remaining priority actions continue to be progressed. In terms of the Making Room for Dignity: Improve the Safety, Privacy and Dignity of Patients priority action, issues identified in September 2024 have resulted in a revised timeline for build completion and go live.

Engagement on the development of a new Trust Strategy started in February 2024 and over recent months has focused on a range of different topics, including the Trust's culture, our vision and values, strategic priorities and brand identity. This has taken place alongside conversations about how we can better address health inequalities, to support the development of a new Clinical Strategy. Engagement has focused on internal audiences initially, including Trust colleagues, staff networks, governors and patient and carer networks. All feedback received has been analysed and used to shape the new Trust Strategy. This includes the development of a revised set of Trust values, and new strategic priorities that will address current challenges and connect to the various teams, roles and professions in place across Derbyshire Healthcare. A new Personal Accountability Charter has also been co-created with colleagues, to provide further details on how the Trust's values will be felt in day-to-day interactions. This will be integral to the Trust's existing people processes.

External engagement on the Trust Strategy was postponed due to the pre-election period that took place in spring 2024. Broader external engagement on the new Strategy will now take place this autumn, ahead of the new Trust Strategy being received by the Board of Directors in November 2024.

The Board is asked to note the Q1, 2024/25 progress in delivering the priority actions as set out in the updated Trust 2022–2025 Trust Strategy, and the progress to develop a new Trust Strategy.

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

None identified.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to note the Q1, 2024/25 progress in delivering the priority actions as set out in the updated Trust 2022–2025 organisational strategy and the progress to develop a new Trust Strategy.

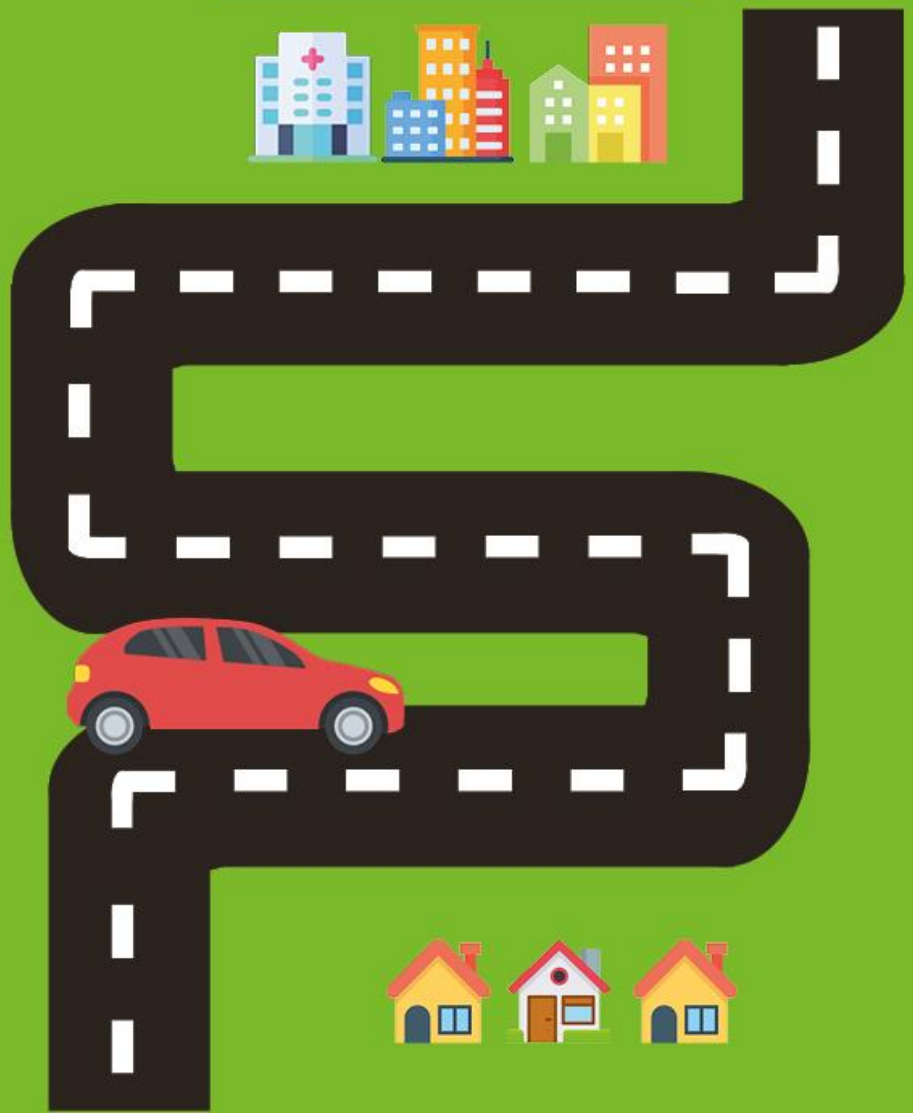
Report presented by: **Vikki Ashton Taylor**
Deputy Chief Executive and Chief Delivery Officer

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

Anna Shaw
Deputy Director of Communications

Priorities we will deliver in 2024/25

- Improve processes for those experiencing stress in and out of work
- Successfully implement and lead the provider collaborative for Perinatal inpatient services
- Deliver perinatal community mental health access standard of 10% of prevalence
- Work in partnership to progress the harmonisation of Learning Disabilities and Autism services
- Develop a consistent approach to people-centred leadership
- Develop a workforce plan
- Making Room for Dignity: Improve the safety, privacy and dignity of patients through our Making Room for Dignity programme
- Each division will have its own specific quality requirement standards
- Deliver a less than 32 days average length of stay on our acute mental health wards



- Deliver electronic prescribing and transfer prescriptions element of the OnEPR programme
- Recover dementia diagnosis rates to national target of 67%
- Improve recruitment and retention to support new services and ensure safer staffing levels
- Deliver our Long Term Plan Commitments including Transforming Care Partnership (TCP) and Living Well
- Be a compassionate and inclusive organisation where staff feel they belong, thrive and are valued
- Optimise the use of SystmOne across the Trust
- Focusing on the safety domain of practice and preparing for changes in mental health legislation
- Deliver planned financial efficiencies to ensure the Trust is a sustainable organisation. Agree our 3-5 year financial plan

Completed
Partially completed
In progress

Progress in Delivering 2024/25 Priorities – Quarter 1 Update

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Making Room for Dignity: Improve the safety, privacy and dignity of patients	Partially completed. Construction / refurbishment completed for Bluebell Ward and Audrey House and commenced at all remaining sites. A number of issues identified in September 2024 have resulted in a change to the timeline as set out below. Recruitment commenced for posts required early to shape new services: Bluebell Ward, Walton Hospital Derwent Unit, Chesterfield Royal Hospital Audrey House Enhanced Care Unit Carsington Unit, Kingsway Hospital Kingfisher House PICU, Kingsway Hospital Jasmine Ward, Radbourne Unit Orchid Ward, Radbourne Unit – pending additional capital	Ongoing Completed February 2025 Completed February 2025 March 2025 Autumn 2025 Summer 2026	Finance & Performance Committee People & Culture Committee
Deliver Perinatal community MH access standard of 10% of prevalence	Delivered. The target is measured on a rolling 12-month period. The full year 10% target has been achieved in February 2024 (10.1%)	Delivered	Finance and Performance Committee
Develop a consistent approach to people centred leadership	Delivered. Leadership development strategy and approach finalised and discussed at May People and Culture Committee. Senior leadership programme has now been commissioned. Ongoing leadership programmes on offer to colleagues and bespoke team development in place. Assurance will continue to be fed into PCC on progress and delivery.	Delivered - September 2024	Quality and Safeguarding Committee People and Culture Committee
Deliver less that 32 days average length of stay on our acute MH wards	In progress. There are a number of workstreams underway to improve patient flow including reducing the number of patients in Out of Area Beds and reducing the average length of stay. The average LOS for July 2024 has come down considerably and is currently ahead of trajectory. Currently 42 days and aiming to achieve 32 days.	March 2025	Finance and Performance Committee

Progress in Delivering 2024/25 Priorities – Quarter 1 Update

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Each division will have its own specific quality requirement standards	Partially completed. The focus is to ensuring services meet fundamental standards. Self-assessment framework against CQC's single assessment process has been established and a schedule of visits / reviews has begun. The prototype quality surveillance tool to identify hotspots has been developed and is to be presented at ELT in August to agree next steps.	March 2025	Quality and Safeguarding Committee
Work in partnership to progress the harmonisation of learning Disabilities and Autism services	Delivered. A MoU has been developed between executive leaders across the organisations to provide a joined-up approach for citizens, a common vision, objectives and purpose and improved quality, pathways or access to care for patients and carers. An integrated leadership structure has been implemented via a single Head of Service Derbyshire Healthcare NHS Foundation Trust (DHcFT) employee)	Delivered	Trust Board
Improve processes for those experiencing stress in and out of work	Delivered. In house staff Clinical Psychologist in place and offering support to colleagues both in and out of work. This is to complement the existing offer via Employee Assistance Programme (EAP) and Resolve. Alignment with long term absences in place.	Delivered	Quality and Safeguarding Committee
Successfully implement and lead the provider collaborative for perinatal inpatient services	Delivered. Approval granted by NHS England for Derbyshire Healthcare NHS Foundation Trust (DHcFT) to become Lead Provider in October 2023. Formal governance arrangements are now established in relation to contracting and quality oversight.	Delivered	Quality and Safeguarding Committee People and Culture Committee
Deliver electronic prescribing and transfer prescriptions element of the OnEPR programme	Delivered. Successful implementation and roll out. Optimisation work underway to improve standard operating procedures in services where improvement opportunities have been identified.	Delivered	Finance and Performance Committee

Progress in Delivering 2024/25 Priorities – Quarter 1 Update

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Recover dementia diagnosis rates to national target of 67%	Delivered. The diagnostic rate is above target (67.4%) and has remained over target month on month following extensive continuous quality improvement work undertaken by the team.	Delivered	Finance and Performance Committee
Focusing on the safety domain of practice and preparing for changes in mental health	Partially completed. Embedding the effectiveness of the Patient Safety Incident Response Framework (PSIRF) work is underway with further improvements planned to improve the timeliness of reviews and the sharing of learning and will be delivered by March 2025.. Changes to the mental health legislation have been significantly delayed, although the incoming government has announced plans to bring this forward, however, there remains uncertainty regarding timetable for change.	March 2025	Quality and Safeguarding Committee
Improve recruitment and retention to support new services and ensure safer staffing levels	Delivered. New approaches developed and embedded that consider a more creative and innovative way to attract and recruit and allow a more diverse pool of candidates both at application through to appointment. Ongoing work to improve retention in place, targeting key professions and teams where turnover is above Trust average.	Delivered	Quality and Safeguarding Committee People and Culture Committee
Be a compassionate and inclusive organisation where staff feel they belong, thrive and are valued	Delivered. Strengthened organisational communication and engagement channels to colleagues, including introducing a face-to-face leadership forum. The staff survey 2023 measures indicate improvements across our key engagement and belonging measures. Bespoke team development programmes arranged where there have been areas of concern or development needed for the team to move to a more compassionate and inclusive approach. Independent review of Michelle Cox lessons learnt has been completed and recommendations feed into the EDI steering group to strengthen our approach on bullying and discrimination. This is a continued priority into the 2024 strategy.	September 2024	Quality and Safeguarding Committee People and Culture Committee

Progress in Delivering 2024/25 Priorities – Quarter 1 Update

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Deliver planned financial efficiencies to ensure the Trust is a sustainable organisation. Agree our 3-5 year financial plan	In progress. The full Trust Long Term Financial Model updated 5-year financial plan is still outstanding. Cost Improvement Programmes (CIPs) of at least 5% per annum for 3 years are the minimum expectation. Our 24/25 plan demonstrate a longer-term plan is required to return to financial balance and sustainability. The medium-term options are being scoped further to consider potential financial impact, and priority of any potential wider transformation and service change. JUCD agreed an approach to refresh the 5-year plan across the derbyshire system. All partners have been requested for the work to be developed in system wide standard format. The ask is to complete templates for submission by 6 September 2025. Initial process builds on 2024/25 plans and adjusts for NR and FYE factors to arrive at the updated underlying deficit . This then models simplistic baselines. (Assume no growth money and pre future efficiency requirement). Recognised, will take longer to develop into a full LTFM. This is also going to need longer to run via Trust governance and formal sign off is not needed for submission but would follow.	September – March 2025	Finance and Performance Committee
Optimise the use of SystmOne across the Trust	Partially completed. Ongoing training to staff and review of standard operating procedure content and application to improve data quality. Focus on inpatient wards following CQC visit. All standard operating procedures(SOPs) and training completed. To further embed the use of the system and new functionalities system training and SOP will be monitor though the agreed digital governance processes. Fully implementation of Communication Annex functionality along with improvement in digital competence and clinical practice issues will help resolve data quality issue challenges.	September 2024	Finance and Performance Committee

Progress in Delivering 2024/25 Priorities – Quarter 1 Update

Priority	Progress (to include delivery to date, rag rating red, amber, green, actions to recover if off track and expected delivery date)	Delivery Date	Assurance Committee
Deliver our Long term Plan commitments including TCP and Living Well	Delivered. The Living Well final wave (wave 3) fully mobilised in quarter 4. Focus now on optimising benefits of new model of care**.** Full System Development Funding (SDF) mapped out and awaiting approval for 2024/25 to deliver on TCP. System partners engaged with and working with health to ensure objectives and deliverables are realistic, achievable and in line with National Health Service England (NHSE) Learning Disability and Autism (LDA) priorities.	Delivered	Finance and Performance Committee
Develop a workforce plan	Delivered. The workforce plan is complete and is on the board agenda for October	Delivered	People and Culture Committee

Derbyshire Healthcare NHS Foundation Trust

Report to the Trust Board September 2024

Board Assurance Framework (BAF) Update
Issue 2, 2024/25 – Version 2.3

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the second issue of the BAF for 2024/25. **Note: this version has been approved under CEO and Chairs emergency powers due to re-scheduling of the Board meeting dates.**

Executive Summary

Director Leads, Deputy Directors, Directors of Operations, Operational Leads and Trust Senior Managers have reviewed the risks to the Trust's strategic objectives for 2024/25 and provided comprehensive updates for the second issue of the BAF. The Executive Leadership Team (ELT) reviewed Issue 2, provided feedback and requested further updates which were then included in the BAF report and approved by the Audit and Risk Committee (ARC).

The main updates to the risks are as follows:

Risk 1A – There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board

One action linked to areas of improvement identified in a previous CQC inspection has been removed as this has been incorporated into the first action under Risk 1A, the implementation of revised priority actions for 'Good Care'.

Following ELT the following updates were made by the Chief Delivery Officer and then approved by ARC:

> *Gap in operating standards for acute and community mental health services – Final stage of mobilisation has now been completed (Quarter 4, 2023/24)*

Risk 1B – There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and PICU and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements

The Senior Responsible Officer for the Acute Care Capital Programme has made the following updates:

> *Dates have been updated to coincide with expected go-live dates for each unit with the exception of the Radbourne Unit, for which a review date of November has been added, when a firm go-live date for Ward 32 is confirmed and it will be known if the Ward 35 refurbishment is being funded and is proceeding. The go-live dates for the two new adult acute units have been updated*

Risk 1C - There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage

The action to close the key gaps in control has an improved RAG rating, going from amber to green as work is in progress and is on track.

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

The amended gatekeeping and purposeful admission process was launched as expected in April 2024.

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

Two actions to close key gaps in control have an improved RAG rating, going from red to amber, as work progresses around the Leadership Strategic Approach, the senior leadership programme and the leadership forum, and the capacity of the People Services team is reviewed.

One action relating to training has been removed as the key gaps in control have been thoroughly reviewed by the Director of People, Organisational Development and Inclusion.

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

One key gap in controls, relating to experience to recruit overseas, has an improved RAG rating, going from red to amber. Following review at ELT the following rationale was provided by the Director of People, Organisational Development and Inclusion and was added to the BAF report:

> *Successfully recruited and objective structured clinical examination (OSCE) conversion completed for two IR candidates*
>
> *Further five candidates recruited and arriving July 2024*

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

The Director of Finance has thoroughly reviewed the risk, has updated the title and the assurances and has added to the actions to close the key gaps in controls and the measures in place to monitor the impact of the actions upon the overall risk.

Risk 4A – Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change may impact negatively on the cohesiveness of the Derbyshire health and care system

One action to close the key gaps in control has an improved RAG rating, going from red to amber – The ICB's change of strategic direction and working methods are resulting in an emerging risk but this is being monitored and work is ongoing to close key gaps in control linked to Risk 4A.

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

Updates have been added to cite the improvements in waiting times for autism assessments, and the expansion of work undertaken by the Director of Nursing, AHPs and Patient Experience in relation to patient and carers forums.

Risk MS1 – There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS in-patient LD bedded care

The risk and progress remain stable, the status is little changed in the last quarter.

Operational Risks

One high level operational risk has been removed from Risk 3A as it was a duplication of the strategic risk which has been thoroughly reviewed and includes all actions and updates previously held in the Datix record.

BAF Reporting Cycle/Format

All changes/updates to this issue of the BAF, compared with Issue 1 2024/25, are indicated by tracked changes (blue text). All text that has been stricken through will be removed from the next issue (Issue 3, 2024/25).

Board Committees receive extracts from the BAF to review the risks they are responsible for at all of their meetings – All updates received from the Board Committees are incorporated into the BAF report for ARC approval and then Board review and approval.

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

Risks and Assurances

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

Consultation

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

Formal Reviews

- Executive Leadership Team, Issue 2.1: 16 July 2024
- Audit and Risk Committee, Issue 2.2: 25 July 2024
- Chief Executive and Chair, under Emergency Powers, Issue 2.3: September 2024

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Recommendations

The Trust Board is requested to:

1. Note this approved, second issue of the BAF for 2024/25 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2. Continue to receive updates in line with the forward plan for the Trust Board.

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

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

Board Assurance Framework 2024/25 – Issue 2.3 Board September 2024

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

Ref	Risk	Director Lead	Risk Rating	Responsible Committee
Strategic Objective 1 - To Provide GREAT Care in all Our Services				
24-25 1A	There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board	Executive Director of Nursing, AHPs and Patient Experience (DON) / Medical Director (MD)	**HIGH**	Quality and Safeguarding Committee
24-25 1B	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and Psychiatric Intensive Care Unit (PICU) and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements	Chief Delivery Officer (CDO)	**HIGH**	Finance and Performance Committee
24-25 1C	There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage	Chief Delivery Officer (CDO)	**MODERATE**	Finance and Performance Committee
24-25 1D	There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur	Executive Director of Nursing, AHPs and Patient Experience (DON) Chief Delivery Officer (CDO)	**MODERATE**	Quality and Safeguarding Committee
Strategic objective 2 – To be a GREAT Place to Work				
24-25 2A	There is a risk that we are unable to create the right culture with high levels of staff morale	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee
24-25 2B	There is a risk that we do not have a diverse workforce with the right number of people with the right skills to support and deliver safe high-quality care	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee
Strategic Objective 3 – To Make BEST Use of Our Resources				
24-25 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties	Executive Director of Finance (DOF)	**EXTREME**	Finance and Performance Committee

Strategic Objective 4 – To be a GREAT Partner				
24-25 4A	Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change may impact negatively on the cohesiveness of the Derbyshire health and care system	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board
24-25 4B	There is a risk of reputational damage if the Trust is not viewed as a strong partner	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board

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

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

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

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the clinical and medical workforce
b) Risk of substantial increase in clinical demand in some services
c) Intermittent lack of compliance with Care Quality Commission (CQC) standards, specifically the safety domain
d) Lack of embedded outcome measures at service level
e) Lack of compliance with physical healthcare monitoring in primary and secondary care, not at the required level for reductions in mortality
f) Restoration and recovery of access standards in autism and memory assessment services
g) Lack of appropriate environment to support high quality care, i.e. single gender dormitories and PICU leading to out of area (OOA) bed use for PICU
h) Local NHS Trusts will offer Recruitment and Retention Premium to Consultant Psychiatrists in specialist services and other clinical staff due to competitive practices that destabilises Trust clinical services and leads to a deterioration in waiting time and potentially in safety
i) Due to the move in Electronic Patient Record (EPR) system there is potential that data quality could adversely affect clinical standards
j) Health inequalities across Derbyshire. Initial insights show gaps in access to service, case load and worsening patient outcomes for our patients
k) Sustained pressure in the crisis and acute care pathway with bed occupancy over 85% and increased waiting time for patients to access bedded care from the community
l) Gaps in Advocacy for Children who are under 18
m) Capacity to learn from other organisations in their ability to maintain adequate mortality, serious incidents and learning reviews to respond to improve practice and to also comply with the coroner's formal requirements

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

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; monitoring and effective responses to infection and control guidance, EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits in and out of hours and Board visits

Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints and risk investigation; clinical audit; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24-hour period
Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment Head of Nursing and Matron compliance visits Board visits and out of hours visits CQC action plan in place in relation to the high level feedback received from April 2024 inspection	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good Trust fully compliant with National Quality Board Learning from Deaths guidance Relationship Meetings with CQC taking place~~(in planning)~~ Patient Safety Incident Response Framework (PSIRF) implementation CQC inspection (April 2024) – Report pending

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Summary of progress	Action rating
Implementation of revised priority actions for 'Good Care' which support the Trust strategy and in response to CQC inspections and recommendations	Redesign improvement plans to align to revised building blocks which support the Trust Strategy [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule detailed in quality dashboard Internal reporting against self-assessment CQC inspection and assessment as a measurement tool	31.03.25	~~Following the CQC inspection of ward 35, the Trust has reviewed its governance structures relating to meeting the fundamental standards~~ Quality Surveillance Dashboard revised (programme of ward visits which are assessed against the CQC's single assessment framework) A CQC/Fundamental Standards Trust Oversight Group has been	AMBER

				established, which scrutinises progress of actions arising from regulatory inspections and Mental Health Act visits and provides sign-off of completed actions CQC Executive Oversight Group in place – Weekly scrutiny of actions and updates reviewed ~~DARs have been reviewed and going forward will become~~ Divisional Performance Reviews (DPRs) now embedded and the Trust Leadership Team (TLT) group has been reviewed ~~and will provide a combined quality and operational function~~	
Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment services	Investment required by ICS to meet assessment and treatment demands [ACTION OWNER: CDO]	Agreed funding allocation has occurred, recruitment to posts is active	(30.~~06~~09.24)	Commissioned target of 26 assessments per month now being sustainably exceeded. Discussions underway with ICB commissioners and executives on next steps to bolster ASD investment through contractual changes. Positive engagement session with GPs on their role in future pathways including need to include ADHD	AMBER

~~Six service areas were assessed as 'Requires Improvement' by CQC in relation to safety~~	~~Develop and implement an improvement plan to promote self-assessment and Trust-wide quality surveillance [ACTION OWNER: DON]~~	~~Internal reporting against self-assessment~~ ~~CQC inspection and assessment as a measurement tool~~	~~31.03.25~~	~~Significant improvement in all services~~ ~~Following the CQC inspection of ward 35, the Trust has reviewed its governance structures relating to meeting the fundamental standards~~ ~~Quality Surveillance Dashboard revised (programme of ward visits which are assessed against the CQC's single assessment framework).~~ ~~A CQC/Fundamental Standards Trust Oversight Group has been established, which scrutinises progress of actions arising from regulatory inspections and Mental Health Act visits and provides sign-off of completed actions~~ ~~DARs have been reviewed and going forward will become Divisional Performance Reviews (DPRs) and the Trust Operational Oversight Leadership (TLT) group has been reviewed and will provide a combined quality and operational function~~	~~AMBER~~

Gap in operating standards for acute and community mental health services	Enhanced monitoring of acute and community mental health services by the Nursing and Quality Directorate [ACTION OWNER: DON] Implement Royal College of Psychiatrists (RCP) Standards across Acute Services [ACTION OWNERS: MD/DON/CDO] Implement Community Mental Health Framework [ACTION OWNER: CDO]	Improvement in operating standards compliance to be overseen by the Trust's CQC oversight group. To be confirmed by internal assessments against the new self-assessment framework and ultimately via external CQC inspection and assessment ~~Accreditation for Inpatient Mental Health Services (AIMS) to be completed by end of Quarter 3 2023/24~~ Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Achievement Reviews and Quality Account Implemented Mental Health Community Framework to Quality and Safeguarding Committee	31.03.25 ~~(30.06.24)~~ 31.03.25	Increased performance management scrutiny and unannounced site visits undertaken with compliance checks Mock inspections and CQC assurance forums continue ~~Work being carried out to become accreditation ready ahead of the implementation of the shift consultation to ensure compliance with European Working Time Directive (required as part of an accreditation application)~~ Policy and Standard Operating Procedure (SOP) for Derbyshire Living Well and Derby Wellbeing Services is published. Internal Trust programme Board in place to strengthen contribution and involvement in system-wide programme and delivery Mobilisation underway in High Peak, Derby City, Chesterfield and North-East Derbyshire System Programme Team now established following vacancies	AMBER

				Final stage of mobilisation now completed in Quarter 4, 2023/24~~is underway in~~ in Amber Valley, Erewash, South Derbyshire and Derbyshire Dales ~~– Completion at end of March 2024~~	
Implementation of clinical governance improvements with respect to: - Outcome measures - Clinical service reviews including reduction in excess waiting times	Develop and implement an improvement plan [ACTION OWNERS: MD/DON/CDO]	Compliance with suite of metrics and reporting schedule	(30.~~06~~09.24)	The re-launched Divisional Performance Reviews commenced in April. The DON is working on the development of a new clinical quality dashboard – A prototype has been developed and a paper will be submitted to ELT in July re second phase deployment	AMBER
Implementation of new quality priorities for: - Sexual safety - Implementing CQUINS and Clinical outcome measures - Recovering services – equally well - New Trust strategy and priorities - Dormitory eradication programme	Develop and implement an improvement plan to enable all quality priorities to be implemented [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule	31.03.25	The Trust has developed a sexual safety plan and has signed up to the sexual safety charter Sexual safety – Improvement work (dashboard, preceptorship training and protocols) commenced. Sexual safety on professional standards video launched with new training Sexual safety checklist for services in design and will be submitted to QSG Committee in July	GREEN

				Dormitory eradication programme in construction Trauma informed practice conference and work programme commenced in May 2023. Trauma lead ~~in post for six months~~appointed to develop training and strategy Plan for existing dormitory stock and to maintain and improve dignity for active bed stock assessed and presented to the ICB	
Learning from other independent and national exposures of abuse presents the challenge that we need to have in place to identify poor or concerning behaviour	Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected [ACTION OWNERS: DON/MD]	Communication and effectively responding to learning from recent exposes Mobilise and emphasise expectations of standards of care and Freedom to Speak Up ensuring that staff are aware of how to raise concerns Facilitate conversations on the risks of harm and closed cultures. Reset the culture and the tone of the requirement for professional scrutiny and all employee requirements to prevent harm and report poor care/ abuse Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so	(30.~~06~~09.24)	Options for staff to have conversations about care delivery and raise concerns available include Trust-wide and divisional engagements, Freedom to Speak Up, Schwartz Rounds Improvements in engagement of temporary staff identified Increased visibility of senior staff through Board visits and mock CQC inspections and out of hours visits Robust oversight of patient safety incidents, concerns, complaints, and	AMBER

		colleagues feel empowered to report any concerns Professional leads are in place to ensure that registered professional staff are aware of the requirements to practice in line with their professional codes To work in accordance with the multi-agency policy relating to PIPOT		compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee External partnership working including Healthwatch, Advocacy services and statutory services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board Trust-wide Learning, Culture and Safety Group launched, providing oversight of teams/services with repeating patterns for improvements to be made	
Clinical improvement in the current use and transformation of Care Programme Approach (CPA), to support safe community practice	Identify the Trust's preferred alternative model to replace CPA Establish transition plan which includes communications and training strategy and clear timeline for go live of the new system and detailing when use of CPA will cease	Review of changes to national policy to replace CPA Safe and effective practice is in place	31.03.25	Ongoing oversight of CPA continues with focus on care planning and risk assessment Planning discussion has taken place in relation to the transition from CPA to the preferred alternative model, Dialogue Plus	AMBER

	Implement an improvement plan to enable all services to provide the highest standard of care [ACTIONS OWNERS: DON/MD]			Fundamentals of Care group oversight of key core aspects of CPA CPA training continues at present until alternative identified	
Clinical improvement in the current practice standards for new mental health in-patient standards released by NHS England	Scrutinise new practice standards and develop a new improvement plan, which establishes the Trust's baseline position against the standards, identifies the gaps in compliance and details specific actions needed to achieve the standard, to enable all services to provide the highest standard of care [ACTION OWNERS: DON/MD]	Review new standards and new reporting requirements with the clinical improvement team	(30.~~06~~09.24)	Commencement of the implementation of the national in-patient standards from January 2024. ~~Arrangements in place for the national~~National lead has~~to~~ presented to the executive team and operational leads ~~in March 2024~~and THE Trust has joined the Culture of Care national programme	AMBER
Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To consider a reset of the Trust clinical strategy	Scrutinise new policy direction and develop new plans Routinely review incidents for learning in suicide prevention including cluster analysis and benchmarking [ACTIONS OWNERS: DON/MD]	Adjust strategy and policy to meet requirements Undertake a cluster analysis of in-patient and acute care pathway deaths	(30.~~06~~09.24)	Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities for 2024/25 focusing on prevention and oversight, linked to new strategies Trust clinical strategy ~~to be reviewed~~in development and in line with the timeline for completion of the Trust Strategy ~~and implemented and (~~to include relevant national strategies)	AMBER

Review of Patient Carer Race and Equality Framework and develop implementation plan	Revisit new policy direction and develop new plans [ACTION OWNER: MD]	Review framework and develop implementation plan	(30.~~06~~09.24)	Patient Experience Strategy event completed Patient Experience Strategy to be renewed, with the voice of patient and carers at the forefront, ensuring race and equality clearly referenced New Patient and Carer Strategy has gone through QSG and will be launched in line with the wider Trust Strategy	AMBER

Related operational high/extreme risks on the Corporate Risk Register:

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
3009	Learning Disabilities Services	Demand for Autism Spectrum Disorder (ASD) assessment service far outstrips contracted activity	20.06.23: There has been no increase in budget but the team now at a full complement of staff after a long period of shortages due recruitment problems and sickness. The team are making changes to pilot alternative assessment processes. 23.04.24: Pilot assessment has proved beneficial so is now being accepted as current working practice. Waiting list has reduced to 2 years and 17 weeks and appears to be decreasing by a month every month. Outstanding risks - waiting time continues to be above NICE targets	01.01.16	23.07.24	HIGH
22790	Corporate Services – Pharmacy	Prescribing Valproate: Failure to comply with MHRA patient safety regulations	24.05.23: ePMA now deployed to all services in the Trust which will help with our understanding of valproate use and can be incorporated into planning. Reporting will need to be constructed as part of the optimisation of ePMA 24.05.24: Agreed at Medicines Management Committee (MMC) that risk remains high and will be a standing agenda item for the time being. Risk title updated as regulations now cover male patients as well. Actions taken detailed in the Datix record. Pharmacy Standard Operating Procedures have been updated	28.02.22	31.07.24	HIGH

Strategic Objective 1 – To Provide GREAT Care in all Services

There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and PICU and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements

Impact:
Low quality care environment specifically related to dormitory wards
Crowded staff environment
Patient safety and dignity risks associated with dormitory in-patient bedded care
Non-compliance with statutory care environments
Non-compliance with statutory health and safety requirements

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
d. National capital funding restrictions for business-as-usual capital programme for Trusts and Integrated Care Systems

BAF Ref: 24-25 1B	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 3	Impact 5	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through DATIX; Infection, Prevention Control (IPC) risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; IPC policy and procedure

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

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Deliver two new adult acute 54-bed units with ~~a~~ single room en-suite with additional staffing and new model of care [ACTION OWNER: CDO]	Delivery of approved business cases	~~(30.06.24)~~ 01.12.24	Two new build adult acute unit FBCs nationally approved September 2022, funded by £80m national PDC and £18.6m CDEL. ICS supported and approved revenue funding Delay in national approval and redesign of foundations. Planned to go live November 2024	AMBER
	Older Adult service relocation to refurbished ward with single room en-suite and gender segregation, with additional staffing and new model of care, by September 2024 to eradicate dormitories in Northern Derbyshire and avoid the 12-bed service being isolated in otherwise vacated wards National PDC capital funding approval [ACTIONS OWNER: CDO]	Delivery of approved business case	~~(30.06.24)~~ 02.09.24	Older Adult service relocation FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Scheme re-tendered due to affordability, refurbishment started on site December 2023. This aspect of the project is progressing well and on track to open Bluebell Ward in September ~~August~~ 2024	GREEN
	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire. Service users continue to receive care in non-compliant wards until this refurbishment is completed	Delivery of approved business case	~~(30.06.24)~~ (30.11.24)	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Radbourne Ward 32 refurb commenced November 2023 – ~~January~~ summer 2025 and live March 2025	RED

	National PDC capital funding approval [ACTIONS OWNER: CDO]			Ward 35 refurb scheduled January 2025 – March 2026, subject to funding live ~~April~~ March 2026	
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects taking into account gender considerations) National PDC capital funding approval [ACTIONS OWNER: CDO]	Agreed programme of work with capital funding to support it	~~(30.06.24)~~ 31.03.25	FBC approved by ICS PICU fully funded by national and Trust capital. On track and expected to be operational March 2025	AMBER

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

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

There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage

Impact: This could lead to the disruption in the provision of services with risk to patient safety

Root causes:

a. Increasing reliance on a single electronic patient record
b. Increasing use of video software for the direct provision of care and operational purposes
c. Increased staff home working
d. Increasing electronic collaboration across health and social care partners
e. Increasing global instability and risk from state supported cyber attacks
f. Increase in locally developed system solutions to support DHCFT and partner operations and performance, i.e., ~~Covid and~~ flu vaccination, health risk assessments

BAF Ref: 24-25 1C	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 2	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Trust utilises NHS provided solutions as widely as possible, i.e., Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure Health and Social Care Network (HSCN) specified by NHS Digital. Staff training on data security and protection. Regular all staff communications regarding safe ways of working and phishing emails. Contract with NHS Arden and Greater East Midlands Commissioning Support Unit provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust's compliance against them
Detective – Cyber essentials framework: NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities
Directive – Compliance with NHS Digital requirements. Monthly rigor review meeting with NHS Arden and Greater East Midlands Commissioning Support Unit. Security and Protection Policies and Procedures. Business continuity policy and procedure

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

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNER: CDO]	Reporting to the Divisional Performance Reviews (DPRs)	(30.~~06~~09.24)	Business impact assessments collected. Business continuity training for Trust leads starts March 2024. Revised business continuity policy ~~- Ratification expected~~ was ratified April 2024. Wider business continuity work (e.g. Audit) will take place in Quarter 2 as part of the EPRR Core Standards Recovery Action Plan – This is on track	~~AMBER~~ GREEN

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

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

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

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

Root causes:

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

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

Key Controls

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

Preventative – Screening of each admission considering safety, care and infection control needs supported by the infection control team, health and safety audits; risk assessments; physical health care screening and monitoring; Maintaining environments and cleaning, Director and senior leader visits. Board visits. Quality governance structures, teams and processes to identify quality related issues. EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Mock inspections
Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints, and risk investigation; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24 hour period, cleaning schedules and maintenance logs. Compliance to Delivering Same Sex Accommodation requirements
Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee, Making Room for Dignity programme

Board Assurance Framework 2024/25 – Issue 2.3 Board September 2024

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards Bed Management processes Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits Infection Control Board Assurance Framework reported to NHSE Positive and Safe self-assessment Head of Nursing/Matron compliance visits Cleaning and maintenance schedules IPC training Level 1 and 2 Trust targets of 85% compliance	Delivery of Same Sex Accommodation Guidance Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good Estates and Facilities Management internal audit Transitional Monitoring Meetings with CQC (bimonthly) Patient Safety Incident Response Framework (PSIRF) implementation Monitoring of IPC standards compliance and reporting – ICS IPC Team

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

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

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

Strategic Objective 2 – To be a GREAT place to work

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

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

Root causes:

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

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

Key Controls

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

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; annual review of people development plan commissioned through People and Inclusion directorate; provision of information through induction processes for new staff; staff engagement sessions; Equality, Diversity and Inclusion (EDI) Delivery Group meeting; supported networks for diverse staff groups and allies; Health and Well-being Network; workforce planning design meeting; Culture and Leadership Delivery Group
Detective – Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams
Directive – Joined Up Care Derbyshire (JUCD) People Strategy, National People Plan; People building blocks and priorities; Strategic people priorities, Communications Strategy, ICS People 5x7 plan

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

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of planned leadership development growth, stretch programmes and opportunities including coaching and mentoring	Strategy developed to align to organisational leadership needs Review and development of Trust leadership offer and impact Re-establish leadership forum Development of coaching access at local, system and national [ACTIONS OWNER: DPOI]	Percentage of leaders with development plan as part of objectives	(30.~~06~~09.24)	Third cohort of Aspiring-2-Be leadership course launched ~~Development of Leadership Development strategy has commenced to be ready April 2024, being revised~~ Leadership Strategic Approach finalised and signed off at ELT and PCC in June 2024 Senior leadership programme commissioned Leadership forum now embedded and running regularly	~~RED~~ AMBER

Fully embedded person-centred culture of leadership and management	Review of policies to support a person-centred approach to leadership Introduce just and restorative culture approach Review of leadership development offer Re-establish line manager development sessions Scrutiny of people data at divisional level [ACTIONS OWNER: DPOI]	Reduced number of formal staff relations issues/cases reported in monthly people assurance report to ELT Staff survey results Reporting to TLT	(30.~~06~~09.24)	Review of cases and case management reported to ELT bi-monthly with reasons for delays identified Civility, Respect and Resolution Policy to be launched October 2024 – Organisational Development plan being developed to support	AMBER
No operating framework through which to maximise the impact of staff networks	Collaboratively develop and Implement Staff Network Framework to provide consistency across the networks with clear framework, clarity of roles and objectives to increase engagement with under-represented staff Support to Bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager [ACTIONS OWNER: DPOI]	Engagement and buy-in by network Chairs Sign up to the framework by network Chairs and Executive Directors Annual updates by network Chairs of engagement undertaken to be included in annual reports	(30.~~06~~09.24)	~~New executive model implemented in December 2022. Draft framework developed and engagement with key stakeholders commenced~~ ~~New EDI steering group established; meetings commenced~~ ~~Network chair meetings operating and attended by DPI and Head of EDI~~ Collaborative staff network actions agreed and regular meetings with chairs and vice chairs taking place to align power of staff networks on Staff network guidance/framework developed and co-designed with networks	AMBER

The current capacity and structure of the People and Inclusion directorate is not able to meet the Trust, system, regional and national demands alongside challenges from outsourcing key services via People Services in DCHS and UHDB	Review of current People and Inclusion structure to align to needs and priorities of Trust, identify gaps and develop plan to mitigate Review of gaps in services delivered by People Services or UHDB and develop accountability framework Formalise existing governance meetings to ensure clear processes in place for People and Inclusion Services contract and UHDB key service contracts Review of current communications and engagement and people priorities across the Trust and system [ACTIONS OWNER: DPOI]	A People and Inclusion structure that can support the Trust to deliver against the people priorities Accountability dashboard presented to ELT quarterly Terms of reference in place and regular meetings A People and Inclusion structure that can support system-wide priorities People and Inclusion staff survey results	(30.~~06~~09.24)	Contract review meetings established for Occupational Health and Payroll Services (UHDB) New governance structure to be developed to manage the Joint Venture – Discussions commenced Monthly payroll contract meetings in place - Improvement Manager appointed by UHDB for six months to support contract, data and system standardisation	~~RED~~ AMBER
Lack of maturity of EDI framework	Produce and implement EDI framework with clear legislative, and mandated NHS national regional and local deliverables required for the EDI function and structure to deliver [ACTIONS OWNER: DPOI]	Agree framework and capacity requirements to deliver Regular wider engagement with EDI Delivery Group, and divisional leads taking place Final presentation to PCC Roll out of framework Delivery against the People Performance Dashboard	(30.~~06~~09.24)	Trust Reducing Health Inequalities Board now established, meeting with Trust-wide and system stakeholders to direct our response to reducing health inequalities ~~Draft framework outlines measures~~ Framework, including clear actions to progress, being presented at PCC and due to go to Board Development July 2024	AMBER
We have not engaged with our Bank staff to develop a strong sense of belonging, engagement and psychological contract with the Trust	Regular monthly engagement sessions Staff survey participation Clinical supervision and appraisal participation	Staff survey engagement scores Attendance at engagement sessions	(30.~~06~~09.24) (30.~~06~~09.24)	Aligned all bank staff bands 2, 3, 4 and 7 to Agenda for Change pay scales Band 5/6 bank pay approved for alignment to Agenda for Change	AMBER

	Alignment to Agenda for Change for pay and conditions [ACTIONS OWNER: DPOI]			Review of bands 2 and 3 roles on bank versus substantive roles and agreement on transition into band 3 with training - Complete Review of training competences for bank and agency commenced and nearing completion	
Lack of visible and differential staff benefits and responsive support for staff that reflects current working conditions, e.g., cost of living crisis	Review of gaps in benefits to realign to staff needs Review of current reward and recognition framework Develop range of staff benefits that align to Trust values and 'people first' approach Develop the salary sacrifice offer to support colleagues with cost of living crisis [ACTIONS OWNER: DPOI]	Staff survey engagement score Staff turnover Pulse check scores	(30.~~06~~09.24)	~~Delivering Excellence Every Day awards (DEEDs) revised and re-launched~~ ~~System-wide discussions commenced regarding a benefits package~~ ~~Review of lease cars with view to offer a more attractive rate as a retention tool completed~~ ~~Learning shared from UHDB survey on what matters most to colleagues when at work~~ ~~Flexible working engagement programme planned for launch~~ New benefits programme being launched for staff including increased salary sacrifice options	AMBER

Inconsistency in application of an inclusive approach impacting on developing and sustaining a sense of belonging	Embed an inclusive approach, promoting equality and ensuring diversity at all levels through learning and development, Schwartz Rounds, personal development reviews, mid-year reviews, rewards and awards, objective settings [ACTION OWNER: DPOI]	Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks Data drawn from all engagement activities to identify impacts on staff experience and any inequalities that need to be closed	(30.~~06~~09.24)	Work commenced - Divisional level EDI staff survey data shared with divisions. Divisional People Leads are leading discussions on actions on improvements and achievements	AMBER
~~Systematic planning and attendance of training~~	~~Training to be embedded in e-roster and designed to support safe staffing by minimising face to face sessions needed~~ ~~Progress the breaks and shift pattern change process~~ ~~[ACTIONS OWNER: DPOI]~~	~~Full compliance with safer staffing levels in line with NHSI Workforce Safeguards~~ ~~Training compliance in line with CQC requirements~~ ~~Staff survey health and wellbeing scores~~ ~~Comprehensive system and trust level health and wellbeing offer~~ ~~Compliance with NHSI workforce safeguards requirements~~ ~~Staff are able to take breaks and access the right health and wellbeing support~~ ~~E-roster team appropriately resourced and supported~~	~~(30.06.24)~~	~~New reporting processes in for TLT, PCC and Board – Now embedded with triangulation on staffing/agency/bank to be included at PCC~~ ~~Shift and break consultation being planned to commence 2024~~ ~~Training lead meeting regularly with all service managers to review staff training plans~~ ~~Meetings scheduled with neighbouring mental health Trusts to compare training offers and delivery modes~~	~~AMBER~~

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

Strategic Objective 2 – To be a GREAT place to work

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

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

Root causes:

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

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

Key Controls

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

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

Board Assurance Framework 2024/25 – Issue 2.3 Board September 2024

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

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data Establish a workforce transformation group to develop workforce development plans and ownership at divisional level [ACTIONS OWNER: DPOI]	Vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs	(30.~~06~~09.24)	Work commenced to map apprenticeship plan and resources required Agency reduction plan in place	AMBER
We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts [ACTIONS OWNER: DPOI]	Career conversations taking place Internal appointments/promotions Turnover rate Key staff survey measures	(30.~~06~~09.24)	Talent Strategy finalised Pilot launched for senior leaders in January 2023 – Phase one meetings with each executive taking place Deputy DPOI is system lead on talent management System appraisal developed to support system movements and talent management	RED
Lack of capacity, experience and plans for recruiting overseas	Develop International Recruitment (IR) plan and programme Appoint IR team to lead programme	Number of IR appointments Retention rate of IR	(30.~~06~~09.24)	Regular meetings established with midlands IR lead System AHP IR bid successful	~~RED~~ AMBER

	Engage with national IR support Access national IR funding Support Trust teams to prepare for IR arrivals [ACTIONS OWNER: DPOI]			IR pastoral support officer appointed Clinical Educator of IR appointed Recruitment and Retention Lead appointed Stay surveys regularly undertaken in teams Successfully recruited and objective structured clinical examination (OSCE) conversion completed for two IR candidates Further five candidates recruited and arriving July 2024	
Onboarding and Retention process and planning needs to be embedded	Understand the key retention issues for posts/teams/professions with the highest turnover Ensure 'stay conversations' form part of regular 1:1s Develop NHS retention framework for nursing [ACTIONS OWNER: DPOI]	Improvements to turnover Staff survey engagement scores	(30.~~06~~09.24)	Nursing retention framework self-assessment completed System retention lead appointed to support Trust level and system work Recruitment and Retention Lead appointed	AMBER
Medical staffing team and role not sufficiently developed Workforce plan for medical staff not in place	Review existing medical staffing team and workforce support and identify gaps Develop new model to support and maximise the medical workforce Develop medical agency model to ensure efficient usage	Engagement of medical workforce Reduction in agency spend	Complete (30.~~06~~09.24)	Further discussions held as part of the agency summit – Agreed action to support agency reduction	AMBER

	Develop a medical staff workforce plan [ACTIONS OWNER: DPOI]				
Lack of culturally competent recruitment processes	Completion and implementation of recommendations of the Above Difference recruitment and retention system pilot Wider engagement with recruiting managers, staff networks, clinical leads and operational leads Quartile monitoring of utilisation of Above Difference recruitment and retention tools Continuous improvement approach to implementing learning [ACTIONS OWNER: DPOI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	(30.~~06~~09.24)	Recruitment leads across the system all trained through Above Difference programme	AMBER
Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPOI]	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	(30.~~06~~09.24)	Trust Strategic Recruitment and Retention Lead appointed Successful recruitment events in place including attendance at universities A range of recruitment methods are being deployed to ensure we attract a diverse range of applicants	AMBER

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

Strategic Objective 3 – To Make BEST use of Our Resources

There is a risk that the Trust fails to deliver its revenue and capital financial plans caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties

Impact: The Trust becomes financially unsustainable

Root causes:

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes
b) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements. System financial position resulting in required additional financial savings to support the System position from Mental Health funds
b) Non-delivery of expected financial benefits from transformational activities
c) Non-delivery of required levels of efficiency improvement
d) Lack of sufficient cash and working capital
e) Loss due to material fraud or criminal activity
f) Unexpected income loss or non-receipt of expected transformation income (e.g. long-term plan (LTP) and Mental Health Investment Standard (MHIS) without removal of associated costs
g) Costs to deliver services exceed the Trust financial resources available
h) Lack of cultural shift/behaviours to return to financial cost control regime
i) Inability to reduce temporary staffing expenditure

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

Key Controls

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

Preventative – Operating plan and financial plan agreed for 24/25 in line with ICB requirement. Integrated Care System (ICS) signed off and fully support the dormitory eradication programme. Devoted and adequate team for Programme delivery. High quality business cases. Regular meetings with NHSE on programme progress. Meaningful stakeholder engagement (internal and external). Robust cash flow forecasting and delivery. Multi-disciplinary development of financial plans for new programmes of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counter fraud training and annual counter fraud work programme: Enhanced cash management and forecasting aligned to large capital and transformational programmes
Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); scrutiny of financial delivery, bank reconciliations; continuous improvement including cost improvement planning (CIP) and efficiency / QI delivery; contract performance, local counter fraud scrutiny
Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; Treasury management procedures, budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol and Plan Do Study Act. Risk and gain share agreements, Local Operating Procedure for Acute Capital Programme

Assurances on controls – Internal	Assurances on controls – External
Operational plan; financial planning including CIP planning, processes and delivery monitoring CIP programme group established to strengthen oversight Vacancy control process in place with Executive oversight Performance management processes in place and being refreshed to add to assurance levels Dormitory eradication and PICU Programme monitoring and reporting Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific including 'Use of Resources' reporting updates Assurance levels gained at Finance and Performance Committee Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations Independent assurance via internal auditors including HFMA checklist, external auditors and counter fraud specialist that the figures reported are valid and systems and processes for financial governance are adequate Local Operating Procedure in operation for Acute Capital Programme Board and F&P oversight of Acute Capital Programme delivery	Monthly reporting into ICB and NHSE, in addition to Trust internal reporting All CIP plans and progress reporting into the EPMO for shared system oversight across the ICB NHSE feedback throughout progress of dormitory eradication Programme and business cases in programme Systems Finance and Estates Committee/System Project Management Office/system DOF meetings Internal Audits – Financial integrity and key financial systems audits External Audits – Strong record of high-quality statutory reporting with unqualified opinion National Fraud Initiative – No areas of concern Local Counter fraud work – Referrals show good counter fraud awareness and reporting in Trust and no material losses have been incurred. Use of risk-based activity in new counter fraud standards Information Toolkit rating – Evidencing strong cyber risk management Programme Director, Senior Responsible Officer completed NHS Better Business Case Training

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Trust cash and capital risks related to national funded acute capital programme:	Risk share arrangements with PSCP	Cash and capital reporting as part of finance reporting into F&P and Board ~~and~~ forecasting evidence of plan delivery and/or	31.03.25	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations	AMBER

- Inflation cost risk - Risk-share - Cashflow timings and variability - Guaranteed Maximum Price exceeds national funding envelope (due to hyperinflation and other factors)	Programme approach and engagement with all stakeholders. Close involvement with NHSE Discussions ongoing with ICB and NHSE around the Making Room for Dignity cost pressure of c£7.5m [ACTIONS OWNER: DOF]	indicates areas of required management action		Hyper-inflation cost risk remains – Due to world events and economy but this is reducing National PDC capital funding approved by NHSE for two new builds and three refurbishment schemes, plus PICU year 1 Hyperinflation still affecting sub-contractor costs with significant cost pressures on Radbourne Unit Refurb and Older Adults ward refurb requiring ongoing action HMRC appeal on VAT abatement claim concluded and VAT abatement was agreed. This has reduced a major risk component. Currently in the process of recovering the VAT rebate	
System capital programme funding shortfall for self-funded Trust capital programme: System Capital Departmental Expenditure Limit (CDEL) inadequacy for system capital requirements	System capital draft planning assumes the final year of the self-funded element of the PICU build through system CDEL / Trust cash reserves Access any new national funding streams in year to maximise system capital plan in order to redirect CDEL capital for other schemes [ACTIONS OWNER: DOF]	Ongoing reporting will ascertain how and when the shortfall can be bridged by additional capital sources There remains a risk we will overcommit our CDEL allocation in 2024/25. Ward 35 decision is a key risk later this year and would have wider impact on the strategic objective to eradicate all dorms	31.03.25	System capital plan has been submitted as part of planning process Risk remains in relation to the Making Room for Dignity cost pressure and discussions with ICB and NHSE remain ongoing	AMBER
Additional revenue related to new builds, refurbishments and PICU not fully funded by system	Close partnership working with ICB and system partners. National funding for PDC revenue costs included in allocations for 2023/24 plan Early recruitment to staffing built into revenue plan of the Trust and funded	Monitoring and reporting of income allocations and expenditure in year Transparent reporting of position shared with ICB to	31.03.25	Funding for PDC revenue from NHSE included in financial plan submission. Guidance change has removed £2.5m of income	RED

	by the system (both income and expenditure in the plan) as part of operating plan for 2024/25 [ACTIONS OWNER: DOF]	reduce challenge and ensure joint understanding and support		~~Funding for early recruitment costs from ICB allocations included in the financial plan submission~~ MHLDA DB agreed to oversee revenue delivery contained within programme spend	
Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight Agency progress monitored and strengthened links to CIP oversight group Direct engagement solution being implemented re medics [ACTIONS OWNER: DPOI/DOF]	Enhanced bank and agency costs reported as part of wider financial and workforce reporting Continued workforce strategies progressed to reduce agency and increase bank reducing risk	31.03.25	Reports to ELT and F&P outlining current areas of pressure and required actions to be taken as part of the financial planning decision making process Funding contribution agreed with Eating Disorder Provider Collaborative for exceptional agency costs, further costs are being recharged but are in dispute Patient is expected to move to a more appropriate provider during quarter 2	RED
Non-delivery of required recurrent cost reduction and improved efficiency and Quality Improvement	Compilation and delivery of planned Trust efficiencies and quality improvements to deliver ~~2023/24~~2024/25 plan including recurrent long term cost reductions to return to breakeven Planning for 2024/25 has led to a recent ask for directorates to develop plans of 4% cost improvement in addition to various transformation schemes CIP governance and reporting processes strengthened. Close links to wider work re agency reduction, effective rostering and vacancy control [ACTIONS OWNERS: DOF/DPOI]	Efficiency and QI reporting to Execs and F&P	31.03.25	~~Limited schemes identified at time of draft plan submissions. Current target for cost improvement is £10.4m, which still results in a deficit of circa £11.7m~~ CIP gap continues to reduce. The percentage which has been identified recurrently continues to increase Executive vacancy panel established in December 2023 ~~Further reviews on all roles on the Trak recruitment system are underway to reassess need~~	RED

Financial cost pressures created both internally and by system first decisions leading to the requirement for mitigations to close both the internal gap and the system financial gap	Additional 'stretch' management action required to reduce other cost and mitigate impact to achieve overall financial position Long list of unpalatable options drawn up and supported in principle by Board for further review. These are for consideration post planning nationally due to potential to impact patients and core Trust NHS offer. Need to develop these into costed and prioritised plans with clarity of patient and wider staff impact [ACTIONS OWNER: DOF]	~~Achievement is incorporated into most likely case forecast reported to ELT, F&P, and system reporting~~ ~~Business cases to go through ELT before any financial commitments are made, ensuring good governance process are followed~~	31.03.25	The financial position for Derbyshire is a risk to the statutory duties for DHCFT to manage its financial position Financial plan for 2024/25 ~~is at the first stage of draft planning but the national process has now been delayed and planning will be extended into May~~ is concluded but we need to continue to work on reducing the deficit All new investments to follow governance processes with business cases via ~~to~~ ELT, F&P and Board where appropriate	RED

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

Strategic Objective 4 - To be a GREAT Partner

Principal risk: Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change may impact negatively on the cohesiveness of the Derbyshire health and care system

Impact: Financial position of the Derbyshire Health and Care system worsens; working relationships across the system deteriorates; loss of confidence from regulators in the Derbyshire system

Root causes:

a) New senior management relationships across organisations, with potential new appointments in system leadership roles and the creation of provider collaboratives
b) Creation of mental health, learning disability and autism provider collaborative may destabilise some of the established relationships in place across Derbyshire
c) Creation of system level governance structures, for example Provider Collaborative Leadership Board, may impact on provider Foundation Trust governance arrangements and decision-making processes
d) Staff impacted by change, may lead to increased staff turnover in teams supporting the delivery of the Mental Health Long-Term Plan and subsequent loss of organisational memory
e) The Trust taking on additional lead-provider responsibilities at an ICS or regional level could impact on the quality, performance and financial risks faced by the organisation

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

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Governance structures in place at a system and Delivery Board level. Ongoing close communication with NHSE, mental health and learning disability teams at a regional and national level. Assumed NHSE -led appointment process to new ICS Board positions
Detective – Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives. Due diligence processes undertaken prior to accepting any lead provider responsibilities
Directive – Mental Health, Learning Disability and Autism System Delivery Board to engage widely across membership on the development of any provider collaborative with agreed plans and processes. Gateway process run by NHSE prior to agreement to establish the Trust as lead-provider in any regional collaborative

Board Assurance Framework 2024/25 – Issue 2.3 Board September 2024

Assurances on controls – Internal	Assurances on controls – External
Regular reporting of position to Board by CEO Regular ELT updates and discussions NED Board members on JUCD committees and Board Board agreement required prior to undertaking of lead-provider responsibilities	Mental Health and Learning Disability assurance meetings with NHSE and ICB Gateway process run by NHSE prior to agreement to establish a Trust as lead-provider in regional collaboratives Representation on system-wide governance groups

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Increased decision-making at a system and/or provider alliance level may create conflicting accountabilities with the Trust-level governance structures which could result in an increased governance burden	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements [ACTION OWNERS: CEO/DCA]	Board level confidence in new and emerging governance structures and ability to gain assurance on DHCFT risks and issues via system level governance regime	(30.~~06~~09.24)	Ongoing review of Trust governance to ensure operational performance delivery of MHLDA constitutional standards that DHCFT is a lead or main provider of the performance Derbyshire Provider Collaborative Leadership Board have an agreed work programme as approved by ICB The Trust is an active member of and provides regular assurance to system-wide governance groups, e.g. their quality and safety group	AMBER
Internal ICB capacity changes to achieve revised expenditure requirements in 20023/24 and 2024/25 may impact on capacity and capability to deliver key deliverables such as system planning, and programmes of transformation	Keep changes to staffing levels and work programmes under regular review. This may lead to system wide agreement on priorities [ACTION OWNER: CDO]	Impact monitored through system wide MHLDA Delivery Board, Provider Collaborative Leadership Board and ICB Board, of which the CEO is a member	(30.0~~9~~6.24)	Escalation of risk and impact internally to ELT and Board as appropriate and to ICB Review DHCFT staffing to identify succession planning opportunities and/or cover arrangements ongoing	~~RED~~ AMBER

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

Strategic Objective 4 – To be a GREAT partner

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

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

Root causes:

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

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

Key Controls

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

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

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

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
System partners report that some of its core constitutional targets were not being met and was failing to make progress, at pace and scale	New internal performance improvement group and clarity to Trust Board on which DHCFT constitutional standards are not being met and whether the DHCFT contribution is the lead or material and how performance will improve Recovery action plans for areas where constitutional standards are not being met [ACTIONS OWNERS: CDO]	Improvement in performance in constitutional standards Recovery action plans in place in all required areas	(30.~~06~~09.24)	Integrated performance report allows insight on key areas of improvement, with actions and narrative around next steps. Progress with recovery action plans: Performance improvement in dementia diagnosis and perinatal access has resulted in DHCFT now delivering the core constitutional targets in this area and others Ongoing work to reduce inappropriate Out of Area Placements, underpinned by a Recovery Action Plan continues including a Multi-Agency Discharge Event and planned opening of local PICU, however inappropriate Out of Area placements remain above trajectory	RED
System partners report that DHCFT is inward looking and does not fully support PLACE developments	Managing Directors to design a communication and improvement plan, with 360 feedback that PLACE partners feel DHCFT support, data is provided and their support named Managing Director is accessible [ACTION OWNER: CDO]	PLACE / PCN and GP Directors provide direct feedback to Managing Directors on their relationship, knowledge and impact of the additional leadership support. This includes examples of collaboration and the impact of this support Confirmation of frequency of contact, joint action / achievement log of issues raised and achieved	(30.~~06~~09.24)	Managing Directors (MDs) actively engaging with Primary Care Networks (PCNs) MDs are now members of Derby City PLACE Board and PLACE County Partnership Board Executive Directors are members of Integrated Place Executive. Senior management representation named for all	GREEN

		Managing Directors reports to TLT with summary of impact to ELT		PLACE Alliance groups. City and County Partnership Board currently developing purpose, MDs are actively involved in. MDs are also linking in with local GP forums within the City and County CEO meeting with GP network monthly Appointment of a Lead GP – Mental Health specifically for Derby City Place to support relations, pathways and opportunities between the Trust and primary care. GP support only in place until May 2024; case for the GP support to be presented to the MHLDA Board in April	
Social care partners have reported that the lack of progress on autism diagnostic reductions is difficult and would like to see increased pace of improvements	Improvement plan for joint autism service [ACTION OWNER: CDO]	Feedback from social care on awareness of the Autism Strategy and autism waiting times reduce across the interagency investment plan	(30.~~06~~09.24)	November 2023 Derbyshire System Delivery Board: Agreement to recognise that the current commissioning landscape and output from investment still has major gaps, with a subsequent impact on other local services. Support for the development of fuller proposal for re-use of resource allocated for an improved offer, recognising this may require reallocation of current spend Autism waiting times continue to be achieved for the 26 contracted assessments per month~~, and sustained for year to date~~. Internal quality	AMBER

				improvement work has resulted in significant improvement in waiting times for assessment and reduction of wait lists	
Police partners report they do not always feel supported by mental health services and are under pressure to respond to mental health crisis	Police education and support, communication and improved partnership working [ACTION OWNER: CDO]	Training sessions offered to Police partners: • Police mental health awareness training sessions • Suicide prevention work • Joint working with Trust safeguarding teams • Collaborative response to Right care Right Person (RCRP)	(30.~~06~~09.24)	Police are a formal member of the MHLDA DB and attending and contributing Street triage pilot was established between Police and Trust. This ceases on 31.03.24 and will be replaced by Right Care Right Person~~lace~~ (RCRP~~)~~ Mental Health Response Vehicle (MHRV) to be implemented during 2024, to reduce pressure on Police to respond to mental ill health calls Crisis café have opened in Buxton, Ripley and Swadlincote Trust is a member of the RCRP implementation executive group ~~across~~ covering the Derbyshire system with Police stakeholders and system colleagues	AMBER

Patient and carers groups report that they would like to see more progress in service user and carer involvement and moving from engagement to decision making	Peer support strategy and objectives for EQUAL and the Mental Health Engagement Group [ACTION OWNERS: DON/MD]	Peer support strategy Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	(30.~~06~~09.24)	EQUAL group established to support service user and carer engagement. EQUAL has created several sub committees and informs future service improvements across the East Midlands Perinatal Mental Health Provider Collaborative DON has worked with the Patient and Carers Committee, EQUAL and the Carers Engagement Group to review their terms of reference and linkages to strengthen the cross-working of the groups and effectively use action logs to reflect improvements made in service developments and patient care	AMBER

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

Board Assurance Framework 2024/25 – Issue 2.3 Board September 2024

PART TWO – SYSTEM BASED RISK IMPACTING ON AND MITIGATED BY MULTIPLE SYSTEM ORGANISATIONS

Multiple System Strategic Risk

There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership and in ICS in-patient LD bedded care

Impact: May lead to avoidable harm and delays in accessing appropriate services, affecting patients, their family members and staff

Root causes:

a) The community Intensive Support Team and Learning Disability models have non-standardised operating models and require more capacity
b) Currently the delivery and commissioning partnership in Derbyshire have not met national standards or local ambitions for more robust community-based offers, working across the geography and in an integrated way with partners including social care and the voluntary sector
c) The collective vision for Learning Disability services across Derbyshire and the formal outcome to achieve repatriation to Derbyshire has not been effective with some people remaining in outsourced areas of England for extended and significant periods of time
d) Inpatient bedded facilities do not meet safer staffing levels due to vacancies
e) Derbyshire bedded facilities do not meet current standards, e.g., en-suite accommodation, safety and environmental standards and the seclusion room does not meet the required standards as outlined in the Mental Health Act Code of Practice
f) The current LD bedded care facilities do not meet the national specifications for the Royal College of Psychiatrists Learning Disability recommended standards and are not in line with future clinical model for the LD&A pathway for Derbyshire
g) Derbyshire bedded care facilities for LD services had not had a full CQC inspection since 2016 as a core service
h) Health inequalities across our Derbyshire footprint – Initial insights show gaps in access to service, case load and worsening patient outcomes

BAF Ref: 24-25 MS1	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee within DHCFT Quality and Performance Committee within the Derbyshire ICS Mental health, LD and Autism Board in terms of system operational delivery

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Health and safety audits; risk assessments; investment in estates development; workforce plan covering recruitment and retention. Mental Health Act Code of Practice
Detective – CQC inspection reports; Board visits virtual clinical service contact visits; incident, complaints and risk investigations; safety check log; Head of Nursing and Matron compliance visits
Directive – Trust Strategy and commitments; Quality Improvement Strategy; Physical Health Care Strategy; Safeguarding Strategy; Trust Policy Dashboard

Assurances on controls – Internal		Assurances on controls – External			
Regional and national escalation process – Internal preparation		Advisory support provided by DHCFT to the system on bedded care standards for Learning Disability in-patient services Involvement of Local Government Association to deliver a peer review Involvement of external consultants			
Key gaps in control	**Actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion or (review)**	**Summary of progress on action**	**Action rating**
The community Intensive Support Team and Learning Disability models require improved models of support	Review all models of support offered by the Intensive Support Team (IST) [ACTION OWNERS: CDO/DON/MD]	Outcome of review – Improved models of support	(30.~~06~~09.24)	Review outcome: Services brought together across the North and South under a single manager and now have single clinical pathways ICB have presented work to both providers which looks at how to ensure community offers like IST are enhanced further through the review of ~~other~~ pathway offers where resource is disproportionately allocated ~~Next steps are~~Ongoing discussions to commit more resources to community pathways including IST is interdependent on the future bedded model which is being explored by the ICB	AMBER
Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live their	Continue to work on developed delivery improvement plan, owned by system partners, to improve position. This includes new cohort stratification approach that has been developed –	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients working across partner systems	(30.~~06~~09.24)	Derbyshire ~~has been stepped up of~~is no-longer in national escalation regarding performance with inpatient services	AMBER

lives in the least restrictive manner as close to home as possible	key action to implement and fully embed approach to ensure focussed system action on existing inpatients who are place inappropriately and out of area [ACTION OWNER: CDO]	Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission and market stimulation and development, including improvement in the use of Dynamic Support Registers as a means of admission avoidance Make significant impacts on the number of stranded patients who have delayed discharges in units across the country resulting in the NHSE escalations		after demonstrating significant progress and improvement against plans and clear grip. New Dynamic Support Pathway (DSP) launched following cross-agency redesign work Cross-system delivery plan continues to be monitored through Neurodevelopmental Delivery group Board – Includes action plan in response to inflow, flow and outflow as discussed with NHSE and ICB leaders	
Current substantial staff vacancies are negatively impacting on safer staffing levels in a non-DHCFT Derbyshire bedded care facility	Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements [ACTIONS OWNERS: CDO/DON]	Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards	(30.~~06~~09.24)	Reviews of safer staffing and stabilisation in non-DHCFT Derbyshire bedded LD facility - New period of service stabilisation underway with a focus on expediting discharge of current inpatients, and not accepting further admissions Workforce issues including recruitment and retention, staff wellbeing and mitigations against use of agency staff being addressed with rapidly mobilised short-term leadership from DHCFT into the unit	AMBER

				Improved engagement with universities and final year student nurses	
Clinical care standards in a non-DHCFT Derbyshire bedded care facility including care plans, levels of incidents, restrictive practices including the use of long-term segregation are not compliant with clinical care standards	Develop an improvement plan for all Derbyshire in-patient LD&A services [ACTION OWNERS: CDO/DON]	Full compliance with required care standards External review of Long-Term Segregation and review to end restrictive practices	(30.~~06~~09.24)	Joint paper from Trusts to ICB regarding overall bedded offer and inpatient review discussed with ICB executives March 2024 Overall quality plan for improvement for LD&A inpatients in place following review by ICB - This includes trying to reduce the level of out of area care	AMBER
Lack of adherence to national guidance and policy on in-patient care in a non-DHCFT Derbyshire bedded care facility	Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER: CDO/DON]	Delivery of approved business cases for development of single en-suite facilities, seclusion suite at specification standards and other improving the therapeutic and healing environment requirements Implementation of programme of work	(30.~~06~~09.24)	Partnership working with DCHS and ICB to agree future plans and direction of travel for bedded offer for Derbyshire patients continues. Executive level discussions are underway for the long term goal, whilst providers work together to stabilise position in current unit and expedite discharges Broad expectations on model of care (bed 'type') agreed across partners, including offering community-house step up/step down options – Large scale ongoing work	AMBER

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

Board Assurance Framework 2024/25 – Issue 2.3 Board September 2024

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

Risk Assessment Matrix					
Risk Score = Consequence Rating X Likelihood Rating					
	CONSEQUENCE				
LIKELIHOOD	INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
RARE 1	1	2	3	4	5
UNLIKEY 2	2	4	6	8	10
POSSIBLE 3	3	6	9	12	15
LIKELY 4	4	8	12	16	20
ALMOST CERTAIN 5	5	10	15	20	25

RISK RATING	RISK APPETITE
Very Low	Accepted
Low	
Moderate	Tolerated
High	Not Accepted
Extreme	

Actions Against Gaps in Key Controls - Expected completion dates to be included or next review dates to be shown in brackets	Action Rating
Action **completed**	Blue
Action **on track** to completion within proposed timeframe	Green
Action **implemented in part** with potential risks to meeting proposed timeframe	Amber
Action **not completed** to original or formally agreed revised timeframe. Revised plan of action required	Red

Action Owners

CEO	Chief Executive Officer		
DOF	Director of Finance	DON	Director of Nursing, AHPs and Patient Experience – Interim
MD	Medical Director	DPOI	Director of People, Organisational Development and Inclusion
CDO	Deputy Chief Executive / Chief Delivery Officer	DCA	Director of Corporate Affairs and Trust Secretary

Definitions

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2024

Freedom to Speak Up Guardian (FTSUG) Report

Purpose of Report

This paper is a half-yearly report to ensure the Derbyshire Healthcare Foundation Trust (DHcFT) Board is aware of Freedom to Speak Up (FTSU) cases within the Trust; an analysis of trends within the organisation and actions being taken to improve speaking up culture.

Executive Summary

The FTSU report to Board sets out the number of cases and themes raised in the last six months from January to June 2024 at DHcFT.

Total case numbers: 82 cases seen in this report to Board for the period are an increase on the 66 cases reported in the March 2024 FTSU report to Board for the period July to December 2023.

Emerging, or ongoing, themes include:

- **Culture:** a number of concerns about culture including issues with leadership within a team
- **inappropriate attitudes and behaviours** linked to **patient experience and patient safety** in relation to a team.

The report also contains a list of actions taken to enhance visibility and promote FTSU to ensure that speaking up culture is continuously improved.

The Speaking Up Champions' network also supports workers to raise their concerns at the earliest opportunity and signposts workers to the FTSUG for advice and guidance.

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.	

Risks and Assurances

Reporting on speaking up is presented to the Trust Board and the Audit and Risk Committee (ARC) every six months to provide assurance on progress made. The People and Culture Committee (PCC) also receives FTSU information as part of the wider staff feedback dashboard.

The Board completed the Freedom to Speak Up Follow Up training in May 2024. The Follow Up training allows the Board to have a stronger awareness of the importance of following up on Speaking Up themes and gaps in FTSU provision or barriers to speaking up.

The Audit and Risk Committee continues to monitor the progress of the FTSU action plan.

There are risks to having a culture where workers do not feel able to safely voice their concerns. There are potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as possible reputational risks and regulatory impact.

Consultation

Executive Leadership Team.

Governance or Legal Issues

Trusts are required to have a FTSUG as part of the NHS standard contract terms and conditions.

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 joint working of the Equality Diversity and Inclusion (EDI) team and FTSUG supports future ways of working to support staff with protected characteristics to raise concerns
- Assurance is sought by the FTSUG that concerns logged from staff with protected characteristics are supported by employee relations/EDI processes; and that any wider issues are being considered by senior Trust leadership
- This report highlights some areas of good practice, including having FTSU Champions from a diverse range of backgrounds, as well as numbers of BME colleagues speaking up.

Recommendations

The Board of Directors is requested to:

1. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda
2. Discuss the report and determine whether it sufficiently assures the Board of the FTSU agenda at the Trust and that those proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up.

Report presented and: **Tamera Howard**
prepared by: **Freedom to Speak Up Guardian**

Freedom to Speak Up Guardian (FTSUG) – half-yearly report

1. Introduction

1.1 The Freedom to Speak Up Guardian (FTSUG) is part of a culture of speaking up and acts to enable patient safety concerns to be identified and addressed at an early stage. Freedom to Speak Up (FTSU) has three components: improving and protecting patient safety, improving and supporting worker experience and visibly promoting learning cultures that embrace continual development. The Care Quality Commission (CQC) assesses an NHS trust's speaking up culture under the Well-Led domain of its inspections.

1.2 The FTSU report covers the period from January to June 2024: Quarter 1 2024/25 and Quarter 4 2023/24. Reporting to Board is on a six-monthly basis.

2. Aim

2.1 This report aims to provide the Board with:

- Information on the number of cases being dealt with by the FTSUG and themes identified from January to June 2024
- Information on what the Trust has learnt and what improvements have been made as a result of workers speaking up
- Actions taken to improve FTSU culture in the Trust, including progress in the promotion of the FTSUG role and addressing barriers to speaking up
- Updates from the National Guardians Office (NGO)
- Key recommendations to Board.

3. Summary of Freedom to Speak Up Concerns

3.1 Concerns are categorised in accordance with NGO guidance. The NGO requires concerns relating to Patient Safety, Bullying and Harassment, Inappropriate Attitudes and Behaviours, Worker Safety and Wellbeing, Public Interest Disclosure Act (PIDA) concerns, anonymous concerns and those suffering detriment or demeaning treatment, as a result of speaking up, to be reported on a quarterly basis.

3.2 **Table 1** shows that the FTSUG logged 52 cases in Q1 2024/25 and 30 cases in Q4 2023/24. In Quarter 2 2024/25, 25 cases have been logged.

In 2023/24, DHcFT averaged 37 cases per quarter (12 months).

NGO data shows that for Mental Health trusts there were on average **27.5 cases per 1,000** workers in 2023/24. In the NGO analysis for DHcFT, they calculated that the FTSUG received an average of **41.7 cases per 1,000 workers.** This is based on a headcount of 3,143.91 (April 2023-February 2024 average from NHS workforce statistics). From: Summary of Speaking Up to FTSUGs: 2023/24.

3.3 **Patient safety and quality:** During Q1 2024/25 and Q4 of 2023/24, patient safety and quality concerns represented 8.5% of cases. From July to December 2023, they represented 6.1% of cases. Patient safety and quality concerns are directed to the Director of Nursing, AHPs, Quality and Patient Experience.

According to the Summary of Speaking Up to FTSUGs: 2023/24, patient safety concerns represented 18.7% of all concerns nationally.

Table 1: FTSU Data Q1 2024/25 and Q4 2023/24

Types of Concerns	Q4 2023/24	Q1 2024/25
Patient Safety & Quality (NGO/PIDA)	**3**	**4**
Bullying & Harassment (NGO/PIDA)	**11**	**6**
Inappropriate Attitudes & Behaviours (NGO)	**12**	**25**
Worker Safety & wellbeing (NGO)	**6**	**28**
Potential Fraud or Criminal Offence (PIDA)	**0**	**0**
Total Cases reported to FTSUG*	**30**	**52**
Public Interest Disclosure Act (PIDA) concerns	**14**	**10**
Reportable to NGO: Bullying and Harassment / Patient Safety / Worker Safety / Inappropriate Attitudes & Behaviours	32	63
Anonymous / Other	5	3
Person indicates suffering detriment as a result of speaking up	1	2
Number of cases that have received feedback	25	44

***Individuals (cases) approaching FTSUG may log more than one concern.**

3.4 **Bullying and Harassment concerns** represented 21.9% of cases raised to the FTSUG from January to June 2024, which is higher than the 19.8% raised nationally to FTSUGs during 2023/24. (Summary of Speaking Up to FTSUGs: 2023/24). This is an increase on the 19.7% of cases raised from July to December 2023. Bullying and harassment levels for DHcFT for 12 months from July 2023 to June 2024 were 20.3%.

The FTSUG promotes the Trust's Dignity at Work policy, Trust wellbeing offers, staff-side/union support and Employee Relations where staff require information and support around bullying and harassment matters.

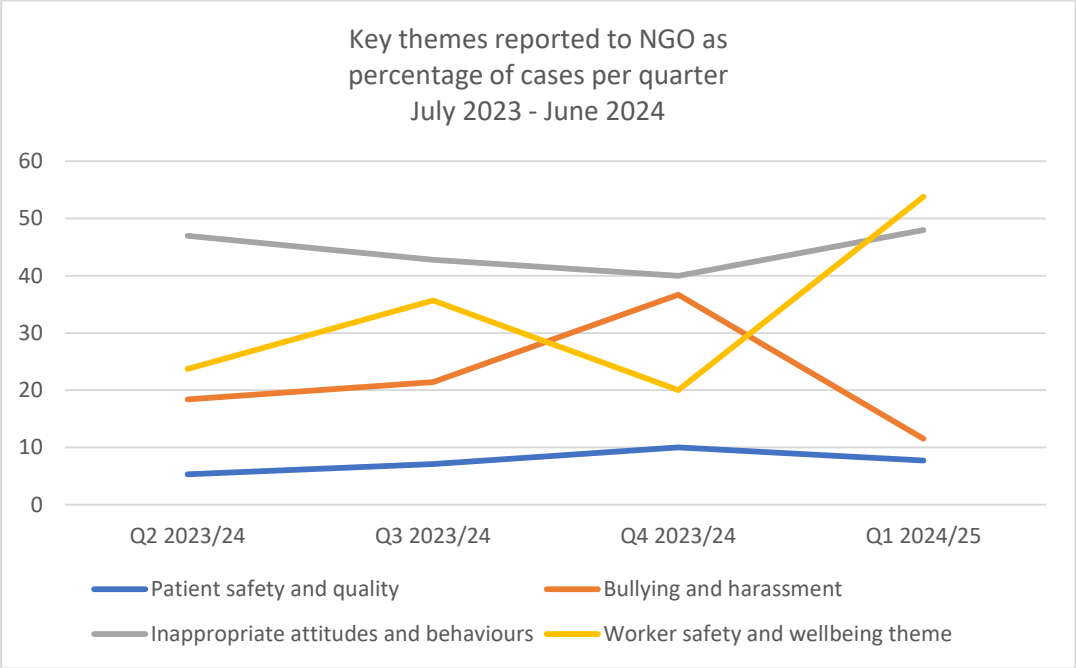
3.5 **Inappropriate attitudes and behaviours concerns** represented 45.1% of cases raised to the FTSUG from January to June 2024. The NGO figure for 2023/24 is 38.5% (Summary of Speaking Up to FTSUGs: 2023/24).

'Inappropriate attitudes or behaviours should be interpreted broadly. The focus should be on the perceptions of the person bringing the case. Examples of other inappropriate attitudes or behaviours may include actions contrary to an organisation's values, incivility and/or microaggressions'. (Page 15: Recording Cases and Reporting Data, NGO)

3.6 **Worker safety and wellbeing theme:** 20.3% of cases in Q1 2024/25 and Q4 2023/24 involved an element of worker safety and wellbeing. This is a decrease on the 28.8% of cases seen in Q2 and Q3 2023/24. Nationally in 2023/24, the average for worker safety and wellbeing was 32.3%. (Summary of Speaking Up to FTSUGs: 2023/24).

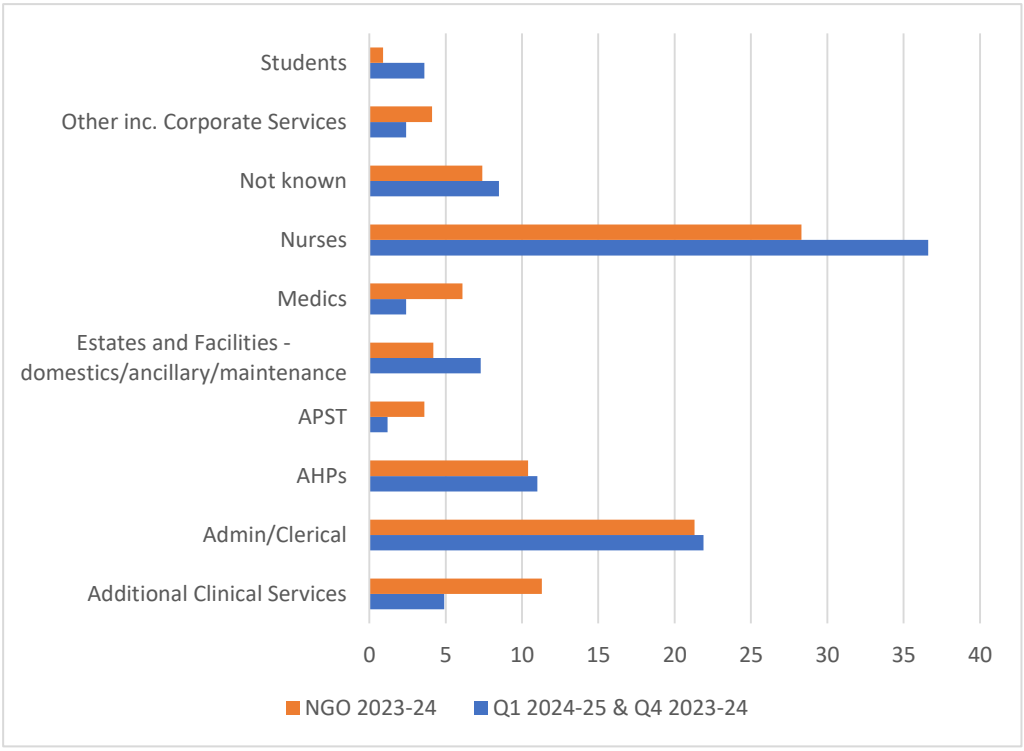
Figure 1 shows Bullying and Harassment, Inappropriate Attitudes and Behaviours, Patient Safety and Quality and Worker Safety and Wellbeing cases as percentage of number of cases per quarter as reported by the FTSUG to the NGO over the July 2023 to June 2024 period (12 months).

Figure 1



3.7 **Professional groups**: In Q1 2024/25 and Q4 2023/24, 36.6% of staff approaching the FTSUG were Nurses. This is similar to nurses approaching in Q4 2022/23 and Q1 2023/24 at 36.4% of staff. It is also higher than the national average reported by the NGO at 28.3%. (Summary of Speaking Up to FTSUGs: 2023/24). See Figure 2.

Figure 2: Professional groups speaking up in Q1 2024/25 and Q4 2023/24 as percentage of total cases per quarter in comparison to NGO 2023/24 data.



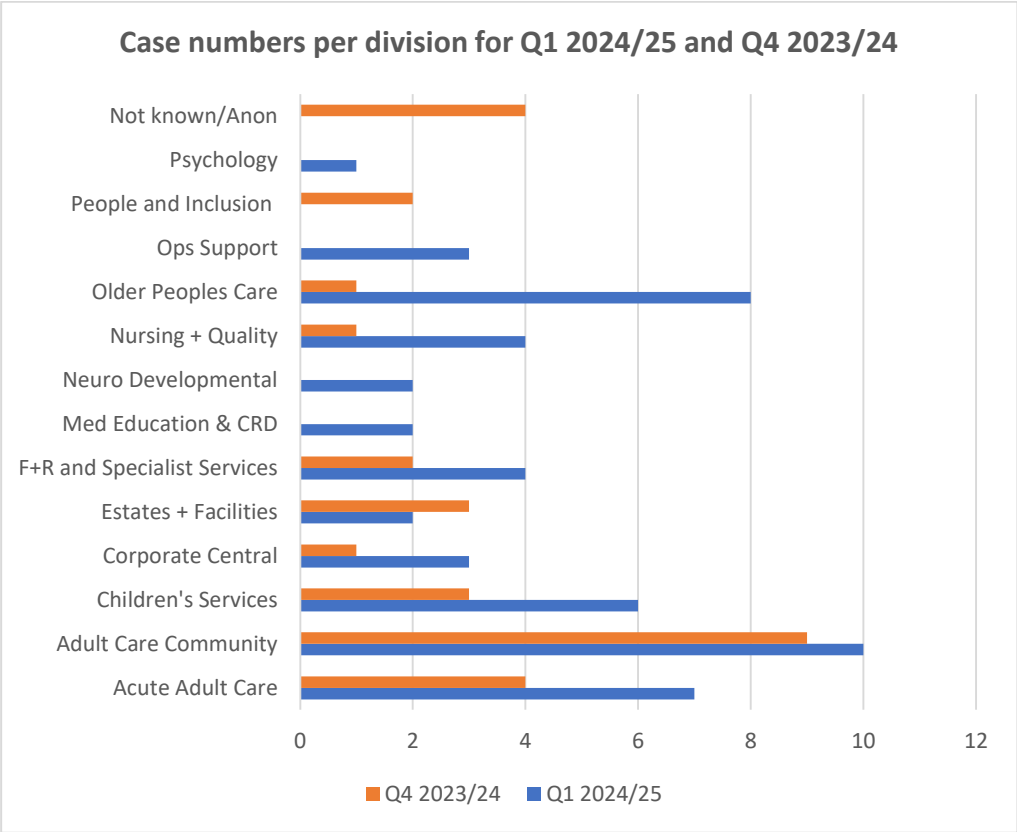
3.8 **Experiencing detriment or demeaning treatment:** In Q1 2024/25 and Q4 2023/24, 3.6% of workers reported that they had experienced a detriment or demeaning treatment as a result of speaking up. NGO average for detriment in 2023/24 was 4% (Summary of Speaking Up to FTSUGs: 2023/24).

3.9 **Ethnicity of workers:** In Q1 2024/25 and Q4 2023/24, 19.5% of colleagues speaking up identified as Black and Minority Ethnic (BME). This is a decrease on Q2 and Q3 2023/24, where 24.2% of staff speaking up identified as BME. 18.95% of DHcFT staff are from BME communities (E&D Dashboard June 2024).

3.10 **Anonymous, Confidential or Open concerns:** Anonymous concerns increased to 9.7% of concerns. In Q2 and Q3 of 2023/24 they were 6.1% of cases. However, this is similar to anonymous concerns reported nationally in 2023/24, which were 9.5% (Summary of Speaking Up to FTSUGs: 2023/24).

3.11 **Concerns raised by Division:** Figure 3 shows the number of cases from divisions across the Trust. Adult Care Community has had higher concerns from two specific teams and Older Adults concerns have come from a range of teams across the Trust.

Figure 3



4. Emerging or ongoing themes with learning/action points

4.1 **Culture:** Concerns about culture including leadership issues within one team.

- **Action:** As a result of concerns raised: One-to-one meetings were held with 27 staff in the team and the General Manager and the Divisional People Lead
- **Learning identified:** Findings shared with team in feedback session. New manager with experience in managing this type of service now in place. Further organisational development work to take place in relation to improving culture including a potential culture review.

4.2 Concerns raised by three staff about **inappropriate attitudes and behaviours** linking to **worker safety and wellbeing** and **possible patient experience and patient safety** in relation to one worker in a team.

- **Action:** Concerns escalated. Two of the three staff have also directly shared their concerns with General Manager. Matter has been discussed with relevant senior leaders to confirm plan in relation to addressing concerns and managing constructively.
- **Learning identified:** Possibility of mediation as an offer. Senior colleague will address behaviours with worker. Could involve more formal process in future.

4.3 Concerns raised from an Acute Adult Care area with some issues around improving **culture**. Concerns linked to **patient safety and quality**. Two of these issues have come from students around their placements on wards which have included patient safety concerns.

- **Action:** These have been shared with General Manager (GM), Area Service Manager (ASM), student and ward leads as well as organisation development lead to address issues.

- **Learning identified:** feedback provided directly to students. One ward area responded promptly by taking action: ward leaders called a meeting to discuss the concerns raised and to remind staff about their own professional accountability. Student allocation was changed and a Band 6 is now on shift to do an induction. The student rota was changed to spread students out across all shifts. The ward is getting in a Clinical Educator to complete further training around professional accountability. Ward leaders have discussed concerns with the staff member who was mentioned in supervision. The Trust's student team has put in roaming assessor support to reduce some of the student pressure on this ward.

5. Improving Speaking Up Culture

5.1 **Improving visibility and networking:** The FTSUG presents at monthly Trust Inductions. The FTSUG attends team meetings on request. The FTSUG is now holding regular face-to-face drop-ins in some acute settings and is involved in listening events in specific areas of the Trust in relation to concerns.

5.2 **Board Culture:** A Board development session was delivered by the FTSUG on the NGO Follow Up training in May 2024. All Board members who attended have now completed their Follow Up training providing them with an important insight into following up on themes and improving speaking up culture.

5.3 **Supporting communities who face barriers to speaking up:** The FTSUG engages with the Equality, Diversity and Inclusion (EDI) team to address inclusion issues and share themes for diverse groups. The FTSU attends the EDI steering group regularly and reaches out to the staff network leads and also attends staff network meetings. The FTSUG also attends the Junior Doctors Forum on a regular basis and presents training on FTSUG at north and south Junior Doctors training sessions.

5.4 **Triangulation of data and FTSU:** the FTSUG is meeting regularly with senior leaders including the Director of People, Organisational Development and Inclusion to discuss triangulation of data. The FTSUG produces a report for the People and Culture Committee to support the triangulation of data from FTSU.

5.5 **Network of FTSU Champions:** The FTSUG holds monthly catch-up meetings with Speaking Up Champions to share good practice, support any speaking up matters and to share NGO information. Champions referred in 19% of concerns during January to June 2024. DHcFT currently has 36 FTSU Champions who come from a range of divisions across the Trust. Children's Services and Adult Community Care have created their own network of divisional champions and the FTSUG meets bi-monthly with the Children's Services group.

5.6 **Non-Executive Directors:** the FTSUG is supported by a Non-Executive Director (NED) lead for Speaking Up, Geoff Lewins. The FTSUG holds monthly meetings with the NED to share FTSUG practice and areas for support and development.

6. Learning, improvement, and development in relation to Speaking Up Culture within the Trust

6.1 **Evaluation feedback on Speaking Up:** An evaluation form for individuals who have spoken up is sent out following contact with the FTSUG using an online link. 80% (20 of 25 responses) of those responding from January to June 2024 said 'yes' they would speak up again. These questions are required by the NGO.

6.2 **Derbyshire Integrated Care System (ICS):** the FTSUG meets monthly with other ICS FTSUGs to discuss system arrangements around FTSU.

6.3 **Speak Up e-learning training launch:** Speak Up e-learning training launched for all staff on 1 April 2024 with completion due by 1 October 2024. Currently at 79% compliance across organisation (2 September 2024).

6.4 **Staff Survey 2023: Raising Concerns**
There are several questions linked to the staff survey on raising concerns. These results were released after the March 2024 Board meeting. As a result of a slight drop in FTSU scores in the 2023 NHS staff survey, hotspot areas were identified by Lucy Moorcroft, Organisational Development Lead, Lucy Moorcroft. Actions and next steps were shared with team managers and ASMs. Gaps and barriers to FTSU were identified. Follow Up training for Board was provided and delivered. There is potential for the delivery of additional face-to-face training or managers and leaders on FTSU in the future.

7 National Guardian's Office and related National Changes

7.1 **FTSU Action and Improvement plan** has been created and monitoring of compliance of the actions will be through the six-monthly reporting by the FTSUG to the Audit and Risk Committee.

7.2 **NGO Strategy:** The National Guardian's Office has set out its six strategic goals to achieve the National Guardian's vision, including improving existing services as well as making some step changes to drive further change across the system. NGO's Strategy for 3-5 years (nationalguardian.org.uk)

8. Conclusion

8.1 Feeling free to speak up represents a significant cultural change across the NHS. Success is not only the responsibility of the FTSUG. It is important that the Trust continues to learn from concerns that workers raise and to build an environment where workers know their concerns, and feedback, are taken seriously and welcomed as an opportunity to guide service improvement and development.

8.2 The Board will continue to use the positive culture around speaking up to drive recommendations from the report forward and to deliver meaningful and visible responses to Trust-wide concerns.

9. Recommendations

The Trust Board is asked to:

1. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.
2. Discuss the report and determine whether it sufficiently assures the Board of the FTSU agenda at the Trust and that those proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up.

Planning Update 2024/25

Purpose of Report

To provide the Board with an update on progress in the development of the 2024/25 operational plan.

Executive Summary

On 27 March 2024, NHS England (NHSE) published the 2024/25 national planning guidance. Joined Up Care Derbyshire (JUCD) is required to submit a system-wide Operational Plan in response to the NHS National Planning Guidance. The development of the system-wide Operational Plan is co-ordinated by the Derby and Derbyshire ICB with input from local NHS providers. The planning submission has three elements: activity and performance; workforce; and finances. The draft JUCD Operational Plan was submitted in April and has been subject to further updates/iterations, in light of the ongoing planning requirements.

Activity and Performance

There are a number of regulatory performance targets set out in the national planning guidance for which the Trust has a key role in delivering. The targets are as follows:

Area	Objective	Performance March 2024	What's our intent?
Mental Health	Improve patient flow and work towards eliminating inappropriate out of area placements	**32 (12 PICU and 20 adult- acute)**	Zero by 31-Mar-2025
	Increase the number of people accessing transformed models of perinatal mental health to 66,000	**1,155**	1,111 people accessing services in Mar-2025
	Increase the number of people accessing children and young people services (345,000 additional CYP aged 0–25 compared to 2019)	**14,115 (ICB)** **3,475 (DHcFT)**	14,555 people accessing by Mar-2025
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery	**68.2% reliable improvement** **50.5% reliable recovery**	67% reliable improvement 50% reliable recovery
	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by Mar-2025	**71.2%**	78% in Q4 24/25
	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by Mar-2025	**67.8%**	68% by Mar-2025

Area	Objective	Performance March 2024	What's our intent?
People with a learning disability and autistic people	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31-Mar-2025	**65.3%**	75% by Mar-2025
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 12–15 under 18s for every 1 million population	**14 per million**	14 CYP per 1 million population
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults for every 1 million population	**43 per million**	35 adults per 1 million population

Of the nine priority areas set out above, the Trust, alongside system partners, plans to achieve the majority of national targets set by NHS England. There remain challenges in terms of delivering this plan, for example, resources, timescales, and uncertainties such as the operating environment:

Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025: To deliver this requires a significant engagement and support from General Practice. The Primary Care and Community Delivery Board will support with GP engagement to increase uptake. A Recovery Action Plan has been requested by the LH, LD and A System Delivery Board.

Reduce inappropriate out of area placements: We have set a trajectory to reduce to zero by the end of March 2025. Although the new build will support achievement of this target, there are also a number of mitigating actions underway which are set out in an organisational Recovery Action Plan (RAP).

There is only one target where the Trust and system partners have agreed that improvements on last year's performance can be made but that it is not possible to achieve the 2024/25 target, as follows:

Reduce the number of adults who are autistic, have a learning disability or both who are in beds: The Trust, alongside system partners is planning to reduce the number of adults, who are autistic, have a learning disability or both, in beds by March 2025: Whilst we do not anticipate achieving the target, it is improvement on the 2023/24 position. This will be achieved by maintaining low level of admissions for people who are autistic, have a learning disability or both into adult mental health beds and reducing length of stay for any individuals who are admitted.

Finance

As a Trust, we are part of the Derby & Derbyshire ICB system financial plan, which is currently highlighting a challenging financial position.

The previous Financial Plan for 2024/25 was submitted to NHSE on 2 May, which for us, was a deficit of £6.4m. NHSE have requested a resubmission of the collective plan on 12 June, in order to reduce the previous system deficit from c£68m to c£50m, which is now the allocated revenue limit that has been set and agreed collectively by the system.

There have been very few changes to our Provider Plan, but further work will continue in-year to help the system deliver on its collective objectives:

- Deficit plan - Our overall deficit has not changed and remains at £6.4m
- Capital – BAU expenditure plan reduced in line with reduced system allocation due to system performance related penalties
- Efficiency – efficiency target remains at £12.5m, however the plans to date have been updated to reflect current progress. Reduced gap and reduced level of risk.

The Trust is continuing to develop efficiency schemes and process these via a quality and equality impact assessment process to close the gap and mitigate risks of non-delivery.

Progress updates will be reported to future Board meetings and provide assurance on the development, delivery and monitoring of the efficiency and transformation programme.

Workforce

The Trust continues to invest in its workforce, focusing on models of care which meet our population's health needs, and working in partnership with all providers across health and care. Over the course of the 2024/25 financial year, there is planned investment growth of 289.38 WTEs, of which 258.01 WTEs are assigned to the Trust's Making Room for Dignity programme, a national programme to eradicate dormitory accommodation from mental health facilities across the country to improve safety, privacy and dignity of patients experiencing mental illness.

Trust strategic recruitment continues to focus on a range of initiatives, which include improved retention, bank to substantive conversions, trainee nurse associate recruitment campaigns, future cohorts of international recruitment for Registered Mental Health Nurses (RMNs), return to practice and retire & return campaigns.

The Trust also continues to work towards its cost improvement programme to meet the current financial challenge both in the Trust and within the Derbyshire System (Derbyshire Integrated Care Board). The Trust is planning to make efficiencies through new ways of working, staff turnover and a reduction in temporary staffing usage, with a particular focus on agency usage which is at a greater cost.

Trust Operational Plan

Historically, NHS providers have been required to submit individual operational plans to regulators in addition to the above. However, this is no longer a requirement and instead providers are required to support the JUCD Operational Plan submission.

The Operational Divisions and Corporate functions have worked collaboratively to develop the Trust 2024/25 Operational Plan, and to contribute to the broader system plan. This work will be finalised once the financial position is confirmed. The operational plan format for 2024/25 has been amended in line with the approach suggested by ELT that the narrative plan for this year is more streamlined and removes duplication from other streams of work. It is intended that the Divisional Operational plans are presented to the Finance and Performance Committee.

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

Risks and Assurances

- Non achievement of key targets and statutory responsibilities
- Impact on staff morale and ability to recruit and retain staff
- Across Derby and Derbyshire, NHS and Local Authority organisations are disinvesting in services
- EQIA assurance for all transformation programmes
- Board approval of 2024/25 financial plan
- Aligns with and seeks to deliver against the Trust's strategy.

Consultation

- Ongoing staff engagement during the development of the plans
- Formal consultation on any aspect of the plan will be undertaken

Governance or Legal Issues

None identified.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

- To be determined following triangulation of the finance, workforce and activity
- EQIAs to be completed for all transformation programmes.

Recommendations

The Board of Directors is requested to note the progress report on the 2024/25 Planning Process.

Report presented by:

Vikki Ashton Taylor
Chief Delivery Officer and Deputy Chief Executive Officer

James Sabin
Executive Director of Finance

Rebecca Oakley
Director of People, Organisational Development and Inclusion

Report prepared by:

Vikki Ashton Taylor
Chief Delivery Officer and Deputy Chief Executive Officer

James Sabin
Executive Director of Finance

Rebecca Oakley
Director of People, Organisational Development and Inclusion

Pete Henson
Head of Performance

Jenny Sutcliffe
Head of Contracting and Commissioning

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2024

Emergency Preparedness, Resilience and Response (EPRR) Core Standards

Purpose of Report

To provide the Board of Directors with an update on the Emergency Preparedness, Resilience and Response (EPRR) core standards and development of the EPRR portfolio within the Trust. It will outline the regional context for 2022/23 and DHcFT submission for 2023/24.

Executive Summary

Following 2022/23 non-compliance for the EPRR core standards, a work plan was implemented to improve the position and raise the Trust's level of compliance. Unfortunately, due to vacancy and staff absence, capacity within the team has been reduced and there has been a delay in rectifying the level of compliance. Since April 2024, the vacancy has been filled and staff have returned to work. The focus was to further enhance the Trust's response and capability to support the progression of the core standards. The Trust has successfully responded to several incidents, outlined in the below report, and made significant progress with compliance against the standards.

The level of scrutiny and requirements for each individual standard has grown substantially. Each domain is split into 10-20 requirements, which all need to be fully compliant for the standard to be compliant overall. The level of work required to facilitate this has significantly increased considering these changes.

As a Trust we are measured against the following domains:

- Governance [100% fully compliant]
- Duty to risk assess [100% fully compliant]
- Duty to maintain plans [100% fully compliant]
- Command and control [100% fully compliant]
- Training and Exercising [100% fully compliant]
- Response [100% fully compliant]
- Warning & Informing [100% fully compliant]
- Cooperation [100% fully compliant]
- Business Continuity [90% fully compliant]
- HazMat/Chemical, Biological, Radiological and Nuclear (CBRN) [70% fully compliant].

This year's deep dive focuses on Cyber [100% fully compliant].

This would bring the Trust up to **substantially compliant**, with the remaining four partial standards completed by December 2024. This report provides an update on business continuity compliance and an overview of the partial compliance standards.

Acronyms used in PowerPoint:

- LHRP – Local Health Resilience Partnership
- MDT – Multi-disciplinary team
- CBRN – Chemical, Biological, Radiological and Nuclear
- ICB – Integrated Care Board.

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

Risks and Assurances

- The Trust continues to prepare and respond to incidents as required
- The workplan is ongoing to support further development and monitoring through the EPRR steering group.

Consultation

This version of this report has been received by Finance and Performance Committee and Executive Leadership Team.

Governance or Legal Issues

- Civil Contingencies Act 2004
- NHS Emergency Preparedness, Resilience and Response Framework 2022.

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:

Any potential equality and diversity implications will be assessed and managed as plans are reviewed, developed and implemented. Initial response to an incident will always consider preservation of life as a priority above all other issues. Following the initial lifesaving phase, all REGARDS issues will be considered in detail.

Recommendations

The Board of Directors is requested to:

1. Note the progress to date
2. Be assured of ongoing work to further enhance the EPRR portfolio within the Trust.

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

Report prepared by: **Celia Robbins**
EPRR & Sustainability Lead

NHS
Derbyshire Healthcare
NHS Foundation Trust

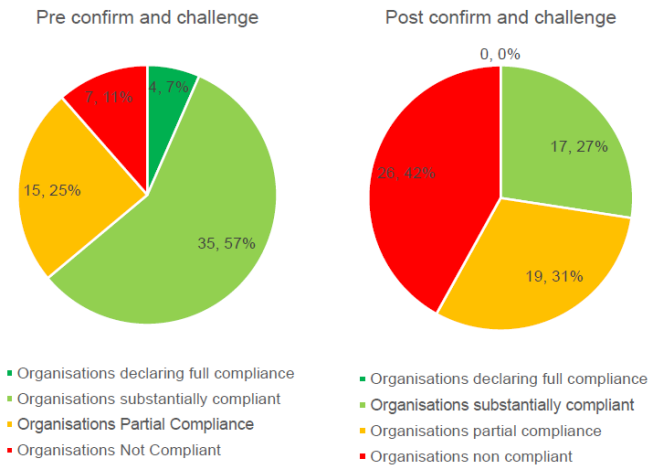
Emergency Preparedness, Resilience and Response (EPRR) Core Standards

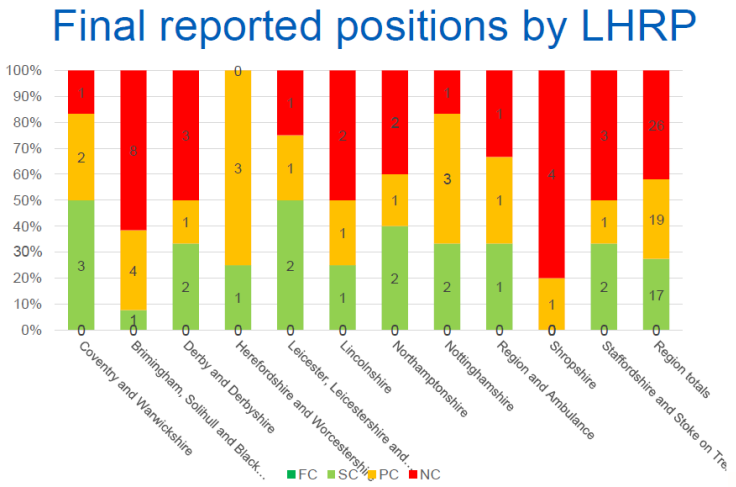
DHCFT @derbyshcft
www.derbyshirehealthcareft.nhs.uk

Making a positive difference

Context

- Annual self-assessment on national standards
- Increased level of scrutiny
- Regionally organisations reduced compliance post confirm and challenge
- Number of trusts within Derbyshire not compliant or only partial.





Making a positive difference

Compliance Levels

Compliance Level	Definition
Fully	The organisation is **100% complaint** with all standards it is expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is **89-99% compliant** with the Core Standards it is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partially	The organisation is **77-88% compliant** with the Core Standards it is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Not compliant	The organisation is compliant with **76% or less** of the Core Standards the organisation is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Compliance Level	Definition
Fully Compliant	Fully compliant with the Core Standard.
Partially compliant	Not compliant with the Core Standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.
Not compliant	Not compliant with the Core Standard. In line with the organisation's EPRR work programme, compliance will not be reached in the next 12 months.

Making a positive difference

2023 vs 2024 submission

- Post confirm and challenge – non-compliant
- Significant improvement
- Submitting – substantial compliance subject to confirm and challenge session
- Four partials remain
- Plans remain proportional and relevant for the organisation – EPRR led with MDT support
- Utilising partners who have higher compliance for peer support.

Making a positive difference

Domains

Domain	Total	Fully Complaint		Partially compliant		Non-compliant	
		2022/23	Aug-2024	2022/23	Aug-2024	2022/23	Aug-2024
Governance	6	3	6	3	0	0	0
Duty to risk assess	2	0	2	2	0	0	0
Duty to maintain plans	11	5	11	6	0	0	0
Command and control	2	2	2	0	0	0	0
Training and exercising	4	1	4	3	0	0	0
Response	5	1	5	4	0	0	0
Warning & Informing	2	2	2	0	0	0	0
Cooperation	4	1	4	3	0	0	0
Business Continuity	10	2	9	8	1	0	0
HazMat/CBRN	10	5	7	5	3	0	0
Total	56	22	52	34	4	0	0

Making a positive difference

Partials

- Business Continuity x1
  - Testing and Exercising local plans
- CBRN/HazMat x3
  - Risk assessment
  - Training resource
  - Staff training – recognition and decontamination

Making a positive difference

Business Continuity

Executive Director	% number of Business Impact Analysis completed	% number of Business Continuity Plans completed
Associate Director of Communication and Engagement	100%	100%
Chief Delivery Officer	94%	94%
Director of Corporate Affairs and Trust Secretary	80%	80%
Director of Finance	100%	80%
Director of Nursing, AHP's and Patient Experience	100%	100%
Director of People, Organisational Development and Inclusion	100%	100%
Medical Director	60%	60%

- Outstanding partial in relation to services exercising local plans.
- Training scheduled for September/October to support this

Making a positive difference

CBRN / HazMat

- Lowest risk of all domains x3 partials
- Further development of EPRR Team competencies
- MDT working with colleagues to develop risk assessment – counter terrorism risks
- Reviewing counter terrorism training programme – strategic level, tactical and operational
- Working with Counter Terrorism Security Advisors, ICB and EMAS

Making a positive difference

Assurance and Risk

- EPRR Steering Group – MDT Trust-wide
- Health partners plan consultation
- ICB scrutinise each plan
  - New and Emerging Diseases completed during staff absence
- We have and do continue to respond well to incidents
- Three-year work plan developed
- Non-compliance to substantial too big shift

Making a positive difference

Deep Dive – Cyber

- Different each year – does not impact overall compliance
- Worked with IMT&R colleagues
- Links with Data Protection and Security Toolkit
- Additional aspects including into EPRR Incident Response Plan
  - Cyber incident cascade
  - Telecomms failure

Making a positive difference

Next steps

- Workplan for next three years
- Core Standards submitted 30 August 2024
- Confirm and Challenge Session with ICB & NHSE Regional EPRR Team 25 October
- +10days resubmission of standards post confirm and challenge
- December Board – final compliance level outcome

Making a positive difference

Board Committee Assurance Summary Reports to Trust Board – 1 October 2024

The following summaries cover the meetings that have been held since the last public Board meeting held on 2 July 2024 and are received for information.

- Audit and Risk Committee 25 July
- Finance and Performance Committee 23 July
- People and Culture Committee 30 July
- Quality and Safeguarding Committee 16 July and 10 September

Key:

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

Audit and Risk Committee - key assurance levels for items – 25 July 2024	
	Review of Board Assurance Framework (BAF) Issue 2, Version 2.2, 2024/25 The Committee reviews the BAF in advance it being sent to the Board for approval. It noted the changes made since the previous version and suggested a further review of the references to the funding, recruitment and quality elements of the Making Room for Dignity (MRfD) programme within the BAF. Connected to the cyber BAF risk, the Committee considered the impact of the recent national computer issue around updates, as well as a cyber-attack affecting some London Hospitals and acknowledged that the Trust and its partners had managed the situation well. The Committee received **significant assurance** on the process of the review, scrutiny and update in identification and mitigation of risks to achieving the Trust's strategic objectives.
	Operational Risk Management (Quarterly Update) The Committee raised concerns at the number of overdue risk reviews but noted that work is ongoing with relevant managers to complete the reviews, however, discipline is required to ensure the Datix system is kept updated. The report provided **significant assurance** regarding the risk management process and the efforts made by the Risk and Assurance Manager to drive that process.
	Salary Overpayments Update The Committee was pleased to see improvement and the on-going commitment to reduce the number of late notice of employment terminations. The new automated notice system is being promoted by the People and Inclusion team to raise awareness. It was noted that this issue is a challenge for all trusts and it was suggested that recharging the overpayment costs to divisional areas might improve the situation. The Trust has a robust process in place to recoup overpayments. **Limited assurance** was accepted on the impact of the actions already taken and the Committee agreed to receive a further update in January.

	Supervision of Staff audit –when a Limited Assurance Opinion is issued, the Executive Director lead attends a meeting of the Audit and Risk Committee to present the management response and any updates. The Committee noted that the audit was welcomed and a small working group has been established to support the delivery of the recommendations. The completion of actions are monitored through the tracker report within the Internal Audit Progress Reports.
	Well Led Action Plan The Committee monitors compliance against the plan and it was highlighted that the amber-rated actions connected to the new Trust Strategy will be completed in November and that all remaining elements should be completed by the end of the year. The Committee gave **limited assurance** based on the fact that actions remain in progress.
	Data Security and Protection (DS&P) Report The Committee acknowledged the submission and positive outcome of the 2023/24 Toolkit, the recommendations from the audit around business continuity and asset ownership were in progress. It was noted that next year's Toolkit will reflect substantial changes, in line with the Confidentiality Advisory Group (CAG) and there will be increased focus on the cyber area with a clear distinction between cyber and data protection.
	Standing Financial Instructions (SFI) The Committee approved revisions to the Standing Financial Instructions (SFIs) ahead of Trust Board for final ratification. **Significant assurance** was received on the content and process for updating the SFIs.
	Standing Financial Instructions (SFI) Waiver Update The Committee receives regular summary reports on the use of waivers and noted the multi-use in respect of two suppliers across several financial years and received **significant assurance** that this is appropriate and **significant assurance** on the process followed to approve and record waivers.
	Internal Audit Progress Report The key messages and progress made against the Internal Audit Plan since the last meeting were noted. The following audit reports had been issued: • Safeguarding – moderate assurance • Data Protection Toolkit – moderate assurance • Joined-Up Care Derbyshire (JUCD) system delayed discharge – this was a benchmarking audit. Terms of reference for the following reports had also been issued: • Health and Wellbeing • Payroll • Performance Management Framework. The Trust is at 100% compliance for completion of audit report actions.
	Counter Fraud, Bribery and Corruption Progress Report The Committee received an update on progress. From the 2024/25 Counter Fraud Functional Standard Return (CFFSR), scores can no longer be carried forward from one year to the next, each year will start at red, and work throughout the year to evidence appropriate actions to move scores towards green. NHS Employers had run a webinar on the use of artificial intelligence (AI), and as a result several trusts have indicated they will not use AI for virtual employment checks.

	It was also noted that five referrals have been closed and it was positive that the Trust was pro-active in reporting fraudulent emails requesting payment as in some Trusts these are deleted without referring, meaning the Counter Fraud team is unable to record the details and implement preventative measures.
	Counter Fraud, Bribery and Corruption Annual Report 2023/24 The Committee noted the key messages and progress made, with another positive year of compliance against the functional standards.
	External Audit Key Performance Indicators (KPI) The successful compliance against the KPIs were received by the Committee and these will be presented to the Council of Governors in September.
	Clinical Audit Annual Report 2023/24 and Clinical Audit Plan 2024/25 The Clinical Audit reports received by the Audit and Risk Committee focus on the effectiveness of the process, noting that Clinical Audit reports considered by the Quality and Safeguarding Committee focus on the clinical outcomes. It was reported that the programme continues to be fit for purpose and additional emphasis will be applied to the timely completion of projects. The Committee noted the steps taken to use Quality Improvement methods to maximise effectiveness of Clinical Audit and ensure priorities flow from the Clinical Strategy and contribute to the Trust Strategy. The Committee received **limited assurance**, noting the action being taken to manage project delays and improve impact.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 10 October 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 – 23 July 2024	
	Assurance on Estate Strategy – specifically Making Room for Dignity Programme (MRfD) The Committee noted that the programme was progressing well, and the build and operational planning risks are reducing. The £7.5m cost pressure and other financial risks remain as there will be some additional costs for the refurbishment works at the Radbourne Unit. Final figures will be updated for the next report. Additional funding is required to proceed with Ward 35 and a request for support has been submitted to NHSE via ICB and awaiting outcome. Overall, no major concerns to escalate other than the above. Questions raised around the formal gateway review planned in September with the Department of Health and Social Care around being ready for implementation. **Limited assurance** was received on the progress of the programme and the risks associated with it.
	Financial Performance – Month 3 Finance Report, incorporating Cost Improvement Programme (CIP) Position The Trust is on plan for Quarter 1 and forecasting to be on plan at year end. Observation costs, high-cost medical agency cover and out of area placements, remain the key drivers.

	CIP performance at the end of Quarter 1 showed the plans in place for £11.2m against the £12.5m target, 75% is recurrently identified which is a significant increase on last year, the gap to close is being worked on. Contract risks are being pursued with partners. The Committee noted that capital is ahead of plan but how much we can progress is dependent on receiving national capital for cost pressures. The Trust remains on track to deliver the capital position and has no major concerns over cash, debt or Better Payment Practice Code (BPPC) compliance. The Committee challenged the situation on the contract risks. The Committee gained **limited assurance** on delivery of the financial position due to the level of risks inherent in the plan and the required level of delivery of efficiencies.
	National Cost Collection Submission – Post-Submission Report The good position was noted with recognition of the two areas for continued improvement (floor area and medical job plans). Work is planned to progress these in advance of next year's submission. The Committee received **significant assurance**, the submission was endorsed and approved. Thanks to the team.
	Contracts Update No major risks or concerns flagged. The perinatal contract awards were approved. The Committee received **significant assurance**.
	Continuous Quality Improvement <u>Improvement and Transformation Report</u> The Committee received **significant assurance** on the progress and ongoing training plans. **Limited assurance** was received on sharing best practice and embedding benefits organisation-wide due to some recent staffing gaps which, pending new appointment have delayed some progress.
	Operational Performance – Improving Patient Flow Recovery Action Plan No major new risks or concerns flagged. The Committee gained **significant assurance** on delivery of the performance metrics recognising there are still a number of areas off trajectory and not aligned to agreed contract and performance targets however, action plans and oversight remain in place to ensure progress is being made.
	Demand for Services Report The Committee received **limited assurance** on the actions being taken to improve flow.
	Business Environments – Living Well Programme The update was noted.
	System Updates – Integrated Care Board (ICB) Finance Committee and System Directors of Finance (DoF) - Verbal Update Committee members are sighted on the organisation and system challenge in line with the required delivery of the 2024/25 financial plan. The clear national message was that there would be no additional funding and providers need to manage their own pressures that arise in year. Early indicative figures being shared via the ICB for 2025/26 highlight the increased challenge, c£150m+ as a system.

	Assurance of Emergency Preparedness Resilience and Response (EPRR) The Committee noted that significant progress was being made but there were a number of actions still required to be fully compliant with the NHSE core standards, a lot of areas showed partial compliance. A Recovery Action Plan (RAP) has been put in place, but this has been impacted by reduced staff capacity. The Committee gave thanks for the clarity provided in the report but wanted to understand what the consequences of being non-compliant are. This was a technical non-compliance and assurance was given around the Trust having faced some significant events with flood, fire, power outage and industrial actions, these incidents have all been managed safely and all incidents have been fed back to the Board. **Limited assurance** was agreed on the basis of compliance status.
	Board Assurance Framework (BAF) 2024/25 Risks Overview Minor updates to the three risks under the Committee. No major changes or updates to the risks scores.
	Revised Terms of Reference Approved.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 30 September 2024.
Committee Chair: Tony Edwards	**Executive Lead: James Sabin, Executive Director of Finance**

People and Culture Committee – key assurance levels agreed – 30 July 2024	
	People and Inclusion Assurance Dashboard The Committee accepted **significant assurance** on the progress shown for mandatory training, staff turnover, vacancies and recruitment, attendance and absence, bank usage and Freedom to Speak Up (FTSU). It was noted that there is a current drive on recruitment and retention for Allied Healthcare Professionals (AHP) and an initiative to convert bank staff to substantive posts. The Committee discussed the challenges around clinical supervision, which includes ambiguity around the different types of supervision, required frequency and recording. It was noted that an additional oversight meeting has been implemented. **Limited assurance** was agreed on the updates for Employee Relations, clinical supervision and annual appraisals.
	System Developments – Verbal Update It was reported that the emphasis is on co-ordination of project improvements, along with a national commitment to decrease reliance on agencies, for which Trust usage is minimal in comparison to other system providers. It was noted that a new Psychology faculty will be introduced to the new Derbyshire system academy, along with a faculty around Social Care, Social Workers and AHPs.
	Making Room for Dignity – Programme Update The Committee was delighted at the considerable progress made with recruitment initiatives and commended the stratification of posts data, which revealed the intricacies of the challenge, the associated risks and compulsory elements.

	It was noted that a two-year, cultural change programme will be launched in September, which will focus on purposeful admission, trauma informed care and sensory training. The Committee was encouraged to receive feedback that people feel engaged, seeing the project as a way to reorganise, reshape and re-energise themselves. **Significant assurance** was received on the actions and progress being taken to mitigate the risk of the considerable number of 'hard-to-recruit' and 'national workforce shortage' posts required and **significant assurance** was also received on the development of, and progress with, the service and cultural transformation work, next steps and progress tracking.
	Annual Workforce Plan The Committee supported the work on production of the Trust's Annual Workforce Plan for 2024/25 and current activity around workforce planning processes and triangulation within the Joined-Up Care Derbyshire (JUCD) Mental Health Alliance. It was agreed to undertake a benchmarking exercise with other system providers around turnover within the first year.
	Flu and COVID Campaign 2024/25 The report set out the Flu and COVID vaccination campaign for 2024/25 and the work undertaken to deliver the programme. The Committee received **significant assurance** on the plans in place but accepted that meeting the target would still be challenging. All providers have seen a reduced take up and the Trust sits in the top 35% of Mental Health Trusts.
	Temporary Staffing Review (Agency Focus) The Committee received **significant assurance** on progress to reduce agency usage and the evident trajectory for further improvement. It was reported that gaps have been filled with bank staff rather and any agency usage has been limited to registered Nurses, Medical staff and Healthcare Support Workers. The Trust has met the requirement for zero off-framework spend and there has been no usage for non-clinical staff.
	Talent Management and Succession Planning **Limited assurance** was agreed due to the stalling of progress in succession planning. A simplified, one-page template will be introduced, along with a succession matrix model. The Committee discussed broadening the offer to capture more junior staff who display good succession potential. The Committee accepted **significant assurance** that a number of key lessons have been learnt and will now feed into the next Succession Plan cycle, with clear expectations across the Executive team. The proposal to run a new talent and succession conversation period in October and November was approved with a view to bring a plan to the January 2025 meeting.
	Equality, Diversity and Inclusion (EDI) – Interim Arrangements – Verbal Update It was noted that responsibilities will be undertaken by the senior management team until a new Head of EDI is appointed.
	Staff Survey The Committee received an update on the Trust 2023 NHS Staff Survey results and preparation for the 2024 Survey. It was agreed that 62% for last year was a fantastic achievement, credited to the energy, leadership and drive of the Project Lead. Ongoing work from learning in 2023 is focussed on "YOU SAID, WE DID" actions. The Committee accepted **significant assurance** that plans and actions are in place to build on the 2023 staff survey results and continue to increase the Trust response rate.

	Limited assurance was accepted due to some teams having inadequate response rates.
	Board Assurance Framework (BAF) – key risks identified: It was noted that the Trust has successfully recruited two international Nurses and they have completed the objective structured clinical examination (OSCE) conversion programme. Further to the discussions on Talent Management, it was suggested the BAF needs to be reviewed.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** 24 September 2024
Committee Chair: Ralph Knibbs	**Executive Lead: Rebecca Oakley, Director of People, Organisational Development and Inclusion**

Quality and Safeguarding Committee – key assurance levels for items – 16 July 2024	
	Fundamental Standards Report The Committee received an update on actions taken to improve quality of care arising from the findings of the Care Quality Commission's (CQC) inspections. Considerable strengthening of the governance framework and action plan was noted. The ongoing roll-out of the Trust's fundamental standards visit schedule, which mirror's the CQC's assessment framework, was noted. **Significant assurance** was accepted that the Trust is comprehensively addressing the concerns identified by the CQC to date, noting that this is about the approach and diligence, as opposed to outcome.
	Regulation 28 Reports – Learning The Committee accepted **significant assurance**, that the Trust has developed learning from the Regulation 28 reports to minimise risk to patient safety and considered how the key elements from each have helped improve the investigation process and learning culture. Nationally there has been an increase in Regulation 28 reports issued by Coroners, which is considered to be a learning tool by Coroners. Connected to the most recent Regulation 28 report, an audit will be undertaken into the clinical justification for patient admissions during handover time.
	Medicines and Pharmacy Annual Report The Committee accepted **significant assurance** and noted the good progress made to deliver the Medicines Optimisation and Pharmacy Strategies for 2021-24 and that the medicines expenditure trends and identified risks are understood and actively monitored.
	Physical Healthcare Report Discussions focussed on Care Planning, along with challenges on the availability of equipment. It was agreed that a review of equipment would be undertaken under the current Service Level Agreement (SLA). The Quality and Safeguarding Committee determined a level of **limited assurance** from the report but noted the work that is underway to improve.

	Infection Prevention and Control (IPC) Update The Committee received **limited assurance** but noted the planned work to improve training compliance. Vaccine compliance for front line workers remains challenging but a number of initiatives to improve uptake were being explored.
	Reducing Restrictive Intervention The Committee received an update on steps being taken to share learning through the Restraint Network. The Trust's debrief process following a restraint has been strengthened with the aim of sharing wider learning and support. The Committee agreed **significant assurance** on the Trust's progress in reducing restrictive practices within the Trust, reducing violence, and keeping people safe.
	Safer Staffing Annual Review The new establishment review process includes the implementation of the evidence-based Mental Health Optimal Staffing Tool (MHOST) and will use the safe staffing multipliers relevant to ward types and structured professional judgement to determine the appropriate levels of staffing per ward. It was also noted that the Trust compares favourably with national peers in ensuring safer staffing levels in its services. The Committee received **significant assurance** from the review.
	Sexual Safety – State of Readiness Action Plan **Significant assurance** was accepted based on the Trust being a signatory to the NHS England charter on sexual safety and the agreed actions to meet the ten charter principles, noting that the impact is yet to be demonstrated.
	Complaints – Early Resolution Model – Updated Position From April 2024, of the 149 complaints submitted to the Patient Experience team, 111 have been dealt with via the quick resolution model and the remaining 38 are being investigated through the closer look model. The Committee noted that the intended approach is to resolve complaints from a team point of view, initiating a quality improvement methodology. **Limited assurance** was accepted based on the transition period.
	Board Visits The Committee welcomed the proposal for a new way to capture issues raised from the visits but agreed **limited assurance** based on the past issues with co-ordination, triangulation and response in respect of visits. It was agreed to receive feedback on a six-monthly basis.
	Care Planning/Person-Centred Care The Committee asked to see greater pace in improving compliance against the target and suggested that deeper analysis is required to look at the quality improvement (QI) methodology in the non-compliant areas. **Limited assurance** was given as the Trust was not consistently meeting the 85% target.
	Deep Dive Children's Services – Paediatric Referral to Treatment (RTT) The Committee received an overview of the current service delivery, including the high number of referrals in Paediatrics and ADHD and the challenge around demand and funding for ADHD medication.

	Mitigations to address the gaps have involved various initiatives, such as skill mixing, improved triaging, engagement with local authorities and education partners, school visits and reduction of the ASD assessment to half an hour from three. The Committee received **significant assurance** due to the actions taken to mitigate the risks associated with the current demand on services.
	Escalations to Board or other Committees: None **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 10 September 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 – 10 September 2024	
	Fundamental Standards Report The Committee received **limited assurance** on the completion of CQC actions from the inspections of the Radbourne Unit and Hartington Unit in April 2024, on the basis that some actions were still in progress.. It was noted that the final CQC report had not yet been received and therefore, the action plan may change. Overall, there has been an improving trajectory with 80% of the current actions completed/embedded. Fundamental standard visits are being booked in to test against the standards across all services. Improvements in governance were also observed.
	Quality Dashboard (bi-monthly) Substantial improvements were noted, including positive reductions in seclusions; physical restraints; ligature-related incidents, self-harm incidents; incidents recorded as moderate or catastrophic harm; and falls. The Radbourne Unit, in particular, was praised for the improvements. A performance improvement plan has been put in place for assessment of Venous ThromboEmbolism (VTE) and this will be monitored via the monthly COAT and Divisional Performance Review meetings.
	Patient Safety Report Discussion focused on transfer of care and the handover methodology in clinical and non-clinical environments and it was observed that the Trust policy supports the most appropriate pathway, however the transfer of care process is under review. **Limited assurance** was accepted based on inconsistencies in application, review methods and dissemination of learning.
	Risk Report (quarterly) The Committee reviewed the elements of the report and agreed that inclusion of the appendices is extremely helpful to identify the high and extreme risks in relation to quality. It was suggested that adding the effect of implemented actions and extra mitigations required would further improve, and that a deep dive around Adult Care Acute, Medication Assurance Audits, would be helpful to understand the associated risks. The Quality and Safeguarding Committee accepted **significant assurance** regarding the risk management and reporting strategy.

	Medicines and Pharmacy Update The Committee noted that the update and supported the value and role of the Medicine Management Committee and sub-committees at reviewing and taking appropriate action around medicine safety and governance within the Trust. It was noted that the rapid tranquilisation audit would be repeated in six months.
	Looked After Children Annual Report This report provided an overview of the progress, challenges, opportunities, and future priorities to support and improve the health and wellbeing of Children in Care in Derby City. **Significant assurance** was taken from the work of the Trust and the key priorities set for 2023/24 were agreed. Approval was given for the report to be submitted to the Board on 1 October to provide assurance on how this service is discharging its legal duties and clinical standards requirements.
	Safeguarding Children and Adults at Risk Annual Report The Annual Report is a governance requirement of both the Trust and the Safeguarding Children Partnership and Adult Safeguarding Boards. It provides assurance that the Trust is meeting its governance requirements. The Committee praised the well-structured and considered report, which evidenced the outstanding work of the team and accepted **significant assurance** regarding the fulfilment of legal and statutory duties.
	Sexual Safety and Trauma Report (six-monthly) The Trust is a signatory to the Sexual Safety Charter and an update focussed on the relational security need and patient pathway, along with the importance of detailing the values, principles and guidance. The Committee requested additional data on progress for the next report. **Significant assurance** was received on the basis that the organisation has met the requirements of the charter and work is continuing within the Trust to ensure this work was fully embedded for staff and patients.
	Clinical Audit – Annual Report on Effectiveness and Clinical Audit Plan Improvements in Trust clinical and audit projects were reported, however, alignment with quality improvement processes is not yet fully embedded. The Committee accepted **limited assurance** due to the transition to integrate continuous quality Improvement approaches.
	Getting it Right First Time (GiRFT) (six-monthly) The report outlined progress of service development against the GIRFT recommendations and clarifies the next stage of growth. The current business case is being evaluated by the Executive Leadership Team with an update expected later in September. **Limited assurance** was accepted due to the need for additional development.
	Right Care Right Person (RCRP) Progress Report (bi-annual) The potential increase in activity for mental health services was highlighted, due to some pending decisions around the 'Concern for Welfare and Safety' workstream and system partners were working together on solutions. The process that the Trust will be implementing in the inpatient units would include a checking in/out register along with details of where the person is going. It was reported that the programme is to be implemented by March 2025 and a phased roll out has been agreed for the Derbyshire local system in each principle of the RCRP, for example, the timely handover of section 136 is partially implemented already.

	Patient Experience Report This report provided assurance regarding the themes and changes made to Trust services as a result of feedback on incidents and complaints made to the Patient and Carer Experience Committee. The Committee discussed the challenges around feedback and it was suggested that additional detail is required to better understand improvements, in particular the percentage of patients that use Trust services. Based on previous scrutiny by the Patient and Carer Experience Committee, **limited assurance** was received.
	Learning from Deaths **Significant assurance** was received on the Trust's approach and it was 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.
	Patient Flow/Delayed Discharges Analysis The Committee noted the content of the report, which evidenced no direct correlation between patients that have fallen and delayed transfer of care in the Older People's services.
	Review on Intensive and Assertive Community Healthcare The Committee was briefed on the guidance that had just been published and the ICB review that the Trust had been supporting in order to submit by 30 September. A task and finish group involving other invested partners, eg, social care and housing, is to ensure appropriate oversight is in place, along with effective policies and practices, identification of gaps and how these are to be mitigated. The framework will be presented to the Trust and ICB Boards. It was noted that there are no immediate actions to address and that the Trust does not discharge patients on the basis of 'did not attend' (DNA) - robust processes are followed. The Trust had been using its management and supervision tool (MAST) for some time.
	East Midlands Perinatal Mental Health Provider Collaborative There were no risks to be escalated and a review is underway to look at the potential benefits of streamlining the two support hubs into one. The Committee received **significant assurance** on the quality and safety of services provided.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 15 October 2024.
Committee Chair: Lynn Andrews	**Executive Lead: Michelle Bateman, Interim Director of Nursing, AHPs, Quality and Patient Experience**

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 1 October 2024

Review of Standing Financial Instructions (SFIs)

Purpose of Report

SFIs have been reviewed and proposed changes agreed by the Audit and Risk Committee and presented to Trust Board for final ratification.

Executive Summary

The SFIs were last updated in May 2023 and are due for review. They have been reviewed and proposed changes have been agreed by the Executive Leadership Team and the Audit and Risk Committee.

The following changes are being proposed:

General updates throughout the document for the following:

- Name changes for the Capital Project Group
- Name change for the Director of People, Organisation Development and Inclusion
- Formatting and numbering.

3.2 Budgetary Delegation

It is proposed that the lower authorisation limits remain in place for a further 12 months. Therefore table 3.2.2i has been updated to reflect these changed limits.

£1,000,000 and above	*Board of Directors*
£500,000 to £999,999	*Chief Executive **and** Director of Finance to jointly approve*
£200,000 to £500,000	*Chief Executive or Director of Finance*
up to £200,000	*Deputy Chief Executive or Deputy Director of Finance*
up to £200,000	*Executive Directors voting and non-voting but not Non-Executive Directors*
Up to £50,000	*Managing Directors*
Up to £30,000	*Financial Controller*
Up to £10,000	*General Managers and Assistant/Associate Directors*
Up to £1,000	*Area Service managers and Heads of Service*
Up to £100	*Budget Holders*

8.5 Tendering

This section has been reviewed by the Head of Procurement and the following changes are proposed:

'*All tendering activity must be compliant with Procurement Regulations 2024 or any other such policy that may supersede it".*

8.16 Trust Seal

Changes to this section have been suggested by the Assistant Director of Corporate, Legal and Mental Health Legislation, Head of Procurement and Head of Contracting.

This is to reflect the delegated limits in section 3.2.2i and also to allow a more practical process for the signing of contracts, as the size of the organisation's contract values have grown.

'Save for deeds and contracts relating to the disposal, acquisition or leasing of land and buildings, the following shall apply:

All contract documents, up to the value of £200,000, shall be signed on behalf of the Trust by an Executive Director (voting or non-voting) or nominated officer. Documents above £200,000 shall be signed by the Director or Finance, Chief Executive or nominated officer with appropriate approval limit. Every contract, the value of which exceeds £500,000, shall be executed under the signature of two Executive Directors (voting or non-voting) duly authorised by the Chief Executive and not from the originating department.

All deeds and contracts relating to the disposal, acquisition or leasing of land or property, shall be executed under the Common Seal of the Trust and be signed by the Trust Secretary or a Nominated Deputy and an Executive Director (voting or non-voting) duly authorised by the Chief Executive and not from the originating department'.

9 NHS Service agreements and contracts for the provision of services

9.1 – wording has been added regarding decommissioning of services:

'*The decommissioning of any healthcare service will require approval by Trust Board'.*

14 Asset Registers and security of assets

14.1.3 – wording has been added to clarify the process around disposal of land and buildings:

'The route to market for any sale of land and buildings will be determined by the Head of Estates and Facilities and the Director of Finance but with final agreement by the Trust Board'.

14.3.7 – wording has been added to reflect a new process required in relation to new lease and the impact on capital resources:

'Following the change in accounting treatment and new leases to be funded from Business-as-Usual capital allocations, all new leases must go through the Capital Project Group for approval or recommendation depending on capital limits set out in 13.2.1'.

Appendix 1 – Tendering Procedure

3i, added '*which will include, if available'*

3ii added 'voting'

3iv, amended to '*Director who has the portfolio responsibility for Estates'*

6ii added '*such good and sufficient reasons will be determined by those within the Trust with the requisite skill and experience in the matter being tendered for*'.

Provider Collaboratives

We are evaluating the emerging new governance structure of provider collaboratives and will look to update the SFIs at the next iteration. In the interim, all strategic and risk-based decisions will be agreed via ELT and Trust Board where deemed necessary.

Making Room for Dignity Programme

A paper went to Confidential Trust Board on 5 April 2022 in relation to authorisation of orders within SFIs (see appendix 1).

It is proposed that this agreement is continued and that the Chief Executive and Executive Director of Finance (DOF) sign the orders and authorise expenditure on behalf of Trust Board.

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

These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust. They have been updated to clarify procedures that should be followed to ensure Trust's financial transactions are carried out in accordance with the law and with Government policy.

Consultation

Senior staff within the Finance Department have updated the SFIs with input from the Head of Procurement, Head of Contracting, Assistant Director of Legal, Governance and Mental Health Legislation, General Manager IMT&R and Acting Deputy Director of People and Inclusion.

The Executive Leadership Team has reviewed and approved the proposed changes.

Counter Fraud have reviewed the SFIs and propose no further changes.

Governance or Legal Issues

These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

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 nature and remit of this document means that it has no impact on equality, diversity or inclusion and therefore, does not impact those with protected characteristics.

Recommendations

The Trust Board is requested to review the SFIs and agree proposed changes.

Report presented by: **James Sabin**
Director of Finance

Report prepared by: **Rachel Leyland**
Deputy Director of Finance

Derbyshire Healthcare NHS Foundation Trust

Standing Financial Instructions Policy and Procedure

See also:	Located in the following policy folder on the Trust Intranet
Corporate Governance Framework	
Treasury Management Policy	Corporate and Risk
Counter Fraud and Bribery Policy and Procedures	Corporate and Risk
Disciplinary Policy and Procedure	People and Inclusion
Conflicts of Interest Policy	Corporate and Risk

Service area	Issue date	Issue no.	Review date	
Trust wide	July 2024	1	January 2025	
Ratified by	**Ratification date**	**Committee/Group responsible for review:**		
Trust Board		Audit and Risk Committee		

Document published on the Trust Intranet under:

Did you print this document?
Please be advised that the Trust discourages retention of hard copies of policies and can only guarantee that the Policy on the Trust Intranet site is the most up-to date version

ACCESSIBLE INFORMATION STANDARD
The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Ensure you have considered an agreed process for: sending out correspondence in alternative formats and appointments for patients / service users with communication needs, where this is applicable.

Making a positive difference

Derbyshire Healthcare NHS Foundation Trust

Checklist for Standing Financial Instructions

Summary
These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust.

Name / Title of policy/procedure	Standing Financial Instructions	
Aim of Policy	These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust.	
Sponsor (Director lead)	Director of Finance	
Author(s)	Deputy Director of Finance Financial Controller	
Name of policy being replaced	Standing Financial Instructions	**Version No of previous policy:**

Reason for document production:	To provide a reference document and guidance detailing the financial responsibilities which apply to everyone working for the Trust.
Commissioning individual or group:	Director of Finance

Individuals or groups who have been consulted:	**Date:**	**Response**
General Manager IM&T	23/05/2024	No changes
Head of Contracting	04/06/2024	Changes to 8.16
Head of Strategic Procurement and Tendering	10/06/2024	Changes to 8.5
Assistant Director of Corporate, Legal and Mental Legislation	25/06/2024	Changes to 8.16
Acting Deputy Director of People and Inclusion	25/06/2024	Change to job title
Executive Leadership Team	01/07/2024	Approved

Counter Fraud	12/07/2024	No changes
Audit and Risk Committee	25/07/2024	Approved

Version control (for minor amendments)

Date	Author	Comment
	Job title, not name	

Derbyshire Healthcare NHS Foundation Trust

Standing Financial Instructions

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1. STANDING FINANCIAL INSTRUCTIONS

INTRODUCTION

1.1 Who Should Read These Standing Financial Procedures (SFIs)?

These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes.

You should read these SFIs and be aware of their relevance to you as you discharge your responsibilities if you are:

- A Director of the Trust
- A Service Manager
- A Senior Manager in a support function
- A budget holder
- Involved in placing orders for goods/services on behalf of the Trust
- Involved in negotiating contracts/other arrangements for the provision of goods/services
- Involved with the handling and safe custody of patients' monies and valuables
- Involved in the administration of Charitable Funds

ALL staff must be made aware of section 11 ,Standards of Business Conduct, within the Standing Orders of the Board of Directors and Standards of Business Conduct.

Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance MUST BE SOUGHT BEFORE YOU ACT. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

Overriding Standing Financial Instructions

If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee for referring action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and:

"Trust" means the Derbyshire Healthcare NHS Foundation Trust;
"Board" means the Board of Directors of the Trust;
"Budget" means a resource, expressed in financial terms and whole time equivalent (WTE) terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all the functions of the Trust;
"Chief Executive" means the Chief Officer of the Trust;
"Director of Finance" means the Chief Financial Officer of the Trust, who is also the Director of Finance;
"Budget Holder" means the Director or member of staff with delegated authority to manage finances (Income and Expenditure, Revenue and Capital) for a specific area of the Trust;
"Legal Advisor" means the Trust appointed person properly qualified to provide legal advice.

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or staff who have been duly authorised to represent them.

1.2.3 Wherever the term "staff" is used it shall be deemed to include staff of third parties contracted to the Trust when acting on behalf of the Trust.

1.2.4 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board of Directors

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and staff as indicated in the Scheme of Delegation document.

They may delegate executive responsibility for the performance of operational functions to the Chief Executive in accordance with the Trust's approved Scheme of Delegation.

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1.3.2 The Chair

The Chair is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.

1.3.3 The Chief Executive

Within these SFIs it is acknowledged that the Chief Executive is ultimately accountable to the Trust Board and it is the duty of the Chief Executive to:

- Implement the financial policies of the Trust Board in order to ensure that the Trust Board meets its obligations to perform its functions within the available resources.
- Ensure all staff are notified of the requirements of the Standing Financial Instructions.
- Delegate the management of resources to officers of the Trust in accordance with the Trust's approved Scheme of Delegation.
- Ensure that the Trust's financial obligations and targets are met.
- Take responsibility for the Trust's system of internal control.

In performing these duties the Chief Executive will take due consideration of the advice given by the Director of Finance.

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It is a duty of the Chief Executive to ensure that members of the Trust Board and, staff and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions.

1.3.4 The Director of Finance

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The Director of Finance is responsible for:

- implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
- maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

The duties of the Director of Finance also include:

- the provision of financial advice to the Trust and its directors and staff;
- the design, implementation and supervision of systems of internal financial control; and

- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.5 All Board Members and Staff

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All members of the Trust Board and staff of the Trust have a responsibility for:

- the security of the Trust's assets;
- avoiding loss;
- exercising economy and efficiency in the use of resources; and
- conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

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For all members of the Board and any staff who carry out a financial function, the form in which financial records are kept and the manner in which members of the Trust Board and staff discharge their duties must be to the satisfaction of the Director of Finance.

1.3.6 Budget Holders

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Have a responsibility to:

- Monitor activities to ensure resources are utilised in an effective and efficient manner;
- Ensure activities are conducted within the constraints of budgets;
- Provide all information and explanations required by the Director of Finance to ensure financial control, enacted through the business of the operational meetings, Executive Leadership Team, Finance and Performance Committee and the Trust Board;
- Ensure the security of Trust Assets including property, equipment and cash.

1.3.7 Contractors and their Staff

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Any contractor or staff of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

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2. AUDIT

2.1 THE AUDIT AND RISK COMMITTEE

2.1.1 In accordance with Standing Orders, the Trust Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference (which are contained in the Scheme of Delegation) and following guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control including financial control.

2.1.2 Where the Audit and Risk Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair should raise the matter at a full meeting of

the Trust Board. Exceptionally, the matter may need to be referred to the Department of Health or NHS England.

2.2 ROLE OF THE DIRECTOR OF FINANCE

2.2.1 The Director of Finance is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;
b) ensuring an internal audit service exists to review, evaluate and report on the effectiveness of internal financial control to meet mandatory audit standards;
c) ensuring that an annual audit report is prepared by Internal Audit and External Audit and as required by the Audit and Risk Committee and the Trust Board in accordance with current Department of Health and NHS England guidance.

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2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) access at all reasonable times to any land, premises or staff of the Trust;

c) the production of any cash, stores or other property of the Trust under a member of staff's control;

d) explanations concerning any matter under investigation.

2.3 THE ROLE OF INTERNAL AUDIT

2.3.1 Internal Audit will review, appraise and report upon:

a) Internal Audit shall independently verify the Annual Governance Statement and other declarations in accordance with guidance from the Department of Health.

b) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

c) the adequacy and application of financial and other related management controls;

d) the suitability of financial and other related management data;

e) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately, who shall in turn notify the Trust's Local Counter Fraud Specialist.

2.3.3 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chair and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall report to the Director of Finance who shall refer audit reports to the appropriate officers designated by the Chief Executive.

2.4 THE ROLE OF EXTERNAL AUDIT

2.4.1 The Trust's external auditor is appointed by the Council of Governors and is paid for by the Trust. The Auditor must comply with the principles set out in the Audit Code for NHS Foundation Trusts.

2.4.2 The Governors must ensure that a cost-effective external audit service is provided and periodically review arrangements in conjunction with the Audit and Risk Committee.

2.5 External Auditors for non-Audit Services

2.5.1 The independence and objectivity of the external auditors is an important element supporting good governance within the Trust. The auditor should be, and should be seen to be, impartial and independent. Accordingly, the auditor should not carry out any other work for an audited body if that work would impair their independence in carrying out any of their statutory duties or might reasonably be perceived as doing so.

2.5.2 Prohibited non-audit services
To ensure that the auditor's independence and objectivity is not impaired it is important the external auditors do not:

- Audit their own work
- Make management decisions on behalf of the Trust
- Undertake activities which (potentially) result in conflicts of interest
- Act as advocates for the Trust
- Creating any threat to their independence

Therefore, the Trust will apply the following prohibitions on non-audit work by the external auditor:

- Providing any services specifically prohibited by UK law or supporting guidance.
- Work related to the accounting records and financial statements that will ultimately be subject to external audit.
- Taxation assignments where there is no fixed fee or the fixed fee is greater than that allowed in this policy (see below).

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- Internal audit services.
- Design/implementation of financial information technology systems.
- Valuations services where the valuation has a potentially material impact upon the Trust's financial statements.
- Legal and litigation support or advice where the outcome could have a potentially material impact upon the Trust's financial statements.
- Provision of senior recruitment services.

2.5.3 Permitted non-audit services

Where the work is not disallowed under the previous paragraph the external auditors may be considered for individual assignments. In the majority of cases such assignments will be subject to formal tendering procedures held in accordance with the Trust's SFIs.

In certain circumstances the external auditors' detailed understanding of the Trust's business may result in a recommendation from the Director of Finance to the Audit and Risk Committee for the external auditors to be retained to undertake a permitted non-audit exercise, rather than undertake a formal tendering procedure. This may be, e.g., for reasons of efficiency, confidentiality or expert understanding of the Trust's position. These could include:

- Advice on the preparation of financial information and the application of GAAP or training support for accounting projects and in relation to accounting standards.
- Audit related services as defined in the APB Ethical Standard 5 (Revised).
- Assistance in tax compliance activities and advice on recent developments and/or complex or high-risk areas.

Secondments between the external auditors and the Trust will also be acceptable for lower (sub-Board) positions.

2.5.4 There is no financial limit in any one financial year relating to non-audit assignments secured by external audit through competitive tendering procedures. Nonetheless, the potential for the compromising of independence and objectivity must always be considered. Therefore, it will be the duty of the Director of Finance to draw the attention of the Audit and Risk Committee if the external auditor is awarded non-audit work to a value equal to or greater than the value of the external audit contract in any one financial year.

There will be a strict limit applied to any assignment awarded directly to the external auditor without a competitive tendering process. The value of any one assignment must not exceed £10,000 and there can be no more than two such assignments in any one financial year.

2.5.5 For awards made to the external auditor through a competitive tendering process – the approval will follow existing SFI requirements and will be reported by the Director of Finance to the next Audit and Risk Committee.

For awards made to the external auditor directly, without a competitive tendering process – a written request will be submitted to the Audit and Risk Committee. The Committee will give its consent either at a scheduled meeting or by written consent (as appropriate) based upon a submission which covers:-

- The service to be provided
- An explanation of the rationale for appointing the external auditor
- The safeguards in place to mitigate the threat to auditor independence (e.g., the application of 'Ethical Walls' by the audit firm)
- Estimate of fees and expenses
- An analysis of the expected total proportion of fees earned by the external auditors in the year which will be earned by non-audit work

The Audit and Risk Committee will need to provide approval on a formal, recorded, basis.

2.5.6 For the avoidance of doubt the phrase 'external auditor' in this policy covers not only the audit partner signing-off the Trust's accounts, nor the audit section or department undertaking the external audit but also the firm providing the audit.

2.5.7 Adherence to this policy will be monitored by the Audit and Risk Committee.

2.6 FRAUD and BRIBERY

In line with their responsibilities the Trust Chief Executive and Director of Finance shall ensure compliance with Secretary of State guidelines on fraud and bribery.

The Trust shall nominate an accredited individual to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud Authority. The Trust has in place a Counter Fraud Champion who is currently the Trust Secretary.

The LCFS shall report to the Trust Director of Finance and work alongside NHS Counter Fraud Authority to ensure there is a zero-tolerance approach to Fraud and Bribery within the Trust.

The LCFS will provide a written report, at least annually, detailing the counter fraud work within the Trust which will be presented to the Audit and Risk Committee.

In accordance with the Trust Fraud and Bribery Policy, any suspicions involving financial crime must be reported to the Local Counter Fraud Specialist, and / or the Executive Director of Finance or via the NHS Fraud Reporting Line. All reported concerns will be treated in the strictest confidence and professionally investigated in accordance with the Fraud Act 2006 and Bribery Act 2010. Where evidence of Fraud and / or Bribery is identified all available sanctions will be pursued against offenders. This may include internal and professional body disciplinary sanctions, criminal prosecution and civil action to recover identified losses.

2.6.1 Sanctions and Redress

The Trust is committed to pursuing and / or supporting NHS Counter Fraud Authority in pursuing the full range of available sanctions (criminal, civil and disciplinary) against those found to have committed fraud and / or bribery.

The Trust seeks to recover, and / or support NHS Counter Fraud Authority in seeking to recover NHS funds that have been lost or diverted through fraud and / or bribery.

The Trust publicises cases that have led to successful recovery of NHS funds.

2.7 SECURITY MANAGEMENT

In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

The Trust shall nominate a Non-Executive Director to ensure security has a high profile and is considered appropriately in the Trust's strategic direction.
The Chief Executive has overall responsibility for security management. Key responsibilities are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3. BUSINESS PLANNING, BUDGETARY CONTROL

3.1 PREPARATION & APPROVAL OF OPERATIONAL FINANCIAL PLANS AND BUDGETS

3.1.1 The Chief Executive will compile and submit to the Board an operational financial plan in accordance with current NHS England guidelines with due regard to the views of Council of Governors. The operational financial plan will include:

- In accordance with NHS England annual plan guidance, statements of the significant assumptions on which the plan is based;
- details of major changes in workforce, service delivery or resources to achieve the plan;
- any other relevant information as required by the regulator's guidance issued for the planning submission.

3.1.2 At the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit revenue and capital expenditure start budgets for approval by the Trust Board. Such budgets will:

- be in accordance with the aims and objectives set out in the operational plan;
- accord with workload and workforce plans;
- be produced following discussion with appropriate budget holders;

- be prepared within the limits of available funds;
- demonstrate the achievement of key financial targets such as strategic financial objectives of the Trust and the regulatory financial regime as advised by NHS England;
- identify potential risks and mitigations.

3.1.3 The Director of Finance shall monitor financial performance against budget and plan, and report financial performance to the Trust Board and subsequently to NHS England as required, in the appropriate templates issued by NHS England.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled. This will be enacted through the business of appropriate meetings with managers and the Trust Board.

3.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing with a clear definition of:

- the amount of the budget and the purpose(s) of each budget heading;
- achievement of planned levels of service and individual or group responsibilities;
- the provision of regular reports and authority to exercise virement.

3.2.2 From time to time NHS England may issue guidance or instructions regarding additional approval processes for certain types of Trust expenditure. Where Foundation Trusts are required to comply, NHS England's approval process, as defined by their guidance, will override the authority to authorise as laid out in the Trust standing financial instruction, only for the specific type of expenditure concerned.

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In cases where compliance with any additional approval regime by NHS England is v*oluntary*, the Chief Executive will determine the appropriate course of action for the Trust and will notify budget holders accordingly, with the support of the Director of Finance.

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3.2.3 In exceptional circumstances where large invoices are received which exceed the limits set out on 3.2.2i, then the Chief Executive and Director of Finance can jointly approve.

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3.2.4 Authority for virements between budgets relating to a particular service or function shall be limited to:

over £500,000	Countersigned by relevant Executive Director / Director of Finance

£100,000 to £500,000	Countersigned by Managing Directors /General Manager / Head of Service
Up to £100,000 *	Budget holder (* or total budget if less than £100,000)

3.2.2i With the exception of expenditure referred to in para 3.2.2 and 3.2.3 authority to authorise any one revenue order shall be limited to:

£1,000,000 and above	Board of Directors
£500,000 to £999,999	Chief Executive **and** Director of Finance.to jointly approve
£200,000 to £500,000	Chief Executive or Director of Finance.
up to £200,000	Deputy Chief Executive or Deputy Director of Finance
up to £200,000	Executive Directors voting and non-voting but not Non-Executive Directors
Up to £50,000	Managing Directors
Up to £30,000	Financial Controller
Up to £10,000	General Managers and Assistant/Associate Directors
Up to £1,000	Area Service managers and Heads of Service
Up to £100	Budget Holders

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Deleted: £1,000,000 and above
Deleted: Board of Directors
Deleted: £500,000 to £999,999
Deleted: Chief Executive **and** Director of Finance.
Deleted: £200,000 to £500,000
Deleted: Chief Executive or Director of Finance.
Deleted: £50,000 to £200,000
Deleted: Deputy Chief Executive or Deputy Director of Finance
Deleted: £50,000 to £200,000
Deleted: Executive Directors voting and non-voting but not Non-Executive Directors
Deleted: £10,000 to £50,000
Deleted: Managing Directors and General Managers
Deleted: £1,000 to £10,000
Deleted: Heads of Operational Service Areas
Deleted: (or lower limit for individual budget holders as set by the Chief Executive)
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3.2.2ii With the exception of expenditure referred to in para 3.3.2 authority for planned expenditure of Capital Resources shall be limited to:

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Expenditure on an individual project up to £100,000	Approved by the Capital Project group
Expenditure on an individual project between £100,000 and £1,000,000	Jointly approved by the Director of Finance and one other Executive Director
Proposed expenditure on a project in excess of £1,000,000	Board approval required (and process to be in accordance with NHS England guidance)

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3.2.4 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 13).

3.2.5 The budgetary total or virement limits set by the Trust Board above must not be exceeded. Expenditure for which no provision has been made in an approved budget and which is not subject to funding under delegated powers of virement shall only be incurred after proper authorisation - i.e. by the Chief Executive or the Board of Directors as appropriate within delegated limits.

3.2.6 Unless approved by the Chief Executive, after taking the advice of the Director of Finance; budgets shall only be used for the purpose for which they were provided. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.6 Non-recurring budgets shall not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include monthly financial information presented to the Trust Board in a form approved by the Trust Board.

a) Detailed financial information to Finance and Performance Committee covering but not limited to:
   - i) Income and expenditure position for year to date and forecast year end position
   - ii) Statement of Financial Position including any key exceptions
   - iii) Cash levels and key drivers
   - iv) Capital expenditure against plan.
   - v) Agency performance
   - vi) Key financial risks and mitigations

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b) the production of timely, accurate and comprehensive advice and financial reports to each budget holder, covering the areas for which they are responsible;
c) investigation and reporting of variances;
d) monitoring of management action to correct variances;
e) arrangements for the authorisation of budget transfers;
f) on-going training and support to budget holders to enable them to manage successfully.

3.3.2 The Director of Finance shall keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards, and other events and trends, whether national, local or internal, affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

3.3.3 All Budget Holders are responsible for ensuring that:
a) any likely overspending or reduction of income is not incurred without the prior consent of the Trust Board;
b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and
c) no permanent staff are appointed without the approval of the Chief Executive as per 10.3.1.ii other than those provided for in the budgeted establishment as approved by the Trust Board.
d) In the exceptional circumstance where a member of staff is engaged through terms deemed as 'off-payroll' by Her Majesty's Revenue and Customs (HMRC) and/ or NHS England, the relevant budget holder who is seeking to make these arrangements is responsible for ensuring compliance with HMRC rules and regulations and reporting, as informed by the Director of People, Organsiational Development and Inclusion. All off-payroll engagements should be approved by a Director before commencement.
e) Where costs may be committed by a third party there must be appropriately authorised by a specific governance process defined by a local operating procedure.
f) Off-payroll arrangements will be reported to Executive Leadership Team and to Finance and Performance Committee on a regular basis in advance of the annual reporting requirements.

3.3.4 The Chief Executive or Director delegated by the Chief Executive is responsible for identifying and implementing cost improvements and value for money initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

3.4 MONITORING RETURNS

The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted, accurately and on time and in the required format, to the requisite Organisation.

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4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance, on behalf of the Trust, will:

i. prepare and submit financial returns in such a form as directed by NHS England, with the approval of HM Treasury, specifically in accordance with International Financial Reporting Standards (as applied in the NHS England Annual Reporting Manual and the Department of Health Group Accounting Manual as well as HM Treasury's Financial Reporting Manual - FReM);
ii. lay audited accounts before Parliament and send a copy to NHS England in accordance with the Annual Reporting Manual.

4.2 The Trust's Annual Accounts must be audited by an auditor appointed by the Council of Governors. The Audited Annual Accounts must be presented to the Annual Public Meeting of the Trust.

4.3 The Trust will compile and publish an Annual Report in accordance with NHS England's Annual Reporting Manual.

5. BANKING ARRANGEMENTS

5.1 GENERAL

5.1.1 The Director of Finance shall monitor financial performance for working capital against budget and plan, periodically review them, and report to the Trust Board. All funds of the Trust shall be held in accounts in the name of the Trust. Only staff authorised by the Director of Finance may open a bank account in the name of the Trust.

5.1.2 The Board shall approve the banking arrangements and agree (or delegate agreement on their behalf of) the Treasury Management Policy prepared by the Director of Finance.

5.1.3 Bank and Government Banking Service (GBS) Accounts

The Director of Finance is responsible for:

a) bank accounts and Government Banking Service accounts;

b) establishing separate bank accounts for the Trust's non-exchequer funds where appropriate;

c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

d) reporting to the Trust Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

e) reporting to Trust Board any proposals to draw down any or all of the Trust's working capital facility if such a facility is in place;

f) ensuring the Trust does not exceed the limit of its approved working capital facility if such a facility is in place;

g) monitoring compliance with DH guidance on the level of cleared funds.

5.1.4 ONLY authorised signatories within the Financial Control Team may make changes to Trust banking mandates including Direct Debits. No other persons within the Trust should activate, deactivate or make any changes whatsoever to any Trust direct debit arrangements. Staff wishing to do so should contact the Financial Controller.

5.2 BANKING PROCEDURES

5.2.1 The Director of Finance will prepare financial procedures on the operation of bank accounts for the approval of the Board of Directors.

5.2.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated in accordance with approved procedures.

5.3 TENDERING AND REVIEW

5.3.1 Any commercial banking arrangements of the Trust should be reviewed at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

5.3.2 Competitive tenders should be sought at least every 3 years. The results of the tendering exercise should be approved by the Board. This review is not necessary for GBS accounts.

6. INCOME, FEES AND CHARGES

6.1 INCOME SYSTEMS

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due. These systems shall include income due under contracts or extra-contractual arrangements for the provision of Trust services.

6.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

6.2 FEES AND CHARGES

6.2.1 The Trust shall refer to NHS England's Approved Costing Guidance in setting prices for contracts and services provided to other organisations, where

applicable. However, pricing strategies will be determined by appropriate Trust Committees.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.3 All staff must inform the Director of Finance promptly of money due arising from transactions which they initiate or deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. The Director of Finance and the Chief Executive shall approve all contracts for income.

6.3 DEBT RECOVERY

6.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts. Income not received should be dealt with in accordance with losses procedures. This includes the use of external debt recovery agents.

6.3.2 Should any staff detect that an overpayment has been made they should report immediately to the Director of Finance in order that recovery procedures can be initiated. The Trust will follow the overpayment policy in recovering debt owed as a result of employee benefit overpayment.

7. SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 The Director of Finance and/or the Director responsible for the cashier's service shall prescribe and is responsible for systems and procedures for any staff handling cash, pre-signed cheques and negotiable securities on behalf of the Trust, including:

i. approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.
ii. the security and control of any such stationery.
iii. procedures for receiving and banking of cash, cheques and other forms of payment.
iv. circumstances in which unofficial funds may be deposited in safes.
v. prescribing systems and procedures for handling cash and negotiable instruments on behalf of the Trust. Where the Shared Services Organisation undertakes such issues as stated in 7.1, detailed requirements will be specified in a Service Level Agreement with the Shared Services Organisation.
vi. Issuing of High Street vouchers and the appropriate use of these vouchers.

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7.2 Staff shall be informed in writing on appointment, of their responsibilities and duties for the collection, handling or distribution of cash, cheques, etc. Any staff whose duty it is to collect or hold cash shall be audited by the finance team to ensure the appropriate controls are in place for the safe keeping of the cash.

7.3 During the absence (e.g. on holiday) of the holder of a safe or cash-box key, the member of staff who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash-box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

7.4 All cash, cheques and other forms of payment received by any other staff shall be passed immediately to the holder of a safe or cash-box key or to the cashier, from whom a signed receipt shall be obtained. No member of staff should keep Trust cash, cheques or other forms of payment, for whatever purpose, on Trust premises unless the Financial Controller is aware of the existence of such arrangements and can support and be assured on the systems and processes for the probity of such arrangements.

7.5 Official money may never be used for the encashment of private cheques.

7.6 The opening of coin operated machines (including telephones) and the counting and recording of the takings shall be undertaken by two members of staff together, unless authorised in writing by the Director of Finance. The coin-box keys shall be held only by a nominated member of staff.

7.7 Any loss or shortfall of cash, cheques or other cash equivalents, however occasioned, shall be reported immediately to the Financial Control Team in accordance with the agreed procedure for reporting losses (see also Section 16 Disposals, Losses and Special Payments).

7.8 Petty Cash

7.8.1 All new floats or amendments to floats are authorised by the Director of Finance or Deputy Director of Finance, they will only be approved if they are essential to the service.

7.8.2 All Petty Cash Floats must be held in a secure place and remain under the control of the designated Float Holder/Accounting Officer. The float holders who are going off duty and coming on duty will both check the petty cash together and a formal record of the check will be documented.

7.8.3 Petty Cash disbursements should be for the purpose agreed when the float was established. All disbursements must be supported by receipt(s). In circumstances where staff require an advance of cash to make a purchase, a record must be kept of the details and amount issued to ensure that all cash can effectively be accounted for until receipts and unspent cash are returned within 24 hours. Advances of cash need to be authorised by either the Director of Finance, Deputy Director of Finance or the Financial Controller prior to the advance being issued.

7.8.4 Reimbursements will not be made unless both signatories provided match the authorised signatories that is held on record for the float.

7.8.5 In exceptional circumstances Petty Cash above £50 may be issued with prior authorisation from the Director of Finance, Deputy Director of Finance or the Financial Controller.

7.9 Trust Credit Card

7.9.1 The Trust will hold a credit card in order to support the procurement process in allowing more flexibility to purchase goods but limited to exceptional circumstances. Standard procurement processes should be followed and suppliers set up through the usual procurement system to ensure good procurement governance. If the Trust credit card is used then the Trust's procurement processes will still need to be followed but the credit card will enable quicker payments to be made.

7.9.2 Access to the Trust credit card will be limited to Financial Control and Procurement. The card whilst not in use will be kept in a secure safe. Local procedures need to be in place to ensure the security of the credit card.

7.9.3 Fuel Purchasing Cards are held by the Estates Department, these should be kept in a secure place when not in use and documentation kept on usage.

7.9.4 Purchasing cards for PC World are held by the Financial Control Team. Local procedures need to be in place to ensure the security of these cards.

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7.10 Chip and Pin machines

7.10.1 The Trust holds 5 chip and pin machines at various locations across the Trust.

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7.10.2 The card holder is present when the card machine is in use and no payments are taken over the phone.

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7.10.3 Local Procedures need to be in place to ensure the security of the machines.

8. TENDERING AND CONTRACTING PROCEDURE

8.1 **Duty to comply with Standing Orders** and Standing Financial Instructions

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8.1.1 Every contract (other than for the delivery of Trust services delivered in accordance with the National Contract and commissioned by NHS or other Commissioners, (see 8.21) where made by the Trust, shall comply with these Standing Financial Instructions.

8.1.2 An exception from any of the following provisions of these Standing Financial Instructions may be made by the direction of the Trust or, in an emergency, by the Chair and Chief Executive, in accordance with SO 4.

8.1.3 Staff undertaking procurement activity should refer to the Trust Procurement Manual for further detailed information. The manual also includes reference to the 'No PO no pay' policy.

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8.2 Bribery Act

All staff involved in tendering and contracting and other budget holder activities should be aware of the Bribery Act 2010 and should ensure that all dealings with other organisations and their staff do not bring them in breach of the Act. That could leave them open to criminal proceedings being commenced.

8.3 Public Contract Regulations 2015

On 1 January 2021 the OJEU regulations were transposed into English Law and our public procurement rules are governed under the Public Contract Regulations (PCR) 2015. Procedures for awarding all forms of contracts under PCR2015 shall have effect as if incorporated in these Standing Financial Instructions.

Any rules pertaining to public procurement under PCR2015 cannot be waived.

8.4 Investment approach

Any potential major investment decision must be guided by relevant current Foundation Trust guidance, which sets out governance processes for all major investments undertaken by NHS foundation trusts.

8.5 Tendering

All tendering activity must be compliant with Procurement Regulations 2024 or any other such policy that may supersede it.

Formal Competitive Tendering

The standard method of procurement by the Trust shall be by way of competitive tender. The Trust shall ensure that such tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

8.5.1 Tender and Quotation Limits

The procurement of all goods and services should be preceded by a requisition and official order. By exception, urgent and/or emergency situations may be reasons why this is not possible and in these cases confirmation orders should be raised.

8.5.2 General Position on Quotations and Tendering

Below £10,000 (inc VAT) good purchasing practice is necessary i.e. seeking the best value for money.

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8.5.3 The Trust's Procurement Department must be consulted prior to the commencement of any of the processes listed below

- For purchases between £10,000 (inc VAT) and below PCR2015 limit three written quotations are required.

- Supplies and service contracts above the current PCR 2015 threshold require full compliance with the relevant PCR 2015 procedure.

- In the event that purchases between £10,000 (inc VAT) and £25,000 (inc VAT) are procured through a compliant PCR 2015 framework there is no requirement to obtain additional quotations. For purchases above £25,000 (inc VAT) procured through a compliant PCR 2015 framework the Head of Procurement can recommend to Executives whether further competition is required. At all times value for money should be a prime consideration, even when procuring from a compliant framework.

- With regards to small works procurement (as defined by PCR 2015) these rules shall override any other obligation contained in these Standing Financial Instructions relating to tender and quotation requirements.

8.6 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive except in (c) to (f) below where:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £25,000 (inc VAT) (in which case quotations process not tender process should be followed), or

(b) Where the supply is proposed under special arrangements negotiated by the DH or Regulator in which event the said special arrangements must be complied with;

(c) The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender;

(d) Specialist expertise is required and is available from only one source;

(e) The task is essential to complete the project, **and** arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; this reason for waiver cannot be enacted if NHS England approval is required for management consultancy or other defined expenditure;

(f) There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

Requests for waiving formal tendering procedures should be in the form of a letter signed by the Chief Executive or their nominated deputy. These should then be entered in the waiver register and reviewed by the Audit and Risk Committee.

A waiver is not required for year two onwards of contracts that have already been through the procurement process that is outlined in these Standing Financial Instructions.

8.7 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided by the Chief Executive that competitive tendering is not applicable and should be waived by virtue of the above, the fact of the waiver and the reasons should be recorded in writing to the Chief Executive and documented in a register held by the Trust Secretary.

8.8 Tendering procedures are set out in the Appendix.

8.9 **Quotations** - are required where formal tendering procedures do not apply where expenditure is expected to exceed £10,000 (inc VAT).

8.10 Where quotations are required they should be obtained from at least three firms/individuals.

8.11 All quotations should be treated as confidential and should be retained for inspection.

8.12 The Chief Executive or their nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

8.13 Non-competitive quotations in writing may be obtained for the following purposes:

(a) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations;

(b) the goods/services are required urgently.

Instances of, and reasons for, non-competitive quotations are to be entered in the waiver register and reviewed by the Audit and Risk Committee.

8.14 Where tendering or competitive quotation is not required:-

The Trust shall procure goods and services in accordance with procurement procedures approved by the Trust as laid out in the Trust Procurement Manual.

8.15 **Contracts** - The Trust may only enter into contracts within its statutory powers and shall comply with:

(a) its Establishment and Amendment Orders

(b) The Trust's Standing Orders

(c) The Trust's Standing Financial Instructions

(d) PCR 2015 and other statutory provisions

(e) any relevant directions from NHS England

(f) such of the NHS Standard Contract Conditions as are applicable.

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

8.16 Save for deeds and contracts relating to the disposal, acquisition or leasing of land and buildings, the following shall apply:

All contract documents, up to the value of £200,000, shall be signed on behalf of the Trust by an Executive Director **(voting or non-voting)** or nominated officer. Documents above £200,000 shall be signed by the Director or Finance, Chief Executive or nominated officer with appropriate approval limit. Every contract, the value of which exceeds £500,000, shall be executed under the signature of two **Executive Director (voting or non-voting)** duly authorised by the Chief Executive and not from the originating department.

All deeds and contracts relating to the disposal, acquisition or leasing of land or property, shall be executed under the Common Seal of the Trust and be signed by the **Trust Secretary** or a **Nominated Deputy** and an **Executive Director (voting or non-voting)** duly authorised by the Chief Executive and not from the originating department.

8.17 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.18 **Personnel and Agency or Temporary Staff Contracts** - The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment regarding staff, agency staff or temporary staff service contracts.

8.18.1 Where a member of staff is employed using such temporary arrangements the Director of People, Organisational Devleopment and Inclusion will ensure that up-to-date guidance is available to managers and that compliance with such guidance is appropriately monitored and enforced to ensure that the Trust is able to comply with regulatory requirements including those of NHS England and Her Majesty's Revenue and Customs (HMRC).

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8.19 **Healthcare Services Agreements** – service agreements with commissioners for the supply of healthcare services, are subject to the separate and specific provisions of the terms of authorisation of the Trust and must be in the form of legally binding contracts.

8.20 **Cancellation of Contracts** – Except where specific provision is made in model forms of contracts approved for use within the NHS and in accordance with SFIs 8.18 and 8.19, every contract shall include a written clause empowering the Trust to terminate the Contract and to recover from the Contractor the amount of any loss resulting from such cancellation if the Contractor or any person employed by the Contractor or acting on behalf of the Contractor has offered, paid or given, directly or indirectly, any gift in money or any other form to any employee or agent of the Trust as an inducement or reward in connection with their behaviour in relation to the Contract, or appears to have committed any offence under the Bribery Act 2010 or other appropriate legislation.

8.21.1 **Determination of Contracts for Failure to Deliver Goods or Materials** – There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

8.22 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

8.23 **Contracts Involving Funds Held on Trust** - shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

9. NHS SERVICE AGREEMENTS AND CONTRACTS FOR THE PROVISION OF SERVICES

9.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of health services. In discharging this responsibility, the Chief Executive shall take into account:

(a) The National Contract framework
(b) Local health service planning priorities
(c) The cost, price and volume of services to be provided and method of payment;
(d) The standards and detailed specifications for service quality expected;

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The Trust will work with any partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for mitigating any contractual risks and the financial arrangements should reflect this.

The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Trust Board detailing actual and forecast income from contracts, this responsibility has been delegated to the Executive Director of Finance.

This will include information on any costing arrangements subject to local currency agreements, including any changes to payment systems e.g. National Tariff Payment System.

The decommissioning of any healthcare service will require approval by Trust Board.

10. EMPLOYMENT TERMS AND CONDITIONS

10.1 REMUNERATION

10.1.1 The Board should formally agree and record in the minutes of its meetings, the precise terms of reference of the Remuneration and Appointments Committee, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. The terms of reference of this committee are contained in the Scheme of Delegation.

10.1.2 Except where Agenda for Change rules apply, the Trust Board will approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those staff not covered by the Committee.

10.1.3 The remuneration of the Chair and Non-executive Directors will be determined by the Council of Governors in accordance with the Foundation Trust Constitution.

10.2 FUNDED ESTABLISHMENT

10.2.1 The workforce plans incorporated within the annual budgets will form the funded establishment.

10.3 STAFF APPOINTMENTS

10.3.1 No Director or staff may engage, re-engage, or re-grade staff, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

i) Unless within the approved budget and funded establishment limit and in accordance with appropriate guidance on such employment.
ii) In certain circumstances, following the consideration of an 'Invest to Save' Business Case at ELT, the Chief Executive and the Director of Finance may approve appointments to unfunded posts. These posts must have a return on investment over an agreed period of time. Any agreements that are made will

be reviewed and evaluated on a regular basis in order to access the impact on delivering efficiencies laid out in the business case.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of pay rates, conditions of service, etc., for staff.

10.4 PROCESSING OF PAYROLL

10.4.1 The Director of People, Organisation Development and Inclusion is responsible for:

i) specifying timetables for submission of properly authorised time records and other notifications;
ii) making recommendations to the Director of Finance on the final determination of pay;
iii) making payment on agreed dates;
iv) agreeing methods of payment.
v) maintaining and enforcing a Trust under and overpayment policy and seeking to recover any overpayments in line with that policy.

10.4.2 The Director of Finance and the Director of People, Organisational Development and Inclusion **will** as appropriate, issue instructions regarding:

ii) verification and documentation of data;
iii) the timetable for receipt and preparation of payroll data and the payment of staff;
iv) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
v) security and confidentiality of payroll information;
vi) checks to be applied to completed payroll before and after payment;
vii) authority to release payroll data under the provisions of the Data Protection Act;
viii) methods of payment available to various categories of staff;
ix) pay advances and their recovery;
x) procedures for payment by cheque or bank credit:
xi) procedures for the recall of cheques or bank credits;
xii) maintenance of regular and independent reconciliation of pay control accounts;
xiii) separation of duties of preparing records and handling cash; and
xiv) a system to ensure the recovery from leavers of payments and property due to the Trust.
xv) A system to record and report specific employee costs as required by guidance for example “high-cost off-payroll” employee costs.
xvi) Maintenance of an up to date authorised signatory list for pay.

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10.4.3 Nominated managers have delegated responsibility for:

i) Ensuring all members of staff with any secondary employment complete all required declarations in line with secondary employment policy or successor policy in place at the time.
ii) Ensuring all staff absences are appropriately authorised. In the event of unauthorised absence the line manager is responsible for notifying payroll services to ensure payment for unauthorised absence is prevented or recovered.
iii) Submitting time records, and other notifications in accordance with agreed timetables.
iv) Completing time records and other notifications in accordance with the instructions of and in the form prescribed by the Director of People, Organisation Development and Inclusion or the Director of Finance.
v) Submitting termination forms electronically immediately upon receiving confirmation of a member of staff's resignation, termination or retirement. Where a member of staff fails to report for duty in circumstances that suggest they have left without notice, the Director of People, Organisational Development and Inclusion must be informed at the earliest opportunity.
vi) Submitting all employee-related updates promptly to avoid over or under payment and to ensure that staff records are accurate and up to date for their area of responsibility. These requirements include but are not limited to new starters, change forms and leavers.
vii) An authoriser must ensure that timesheets, expense claims and other such notifications are appropriately checked and agreed as accurate before authorisation is given.
viii) Ensuring that all Rostering systems for their area of responsibility are accurately maintained, in accordance with Trust policy, to ensure correct and timely payments are made to appropriate staff.

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10.4.4 The Director of People, Organisational Development and Inclusion and the Director of Finance shall ensure that the chosen method for providing the payroll service is supported by appropriate contracted terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.4.5 In terminating a contract through the use of severance payments, the affordability of the payment should be assessed by the Director of Finance before proceeding. The Director of People, Organisational Development and Inclusion is responsible for ensuring all appropriate regulatory due process is followed for all types of termination payments. The proposed payment must be authorised by the Chief Executive via the use of the "Termination of Contract – Severance Payments Proforma". This document outlines the details and circumstances of the proposed severance payment. The Director of People, Organiational Development and Inclusion must ensure this guidance is maintained in line with current regulatory requirements.

All exit packages must be within the contractual limits or less. Where the Director of People, Organisational Development and Inclusion and the Remuneration and Appointments Committee proposes payment which exceeds contractual limits,

appropriate approval must be sought from NHS England and the Treasury in line with regulatory policy.

In line with Freedom to Speak Up requirements the Chief Executive will personally review all settlement agreements that contain confidentiality clauses to ensure that such clauses are in the public interest.

Such settlement agreements will be made available for inspection by the CQC as part of their assessment to determine if the organisation is well-led
If the settlement requires Treasury approval the Trust will demonstrate that the confidentiality clause is in the public interest in that particular case.

10.5 CONTRACT OF EMPLOYMENT

10.5.1 The Trust Board shall delegate responsibility to the Director of People, Organisational Development and Inclusion for:

- ensuring that all staff are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
- dealing with variations to contracts of employment; and
- dealing with termination of contracts of employment (except those cases subject to disciplinary rules and procedures) upon the advice of the Director of Finance on affordability.

11. NON-PAY EXPENDITURE

11.1 DELEGATION OF AUTHORITY

11.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

Budget holders so delegated, and others who the Budget Holders shall formally nominate shall be authorised to approve requisitions, invoices and petty cash, subject to appropriate segregation of duties and subject to the scope and limit(s) of their budget(s).

11.1.2 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

11.2.1 Any member of staff authorised to requisition goods or services shall comply with procedures issued by the Director of Finance and, in choosing the item to be supplied or the service to be performed, shall always obtain the best value for money for the Trust. In so doing, the advice of the Procurement department shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance and the Chief Executive shall be consulted.

11.2.2 The Director of Finance shall be responsible for the prompt payment of all properly authorised accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. Payment for goods and services shall only be made once the goods and services are received (except for prepayments as below). Such requirements will be specified in a Service Level Agreement with the Shared Services Organisation as appropriate.

11.2.3 Official orders must state the Trust's terms and conditions of trade and be consecutively numbered. They must only be issued to, and used by, those duly authorised by the Chief Executive and be in a form approved by the Director of Finance.

11.2.4 All goods, services, or works shall be ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash. Verbal orders may only be issued very exceptionally - by a member of staff designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order". Goods may not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

11.2.5 The Director of Finance will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed.

(b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) maintain a list of Directors/staff, authorised to certify invoices.

(e) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

ii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iii) Instructions to staff regarding the handling and payment of accounts within the Finance Department.

iv) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as in SFI 11.2.6).

11.2.6 Prepayments are only permitted where exceptional circumstances apply. In such instances, where material (in excess of £10,000):

a) the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

c) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he must immediately inform the appropriate Executive Director or Chief Executive if problems are encountered, along with their Finance Manager who can ensure the correct accounting treatment is performed.

11.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance and the Trust Secretary in advance of any commitment being made;

b) contracts above specified thresholds are advertised and awarded in accordance with Public Contract Regulation rules on public procurement;

c) where consultancy advice is being considered, the approval and procurement of such advice must be in accordance with current regulatory guidance for Foundation Trusts. When considering consultancy advice internal approval from the Director of Finance should be sought in line with delegated responsibility limits and always before any business case is sent for external approval from the Regulator. Wherever possible the preferred bidder should assist in the preparation of the required business case to the Regulator. The term consultancy advice is defined as the provision, to management, of objective advice and assistance relating to strategy, structure, management of operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the "business as usual" (BAU) environment when in-house skills are not available and will be of no essential consequence and time-limited. Services may include the identification of options with recommendations and/or assistance with (but not delivery of) the implementation of solutions. If in any doubt this is to be referred to the Director of Finance or Deputy for clarification.

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or staff, other than:

   i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

   ii) conventional hospitality, such as lunches in the course of working visits;

   iii) the Conflicts of Interest Policy must be adhered to in all cases.

e) no requisition/purchase order is to be placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

f) all goods, services, or works should be ordered on an official purchase order including wherever possible works and services executed in accordance with a contract but excluding purchases from petty cash;

g) verbal orders must only be issued very exceptionally - by a member of staff designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds or regulatory guidance;

i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

j) changes to the list of Directors/staff authorised to certify invoices are notified to the Director of Finance;

k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and petty cash records are maintained in a form as determined by the Director of Finance;

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l) payments to local authorities and voluntary organisations made under the powers of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

12. EXTERNAL BORROWING AND INVESTMENTS

12.1 EXTERNAL BORROWING

12.1.1 The Director of Finance is responsible for ensuring that the sum of borrowing from all sources both short term and long term represents value for money, comply with any Regulatory limits and guidance and does not adversely impact on future cash flows.

12.1.2 Any application for a temporary loan or overdraft will only be made by the Director of Finance or by a member of staff so delegated by them and in any event a duly authorised signatory.

12.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for temporary loans and overdrafts.

12.1.4 All external borrowing must be consistent with the plans outlined in the current Business Plan and be recommended by Finance and Performance Committee to the Trust Board.

12.1.5 The Trust holds a separate Treasury Management Policy which covers both borrowings and investment in more detail.

12.2 INVESTMENTS

12.2.1 Foundation Trusts have discretion to invest surplus money for the purposes of, or in connection with, their functions. The Chief Executive, as accountable officer, is responsible for ensuring that surplus operating cash is invested in accordance with the Board of Directors' duty to safeguard and properly account for the use of public money.

12.2.2 The Director of Finance is responsible for advising the Trust Board on investment strategies for cash surpluses in accordance with best practice guidance and in line with NHS England's most current published guidance for Foundation Trusts.

13. CAPITAL EXPENDITURE AND PRIVATE FINANCE

13.1 CAPITAL INVESTMENT

13.1.1 All bids for Capital Investment should be approved by the Board of Directors (with due regard to the Trust's cash position and any associated investment strategies).

13.1.2 The Trust will follow NHS England's Cash and Capital Regime and where applicable approval will be sought for any investment and property business cases in line with the requirements of the guidance. See NHS England: 'Capital guidance update 2023/24' and NHS England 'capital investment and property business case approval guidance for NHS trusts and foundation trusts'.

13.1.3 The Trust will follow NHS England capital regime in relation to system sign off and working within CDEL limits set by the Regulator.

13.1.4 The Chief Executive is responsible for ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

13.1.5 The Trust shall appoint the Capital Project Group, or other appropriate meeting structure whose responsibilities shall be:

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a) the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost and meet their overall purpose; and

b) ensuring that capital investment is not undertaken without commissioner(s)/ partner(s) written support, where required, and the availability of resources to finance all revenue consequences and capital charges; and

c) to ensure that a robust financial appraisal is undertaken as appropriate for all business cases (which have been approved by the Trust's Finance and Performance committee as appropriate); and

d) to ensure that appropriate project management and control arrangements are in place; and

e) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in business cases.

13.1.6 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode". The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.1.7 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme (through the Capital Project Group):

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- specific authority to commit expenditure;
- authority to proceed to tender or obtain quotations;
- approval to accept a successful tender or quotation and to place an order.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

13.1.8 The Director of Finance shall issue the capital investment framework and procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.1.9 Delegated limits for the signing-off of expenditure on capital monies are covered in these SFIs.

13.2.1 The section below covers the approval process before orders are placed.

Expenditure on an individual project up to £100,000	Approved by the Capital Project Group
Expenditure on an individual project between £100,000 and £1,000,000	Jointly approved by the Director of Finance and one other Executive Director
Proposed expenditure on a project in excess of £1,000,000	Board approval required (and process to be in accordance with NHS England guidance)

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13.2.2 The extent and progress of the manner in which Capital Investment monies are spent will be regularly reported to the Executive Leadership Team and Finance and Performance Committee. Any variation to the approved capital expenditure plan will require appropriate authorisation, in accordance with the above limits and be appropriately reported to regulators.

14. ASSET REGISTERS AND SECURITY OF ASSETS

14.1 ASSET REGISTERS

14.1.1 The Chief Executive is responsible for ensuring that a system exists for the maintenance of registers of assets, taking account of the advice of the Director of Finance on the form of any register and the means of updating and arranging for a periodic physical check of assets against the asset register to be conducted.

The Trust shall maintain an asset register recording fixed assets. The composition of information to be held within these registers shall be specified in the Trust's capital accounting policies.

14.1.2 Budget holders must confirm to the Director of Finance any fixed asset additions within their remit. Additions to the asset register will be validated by reference to:

- properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- stores, requisitions and wages records for own materials and labour with overheads; and
- lease agreements in respect of assets held under a finance lease and capitalised.

14.1.3 Budget holders must notify the Director of Finance where they propose that assets are to be sold, scrapped, or otherwise disposed of. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate) and accounted for appropriately. (see disposals and condemnations section).

Budget holders must seek approval from the Trust Board to declare any land or buildings as surplus to NHS requirements and available for disposal and income.

The route to market for any sale of land and buildings will be determined by the Head of Estates and Facilities and the Director of Finance but with final agreement by the Trust Board.

Budget holders and service managers must notify the Financial Controller if assets are being transferred between buildings or otherwise relocated, to allow for the asset register to be updated.

If any assets remain in empty buildings, it is the exiting service manager that is responsible for those assets until the building has been handed over to a new service or to Estates.

No assets that have been identified to hold Commissioner Requested Services in accordance with the NHS England Licence Agreement are allowed to be sold without prior consultation and agreement with NHS England in line with current guidance and approval from the Board. The trust asset register includes a list of all assets which have been identified as being locations of Commissioner Requested Services.

14.1.4 The value of owned buildings shall be indexed to current values and all assets shall be depreciated using methods and rates as specified by the appropriate accounting policies in use in the Trust. Periodically non-current assets will be subject to a formal revaluation exercise as described in the relevant Trust accounting policies. The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.1.5 The Director of Finance of the Trust shall calculate and pay capital charges as required.

14.2 SECURITY OF ASSETS

14.2.1 The overall control of assets is the responsibility of the Chief Executive.

14.2.2 Asset control procedures (including fixed assets, cash, cheques, and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

- identification of additions and disposals;
- recording managerial responsibility for each asset;
- physical security of assets;
- periodic verification of the existence of, condition of, and title to, assets recorded;
- identification and reporting of all costs associated with the retention of an asset; and
- reporting, recording and safekeeping of cash, cheques and negotiable instruments.

14.2.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

14.2.4 Whilst each member of staff has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior staff in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

14.2.5 Any damage to Trust premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and staff in accordance with both security policies and the losses procedure.

14.2.6 The organisation will take all necessary steps to recover financial losses due to fraud, theft of, or criminal damage to, its assets on a case by case basis in a timely manner.

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The impact of the recovery of financial losses due to theft or criminal damage of its assets is regularly monitored and soundly evaluated by Executive Leadership Team and, where appropriate, improvements are made to the redress arrangements and the organisations approach to recovery.

14.2.7 IT assets and where practical Plant, Property and Equipment, should be marked as Trust property.

14.2.8 Where appropriate the Trust's assets should be covered by the NHS arrangements for the pooling of insurance**.**

14.2.9 Each member of staff has a responsibility for the security of property of the Trust whilst working remotely or from home, see separate Home Working Policy.

14.3 PARTNERING ARRANGEMENTS, LEASE ACQUISITIONS AND LEASE ASSIGNMENTS

14.3.1 Partnering arrangements involving the occupation of another party's property (NHS or non NHS) or allowing another party to occupy part of the Trust's property, even if no financial consideration is involved, must be covered by formal agreement.

14.3.2 All arrangements where the Trust use or occupy a room, part or all of a building for any length of time must be covered by an appropriate written agreement.

14.3.3 Lease acquisition of properties must be covered by a formal lease arrangement.

14.3.4 The decision to sub-let a Trust property or to take on an assigned lease must be covered by a formal agreement or assignment.

14.3.5 The Trust Secretary must be consulted on the legal position and will advise on the need for lease or license agreement and its content.

14.3.6 The Head of Estates and Facilities is responsible for negotiating the heads of terms and will advise on matters of Health & Safety, rates, utilities, maintenance and insurance obligations.

14.3.7 The Director of Finance must be consulted to advise on the appropriate accounting treatment under IFRS 16. Following the change in accounting treatment and new leases to be funded from Business as Usual capital allocations, all new leases must go through the Capital Project Group for approval or recommendation depending on capital limits set out in 13.2.1.

14.3.8 The Trust Secretary is responsible for maintaining a full record of all agreements in a Trust-wide property database. This will include termination dates, break clause details, rent review dates, notice periods and financial commitments.

14.4 LEASE TERMINATIONS

14.4.1 The decision to vacate a Trust property must be covered by formal agreement.

14.4.2 The Trust Secretary must be consulted on the legal position and will advise on the notice to the landlord.

14.4.3 The Head of Estates and Facilities will facilitate the assessment of dilapidations and cancellation notifications e.g. rates, insurances, utilities.

14.4.4 The Director of Finance must be informed to ensure payments are cancelled in line with the agreement.

14.4.5 A full record of the agreement is to be maintained in the Trust wide property database.

14.5 RENT REVIEWS

14.5.1 As part of the responsibility for record management there is a need to ensure that rent reviews are carried out in accordance with the lease agreement, and that agreement is either concluded within 2 months of the review date, or that the Finance department are advised of the liability that the budget holder may face.

15. STORES AND RECEIPT OF GOODS

15.1 Stores, i.e. controlled stores and departmental stores for immediate use should be:

- kept to a minimum;
- subjected to annual stock take;
- valued in accordance with Trust accounting policy.

15.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to a member of staff by the Chief Executive. The day-to-day responsibility may be delegated by the Chief Executive to departmental staff and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer.

15.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager or Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

15.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

15.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all material items in stock at least once a year.

15.6 Where a complete system of stock control is not justified, alternative arrangements shall require the approval of the Director of Finance.

15.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 16, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.8 For goods supplied by NHS Supply Chain**,** the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

15.9 The Trust will follow any guidance issued by NHS England in relation to any centrally procured goods such as PPE.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

16.1 DISPOSALS AND CONDEMNATIONS

16.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers. Every effort should be made by managers to maintain assets of property plant and equipment in good order.

16.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

16.1.3 Surplus property, plant and equipment or any other Trust asset, which is in serviceable order, should not be disposed of. Due process must be followed whereby the surplus asset is reallocated within the Trust or temporarily stored appropriately. Requests to otherwise dispose of any serviceable asset must be approved by the head of department and notified to the Director of Finance.

16.1.4 All unserviceable articles shall be condemned or otherwise disposed of by a member of staff authorised for that purpose by the Director of Finance. The Condemning Officer shall record condemnation in a form approved by the Director of Finance, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second member of staff authorised for the purpose by the Director of Finance.

16.1.5 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

16.2 LOSSES AND SPECIAL PAYMENTS

16.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.2 Any member of staff discovering or suspecting a loss of any kind must immediately inform their head of department, who must inform the Chief Executive and the Director of Finance at the earliest opportunity. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, then the matter should be reported to the Local Counter Fraud Specialist for a criminal investigation. Consideration of police involvement will be discussed with the Local Counter Fraud Specialist. All security-related incidents must be reported to the Trust's Security Management Specialist.

16.2.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a financial nature, the Trust's Local Counter Fraud Specialist must also be notified at the earliest opportunity.

16.2.4 The Board of Directors shall approve the writing-off of losses. This approval is delegated to the Chief Executive (or Director of Finance / Deputy Director of Finance) in accordance with the Scheme of Delegation. Write-offs will only be reported to Audit and Risk Committee on an exceptional basis by value.

16.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.2.6 For any loss, the Director of Finance should, in consultation with the Trust Secretary, consider whether an insurance claim can be made.

16.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the relevant body.

16.2.9 Losses and special payments will only be reported to the Audit and Risk Committee on an exceptional basis by value or volume if there becomes any issue with a certain area.

17 INFORMATION MANAGEMENT AND TECHNOLOGY

17.1 The Director with responsibility for Information Management and Information Technology, who is responsible for the accuracy and security of the computerised (including financial) data and information of the Trust, shall be responsible for devising and maintaining appropriate Information Management and Technology procedures and policies for the Trust.

17.2 The Director responsible for IM&T shall ensure that financial IM&T systems are developed and maintained in an appropriate manner, even in the event that the maintenance of such a system is outsourced.

17.3 The Director of Finance and the Director responsible for IM&T shall ensure that contracts for computer services for financial applications with another health organisation, any other agency or Shared Services Organisation shall clearly define the responsibility of all parties for the information governance, security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

17.4 Where another health organisation, any other agency or Shared Service Organisation provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

17.5 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy themself that:

(a) systems acquisition, development and maintenance are in line with financial requirements;
(b) data produced by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Only appropriate persons shall have access to such data; and
(d) such computer audit reviews as are considered necessary are being carried out.
(e) Adequate business continuity/disaster recovery arrangements are in place.

17.6 The Director of Finance shall ensure that financial risks to the Trust arising from the use of IM&T are effectively identified and considered and appropriate action taken to mitigate or control risk.

17.7 Freedom of Information

All Directors shall ensure that processes are in place and are subject to adequate control for the provision of information requests in line with The Freedom of Information (FOI) Act 2000.

18. PATIENTS' PROPERTY

18.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in Trust property. Employees are required to follow the Trust Policy and Procedure for Service Users' Finance and Property.

18.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by;

a) notices and information booklets,
b) Trust admission documentation and property records,
c) the verbal advice of administrative and/or nursing staff responsible for admissions.

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The Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3 The Chief Operating Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

18.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

18.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor in writing.

19. CHARITABLE FUNDS

19.1 INTRODUCTION

19.1.1 Charitable funds are those gifts, donations and endowments held on trust for purposes relating to the Derbyshire Healthcare NHS Foundation Trust. They are administered on behalf of the Trust by the Directors of the Derbyshire Community Healthcare Services NHS Foundation Trust, acting as agents of the charitable fund.

19.1.2 The discharge of the DCHS's corporate trustee responsibilities is distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance shall ensure that each charitable fund is managed appropriately with regard to its purpose and to its requirements.

19.2 The Director of Finance shall periodically review the charitable funds in existence and shall make recommendations to the trustees regarding the potential for rationalisation of such charitable funds within statutory guidelines.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

20.1 The Trust Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. Staff should be aware of and comply with the Trust's 'Conflict of Interest Policy'.

20.2 Staff should make themselves aware of, and comply with, the Bribery Act 2010, Code of Conduct for NHS Managers 2002, and the Code of Practice for the Pharmaceutical Industry 2012 relating to hospitality / gifts from pharmaceutical / external industry.

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21. RETENTION OF DOCUMENTS

21.1 The Chief Executive shall be responsible for maintaining a Policy and Procedure for the Retention, Preservation and Destruction of Records which all employees must follow.

21.2 Any documents held in archives shall be capable of retrieval by authorised persons.

21.3 Documents held under the requirements of current directions shall only be destroyed at the express instigation of the Chief Executive, and records shall be maintained of documents so destroyed in accordance with the Policy and Procedure for the Retention, Preservation and Destruction of Records.

21.4 Associated policies which employees should be familiar with are: the Policy and Procedure for Offsite Records Storage, Policy and Procedure for Disposal of Confidential Information and the Information Lifecycle Management Policy and Procedure.

22. RISK MANAGEMENT AND INSURANCE

22.1 The Chief Executive shall ensure that the Trust has a programme of risk management, which will be approved and monitored by the Board of Directors. Employees must comply with the Trust Risk Management policies and procedures.

22.2 The programme of financial risk management shall include:

a) process for identifying and quantifying risks and potential liabilities.

b) engendering among all levels of staff a positive attitude towards the control of risk.

c) management processes to ensure all significant financial risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk.

d) contingency plans to offset the impact of adverse events.

e) audit arrangements including internal audit, clinical audit, health and safety review.

f) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal control within the annual report and accounts.

The Trust Secretary shall ensure that insurance arrangements exist in accordance with the risk management programme.

Insurance arrangements with commercial insurers

22.3 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when the Trust may enter into insurance arrangements with commercial insurers. The exceptions are;

a) Trusts may enter commercial arrangements for insuring motor vehicles owned or leased by the Trust including insuring third party liability arising from their use.

b) where the Trust is involved with a contractual arrangement to lease a building and the landlord or Private Finance Initiative consortium in respect of the PFI contract require that commercial insurance arrangements are entered into.

c) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for NHS purpose the activity may be covered in a risk pool. Confirmation of coverage on the risk pool must be obtained from the NHS Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements, the Director of Finance and Trust Secretary should consult the Department of Health.

APPENDIX 1

Tendering Procedure

1. Invitation to tender

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominatedManager;

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(b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(c) It is submitted in accordance with the instructions issued via The Trust's electronic contract management system

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

2. Receipt and safe custody of tenders

The Trust Secretary or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. In the case of tenders submitted by The Trust's electronic contract management, the tender maybe opened by the Head of Procurement.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

3. Opening tenders and Register of tenders

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two Directors which will include, if available, y the Trust Secretary and a Director who is not from the originating department. In the case of tenders submitted by the Trust's electronic contract management, the tender may be opened by the Head of Procurement. These tenders are held in a secure environment compliant with ISO27001 infrastructure and available as a CESG accredited HMG Impact Level 3 service which allows handling of "restricted documents" classification. In this case sub sections (ii), (vi) and (vii) do not apply.

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(ii) A voting member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £400,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

(iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance from serving as one of the directors to open tenders. The involvement of estates staff in the preparation of a tender proposal will not preclude the Director who has the portfolio responsibility for, Estates from serving as one of the directors to open tenders.

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(v) All Executive Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by the Trust Secretary, or a person authorised by him, to show for each set of competitive tender invitations despatched, including those handled under the electronic contract management system (see 3 (i) above):

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

4. Admissibility

(i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

5. Late tenders

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Trust Secretary or their nominated officer.

6. Acceptance of formal tenders

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

(ii) The most economically advantageous tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary; such good and sufficient reasons will be determined by those within the

Trust with the requiste skill and experience in the matter being tendered for. Such reasons shall be set out in either the contract file, or other appropriate record.

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It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

a) experience and qualifications of team members;
b) understanding of client's needs;
c) feasibility and credibility of proposed approach;
d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

a) not in excess of the going market rate / price current at the time the contract was awarded;

b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

7. Tender reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only.

8. List of approved firms

a) Responsibility for maintaining list

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from whom tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

b) Building and Engineering Construction Works

(i) Invitations to tender shall be made only to firms included on the approved

list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with "Estmancode" guidance (Health Notice HN(78)147).

(ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing staff or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, the Disabled Persons (Employment) Act 1944 and Equality Act 2010 and any amending and/or related legislation.

(iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

c) Financial Standing and Technical Competence of Contractors

The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

9. Exceptions to using approved contractors

If in the opinion of the Chief Executive and the Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

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EQUALITY IMPACT ASSESSMENT TEMPLATE: FRONT SHEET.
(To be completed for Stage 1 and updated for Stage 2)
Please note 'policy' refers to strategy, project, commissioning, saving plan etc

Question	Response
Name of 'policy' being assessed	Standing Financical Instructions
Summary of aims and objectives of the 'policy'	The Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. The Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust.
Is this a new or existing 'policy'?	Existing
Please state which organisation is the EIA being completed for? • Derbyshire Healthcare NHS FT • Joint Derbyshire Healthcare NHS FT and Derbyshire Community Health Services • Other (please give details)	Derbyshire Healthcare NHS FT
Division/Team/Service	Trust wide
Date Stage 1 completed: Screening for Relevance:	25/06/2024
Is a Stage 2: EIA required to be completed after Stage 1? Please provide justification	No
Date Stage 2 EIA completed:	
Name/s, job title/s and contact/s details of person/s completing this assessment	Rachel Leyland, Deputy Director of Finance
Name, job title and contact details of responsible lead Director /Associate Director/Head of Service	James Sabin, Director of Finance
Has this EIA been logged in your Division/Service/Team EIA Tracker?	

EQUALITY IMPACT ASSESSMENT TEMPLATE: STAGE 1 SCREENING FOR RELEVANCE

(Please use plain English http://www.plainenglish.co.uk/, avoiding jargon and acronyms. EIA's are viewed by a wide range of people including decision-makers and the wider public)

Question	Response
1a: Summary of aims and objectives of the 'policy'	The Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. The Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust.
1b: Please state who this 'policy' will affect? • Patients or Service Users • Carers or families • Commissioned Services • Communities, in placed based settings • Staff - • Partners • Stakeholder organisations • Others (give details)	Staff
1c: Will the 'policy' impact equality and or inequalities? • Access to or participation in a service • Levels of representation in our workforce • Reducing quality of life (i.e., health, poverty education, standard of living)	No
1d: If there are 'no' impact on equality and or inequalities, please provide an explanation?	The nature and remit of this document means that it has no impact on equality, diversity or inclusion and therefore does not impact those with protected characteristics.
1e: If there are impacts on equality and or inequalities complete stage 2 EIA	
If you plan to complete the assessment at a later stage, please state the timescale for this.	

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Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2024

Revised Terms of Reference – Finance and Performance Committee

Purpose of Report

To approve a revised version of the Finance and Performance Committee's Terms of Reference.

Executive Summary

The Terms of Reference for the Finance and Performance Committee have been recently amended to provide more clarity on membership and quoracy and is presented for approval.

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

Risks and Assurances

The prime purpose of the Finance and Performance Committee is to gain assurance on all aspects of financial and operational performance, on behalf of the Board. The Committee also oversees and approves business developments as well as considering progress with commercial and contractual matters.

Consultation

The Audit and Risk Committee have noted and supported the revisions.

Governance or Legal Issues

The Finance and Performance Committee forms part of the Trust's Corporate Governance Framework as a Committee of the Board.

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:

Although the Finance and Performance Committee is aware that equality, diversity and inclusion (EDI) issues affect the Trust's workforce there are no equality related impacts associated with this report.

Recommendations

The Board of Directors is requested to approve the revised Terms of Reference for the Finance and Performance Committee.

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

Finance and Performance Committee Terms of Reference

Purpose

The prime purpose of the Committee is to gain assurance on all aspects of financial and operational performance, on behalf of the Board. The Committee also oversees and approves business developments as well as considering progress with commercial and contractual matters. The Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

1. Authority

1.1 The Committee oversees and approves business developments as well as considering progress with commercial and contractual matters.

The Committee may refer specific issues to the Board, Audit and Risk Committee and other Committees and make recommendations as appropriate. Matters formally delegated to the Finance and Performance Committee by the Board of Directors are:

- Continuous Improvement including CIP (Cost Improvement Programme) plan reporting
- Contractual compliance performance reporting, including procurement
- Treasury Management – to approve policy, procedures, controls and monitoring of policy implementation
- Working Capital Facility – to approve (if applicable)
- Estate strategy delivery oversight including assurance on performance of the estates and facilities management function, on maintenance programmes and on statutory and regulatory compliance – twice yearly updates
- Indicative 5-year capital plan – approval
- National Cost Collection: process - sign-off
- Emergency Preparedness, Resilience and Response (EPPR)
- Health and Safety Compliance Report.

1.2 Aside from those specific matters listed, the Committee otherwise gains assurance on matters through reports and exceptions provided to it.

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, and belief, gender, and sexual orientation. The Finance and Performance Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity, and inclusion.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Finance and Performance Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content, and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Focus.

1.8 As a Committee of the Board, the Finance and Performance Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit.

1.9 To receive assurance in relation to the fulfilment of the financial and performance aspects of the Trust's roles and responsibilities as Lead Provider of the East Midlands Perinatal Mental Health Provider Collaborative during the development and subsequent implementation of the provider collaborative, including the effective operation of Northamptonshire Healthcare Commissioning Hub support.

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

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

2. Membership

2.1 The membership of the Committee shall comprise:

Non-Executive Directors x three (one will be appointed as the Chair)
Director of Finance
Deputy Chief Executive and Chief Delivery Officer
Director of People, Organisational Development and Inclusion

Standing attendees comprise of:

Clinical Operational Managing Director leads
Deputy Director of Finance

2.2 If the Chair is not present, one of the Non-Executive Directors will chair the meeting.

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

2.4 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies attending no more than one third of meetings on an exception basis.

2.5 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

3. Attendance

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

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

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

4. Quorum

4.1 A quorum shall be three~~four~~ members, including at least one ~~two~~ Executive Director~~s~~ and two Non-Executive Directors; noting that as a minimum the executive attendance must include either ~~both~~ the Director of Finance (supported by a Managing Director – or their deputies acting as their direct representatives) in the absence of the Deputy Chief Executive and Chief Delivery Officer or the Deputy Chief Executive and Chief Delivery Officer (supported by the Deputy Director of Finance in the absence of the Director of Finance)~~and one of the Clinical Operations Managing Directors or their deputies acting as their direct representative~~.

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

4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.

5. Frequency

5.1 Meetings should be held bi-monthly with additional meetings if required.

6. Duties and Responsibilities

6.1 To monitor the development and delivery of financial and operational aspects of the Trust strategy through:

- Detailed oversight of current and future financial performance including financial risks.
- Detailed oversight of current and future operational performance.

6.2 To monitor delivery of the continuous improvement programme including CIP.

6.3 To oversee progress on contractual negotiations of an income and expenditure basis.

6.4 To receive reports on business and commercial matters.

6.5 To consider outline business cases and proposals and to approve or make recommendations to Board accordingly.

6.6 To receive reports or referrals from committees and other meetings, relevant to the work of this Committee.

6.7 The agenda for the Committee will be informed by a forward plan of regular items but will also receive reports on relevant issues requiring additional scrutiny and assurance pertaining to actual and anticipated performance and/or when required by Trust Board or Audit and Risk Committee.

6.8 To consider the Board Assurance Framework and high-level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk

Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.9 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.10 To ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise, the Committee will undertake to challenge robustly and fairly to develop a culture of continuous improvement, openness, and honesty.

7. Minutes and Reporting

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

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

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

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

8. Terms of Reference Review

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

Approved by Finance and Performance Committee	19 March 2024 Amended 23 July 2024
Approved by Audit and Risk Committee	25 April 2024 Amended 25 July 2024
Approved by Board of Directors	7 May 2024 Amended 1 October 2024

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2024

Annual Workforce Plan 2024/25

Purpose of Report

This report is to provide assurance to the Board that we are:

1. Embedding workforce planning across the organisation and in the Alliance
2. Developing triangulated plans, bridging the financial plan, with data from our people systems
3. Bringing together the plans for all of the transformation activity inside the Trust and in the Alliance
4. Developing our plans for the professions to support workforce transformation and to enable us to maximise supply working with NHSE and the regional people team.

The workforce plan is required to enable the delivery of the Making Room for Dignity project and Living Well programme and is a crucial part of the self-assessment process for Workforce Standards.

Executive Summary

Workforce planning is a risk and a gap nationally, regionally and in the Derbyshire System. There is a long-term skills gap and planning is impacted significantly by the absence of aligned people and finance system that enable strategic and tactical resource planning to take place.

Our workforce plan has been developed with input from all services and supports the delivery of our overall organisational operational plan. The Workforce Plan establishes how we will provide the right workforce, in the right place, delivering the right care for the population of Derbyshire. It also outlines how we will deliver the objectives of the NHS Long Term Workforce Plan, and the NHS People Plan, to ensure that we can achieve the ambitious improvements we want to see for our patients. The plan establishes how we will overcome the challenges we face in terms of our workforce, including staff shortages against a backdrop of growing demand for our services and meeting the financial challenge both within the Derbyshire System and nationally. The Workforce Plan supports innovative system-wide workforce transformation projects that is changing the way our services are delivered for the patients of Derbyshire. This work aims to radically transform healthcare services, making best use of our assets, our workforce, breaking down silos between services and reducing fragmentation in service delivery. For our workforce it means working in different ways, role transformation and improvements in quality of care and outcomes.

Within the NHS Long Term Workforce Plan (LTWP), the Mental Health Implementation Plan provides a new framework setting out our commitment to deliver the most ambitious transformation of community mental health services and the wider mental healthcare workforce we have seen in the last 30 years.

Crucial to this investment and the new roles and reshaping/development of services is the cultural transformational change which needs to be embedded in each stage of these developments. Further development of an inclusive culture which creates a sense of belonging for all our people within the Trust will be our planned cultural intelligence programme, our work on leadership, culture and behaviours which together will mean that the people in Derbyshire Healthcare are delivering high quality care in a way that embraces and celebrates the whole workforce.

Strategic Considerations (All applicable strategic considerations to be marked with X in end column)	
1) We will deliver **great care** by delivering compassionate, person-centred innovative and safe care.	X
2) We will ensure that the Trust is a **great place to work** by creating a compassionate, skilled and empowered leadership, creating a vibrant culture where colleagues feel they belong, thrive and are valued.	X
3) The Trust is a **great partner** and actively embraces collaboration as our way of working.	X
4) We will make the **best use of resources** by making financially wise decisions and avoiding wasting resources to ensure financial recovery and long term sustainability.	X

Risks and Assurances

The developments and actions summarised in the paper evidence how the Trust is aligning the strategic ambitions and plans in line with organisational, regional and national workforce plans.

Consultation

- Consultation with wider operational services, Divisional People Leads, our system colleagues through Joined Up Care Derbyshire (JUCD) and other key stakeholders
- Executive Leadership Team
- People and Culture Committee.

Governance or Legal Issues

Delivery of the workforce plans will ensure that the Trust is compliant with:

- Monitoring and governance of the commitments as defined in the NHS LTWP, ie, investments in both registered and non-registered parts of our workforce and their investments
- Monitoring and governance of the apprenticeship levy
- Safe Staffing Standards
- Financial Directives
- Working Time Directives 1998
- Equality Act 2010
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- NHS Improvement's Agency Directives 2015
- National benchmarking
- Monthly internal report from people resourcing for recruitment, bank and agency usage targets
- Public expectations

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:

Our vision is to be an exemplar of good equalities practice. We are committed to advancing equality of opportunity and working productively with key stakeholders across the protected characteristics. We plan to attract, recruit and retain a wide range of staff from all sections of society to work in a positive, inclusive and nurturing environment. We also want to deliver, with dignity and respect, inclusive and accessible services that meet our patients' individual needs. We want to be the employer of choice for people living in the region, attracting local talent to work with us and for us, by recruiting a diverse, innovative, flexible and creative workforce.

The Trust has a legal requirement under the Equality Act (2010) to analyse and include equality considerations into day-to-day Trust business, including the design of policies, the delivery of services and employment. The law requires that we specifically respond to the three aims of the general equality duty. It is about identifying barriers and removing them before they create a problem, increasing the opportunities for positive outcomes for all groups, and using and making opportunities to bring different communities and groups together in positive ways. This is reflected throughout the workforce plan and its delivery.

Recommendations

The Board of Directors is requested to:

1. Note and support the progress of the workplan outlined.
2. Provide any further direction/comment on the delivery of the plan.

Report presented by: **Rebecca Oakley**
Director of People, Organisational Development and Inclusion

Report prepared by: **Liam Carrier**
Acting Deputy Director of People and Inclusion

NHS
Derbyshire Healthcare
NHS Foundation Trust

Workforce Plan

2024/25

Contents

1.0 Strategic Oversight

This document has been produced to provide the Board, the Trust's Executive Leadership Team, other staff members and our partners with a clear description of the Derbyshire Healthcare NHS Foundation Trust Workforce Plan for 2024/25. The document is intended to provide an update to workforce planning activity within the Trust as part of the annual operational planning round.

The strategic workforce plan reflects the Trusts expected whole time equivalent (wte) by 31 March 2025. The plan takes into account the opening staff in post position as of 31 March 2024 and is then adjusted for expected in year developments (filling of existing vacancies, service developments, cost improvement programmes and workforce transformation). Planned total workforce growth over and above turnover for 2024/25 is 188.59 wte.

	Contracted Staff in Post (WTE)		
Staff Group	Outturn Year End 2023/24	Plan Year End 2024/25	Variation
Registered nursing, midwifery and health visiting staff	1,124.14	1,197.69	73.55
Registered scientific, therapeutic and technical staff	455.13	486.13	31.00
Support to clinical staff	494.60	523.24	28.64
Infrastructure support	714.02	757.60	43.58
Medical and dental	184.27	196.09	11.82
	2,972.16	**3,160.75**	**188.59**

Work continues with our key workforce service developments for 2024/25, where we expect to see an additional 258 wte to support the new Making Room for Dignity (Dorms) programme and an additional 31.37 wte for other key workforce developments. Whilst we expect to achieve an overall increase in wte during 2024/25, it is set against the backdrop of meeting our Derbyshire System commitment to see a potential reduction in wte through Cost Improvement Programmes (CIP) of 100.79 wte, which is expected to be achieved through natural turnover, existing vacancies, skill mix reviews and better use of resources.

2024/25 WTE Change

Workforce Growth WTE	289.38
Dorms	*229.17*
Dorms Estates & Facilities	*28.84*
Recruitment already in the pipeline	*18.32*
Agency	*0.26*
DCHS Psychology	*7.79*
Childrens 0-19	*5.00*
	289.38

Cost Improvement Programme (CIP) WTE	-100.79
Cost improvement programme phased in on an estimated reduction of 8.40 WTE each month	

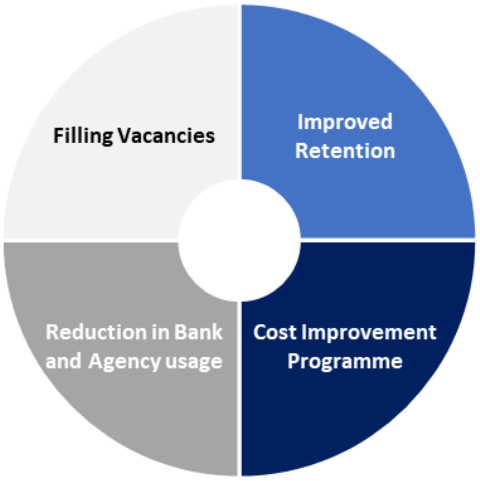
Net Growth WTE		188.59
Investment Growth (including additional agency usage Q1 to Q3 as per CQC) & CIP combined phasing	*Q1*	*75.70*
	Q2	*72.39*
	Q3	*60.00*
	Q4	*-19.50*
		188.59

Bank Usage WTE	0.00

Agency Usage	-4.00

Existing turnover and vacancies remain a challenge with an overall vacancy rate of 10.84% (includes new wte investment for the 2024/25 service developments) and annual turnover of 12.24%.

The Trust continues to work towards its four key workforce priorities:



Trust-wide workforce planning and development capability is improving, and workforce development initiatives are responsive to key workforce needs.

The Workforce Plan presented in this report should be viewed as a point in time; workforce planning, transformation and development is a year-round activity and as such the plan is likely to change as learning progresses, more granular detail is uncovered and in response to the rapidly changing commissioning, political and policy landscape.

2.0 Strategic Forces Impacting on Services and Workforce Planning

Several strategic factors will impact upon the Trust's services and will have workforce implications that will need to be considered. However, some of the workforce implications of these strategic factors are in development and may be subject to change.

Integrated Care Systems (ICSs)

The Health and Care Act 2022 received Royal Assent, from 1 July 2022, for Integrated Care Boards (ICBs) to replace Clinical Commissioning Groups and the role of Integrated Care Partnerships (ICPs), as the committee where health, social care, the voluntary sector, and other partners come together, will be established in law as an Integrated Care System (ICS). The Derbyshire ICS will continue to be known as Joined Up Care Derbyshire (JUCD); JUCD is the Derby and Derbyshire health and social care partnership for adults and children.

Having an ICS which is now established in law, with a new organisation that reflects the collaborative approach required, is very helpful to what we are aiming to achieve. Integrated Care Boards (ICBs) are responsible for developing a plan in collaboration with NHS Trusts and other system partners for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the defined area.

In Derby and Derbyshire, our health and care system has worked in partnership for many years; the duties the Bill places on the local NHS and local authorities are welcomed and fit well with the direction we have been taking to improve the health of the local population.

When the NHS was created in the 1940s its aim was to treat symptoms. It has come a long way since then, supporting people to live healthier lives. This change is continuing along that journey and aims to make social care and health even more aligned. Our health is affected by many things – ethnicity, class, housing, unemployment, financial stress, domestic abuse, deprivation, poverty, and lifestyle choices. We need to look at through a partnership between the NHS, local authorities, and the voluntary sector.

The workforce agenda is seen as critical to the success of the ICS; workforce makes up approximately 75% of all NHS spending, which means workforce planning and workforce transformation are at the very heart of system-wide planning.

The NHS Long Term Workforce Plan

The publication of the NHS Long Term Workforce Plan in June 2023 is one of the most seminal moments in the 75-year NHS history. This is the first time the government has asked the NHS to come up with a comprehensive workforce plan; a once-in-a-generation opportunity to put staffing on a sustainable footing and improve patient care. The Plan is ambitious, and it is bold, while being rooted in the reality experienced by patients and staff now, and it is rigorously aligned to the improvements in care that we aspire to make for patients. Even more crucially, it doesn't just herald the start of the biggest recruitment drive in health service history, but also of an ongoing programme of strategic workforce planning – something which is unique amongst other health care systems with national scale.

The strategic direction for the long term, fall into three clear priority areas:

- **Train:** significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more doctors and dentists, more nurses and midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.

TRAIN; We will train over 450,000 healthcare professionals over the next five years. This means that by 2028:
- Medical training places will grow by 33% to 10k a year
- Nurse training places will grow by 34% to 40k a year
- AHP training places will grow by 13% to 17k a year
- Training places for new roles such as nursing associates, advanced care
- practitioners, anaesthesia associates, peer support workers and others will grow by more than 30% to c16k a year
- Pharmacy training places will grow by 29% to 4,300 a year
- Grown the number of support to clinical workers by more than 110,000
- The number of GP training places will grow by 25% to 5k a year

NHS recruitment processes will be reformed to support this growth and ensure NHS organisations support their local job market.

- **Retain:** ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.

RETAIN; Retention improvements can contribute to retaining up to 130,000 more staff in the NHS. To make this a reality, the NHS will need to continue to improve culture, inclusion and ways of working and make the NHS People Promise a reality for everyone. This includes better opportunities for career development, improved flexible working options, alongside government reforms to the pension scheme.

- **Reform:** improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment and provides the care patients need more effectively and efficiently.

REFORM;
- We will take full advantage of digital and technological innovations, such as Artificial Intelligence (AI), speech recognition, robotic process automation (RPA) and remote monitoring, to provide a more efficient service for staff and patients.
- To ensure patients benefit from a broader range of skilled professionals, we will increase the proportion of new roles from 1% of the workforce in 2022 to 5% by 2036/37.
- We will expand clinical apprenticeships from 7% of training places today to 22% by 2030.
- We will work with universities to improve student experience, reducing leaver rates from courses, and using new technology to prepare people for work in a modern NHS

3.0 Service/Workforce Transformation

In order to better understand the current and future workforce demand and challenge throughout the Trust, the Trust held two Workforce Summits for Leaders last year, one focusing on the NHS Long Term Workforce Plan and one focusing on New Roles. The outcome of both events remains a key focus as we continue to work towards transforming our of services and workforce.

Reflections from the Workforce Summit

1. New Roles • skill mix - how, where and with what support and funding • training re: new roles / new skills / leadership • planned workshop to bring clarity re: what the new roles are, how they are supported, what they can do what they can't, funding implications etc. • Nursing Associate – how can we tailor to MH competency • Governance framework and assurances • Skill mix e.g. new build - what are required tasks to be delivered and build roles/model	**2. Integrated Team Working** • promote integrated team working around patients • balance to recognise and respect professional identity whilst being more integrated/accepting of new roles/ • broader understanding of skills needed to do different tasks traditionally under the remit of one profession • share good practice • dedicated integrated team development days • clinical leadership important • everyone's business - less siloed working • role specific - chief AHP / medical trainees as pipeline for consultants / preserving professional identify

3. Recruitment
• flexibility of roles, even within role i.e. not just new roles
• innovative recruitment approaches:
  ○ branding videos describing role, team, area of work etc.
  ○ limit number of times same JD is put out - take a different approach or new role if unsuccessful x 2
  ○ revisit one-stop shop recruitment initiatives
  ○ alternative recruitment approaches (not NHS jobs)
  ○ slicker processes from application to arrival
• recognise younger generation have different expectations - need to flex to respond to this
• more clinically led recruitment
• breadth of opportunity - how can do placements differently
• onboarding important for retention
	4. Staff Experience
	• robust induction priority – need for innovation
	• leadership modelled throughout the organisation
	• apply flexile working transparently, with innovation, default to 'yes' with some clear expectations, sharing good practice
	• flexibility can be modelled from above - giving managers flexibility also to innovate
	• wellbeing and resilience comes in all shapes and sizes - flexibility / hybrid working / team development / development opportunities
	• processes and procedures need to be slicker e.g. long term sickness - HWB look at policies and processes

Reflections from the New Roles Summit

Non-Medical Prescribers • Explore opportunities for physiotherapists and other AHPs • Ensure there is a clear contractual arrangement • Consider opportunity for NMP roles in Living Well workforce plan • Matching where there are willing Consultants works well • Skill match to service need **Advanced Clinical Practitioners** • Role is very new in mental health • Area specific needs for each role • Personal scope of practice • Dedicated lead needed as per NMP model • Is/will become a regulated role • Royal Derby provides great training • Trusts overview of all these roles • Link ACPs with qualified NMPs as next stage of development **Multi Professional Approved Clinician** • Only 121 in the country with commitment for 1000 if LT WFP • AC database holds details – Louise has access as lead • Can have a nurse prescriber who is also an AC	• Culture – expectation, flexibility, • Skills sets – build around the needs of the patient • Need the right people to discuss we are the converted • Influence at senior level and develop a strategic approach • Need time for planning and reflection (manage chaos) • How develop this as a system working in collaboration – particularly for training and supervision • There should be a mix of these roles within each team • How can we allocate time for training • How do we meet the supervision requirements • Understanding the skill mix we need and have – what is the gap • Clearly defined job descriptions • Retention and career development opportunities • Triumverate model, team discussion • Business case development, cost vs benefit, options appraisal • Where is the value –budgets • Understanding gaps and alternative roles

The Trust continues to work towards introducing and increasing the number of new roles within services.

NMP Non-Medical Prescribers
94 in post + 5 trainee in post

ACP Advanced Clinical Practitioners
2 in post + 9 trainee in post + 1 future trainee

PA Physicians Associates
0 in post + 0 trainee

NA Nursing Associates
2 in post + 23 trainee in post

MPAC Multi-Professional Approved Clinicians
3 in post + 5 trainee in post + 2 future trainee

Staffing Requirements for the Making Room for Dignity Programme (MRfD)

Whilst significant investment in new, modern, and therapeutic mental health inpatient environments will facilitate and enable improvements in service provision, and enhancement of patient experience, increased safety, and patient outcomes, it is our healthcare teams who provide care that will continue to deliver on our Trust's vision: 'To make a positive difference in people's lives by improving health and wellbeing.' In total, 234.53 whole time equivalent staff are being recruited, with additional staff for existing services recruited six weeks before go-live, and new specialist service staff recruited five months before go-live. A 'branded' recruitment programme has been developed, in addition to employment and training of student nurses and nursing associates. The table below highlights the expected operational dates, the target dates for staff recruitment, and the total additional workforce needed to ensure the successful launch of these MRfD programme.

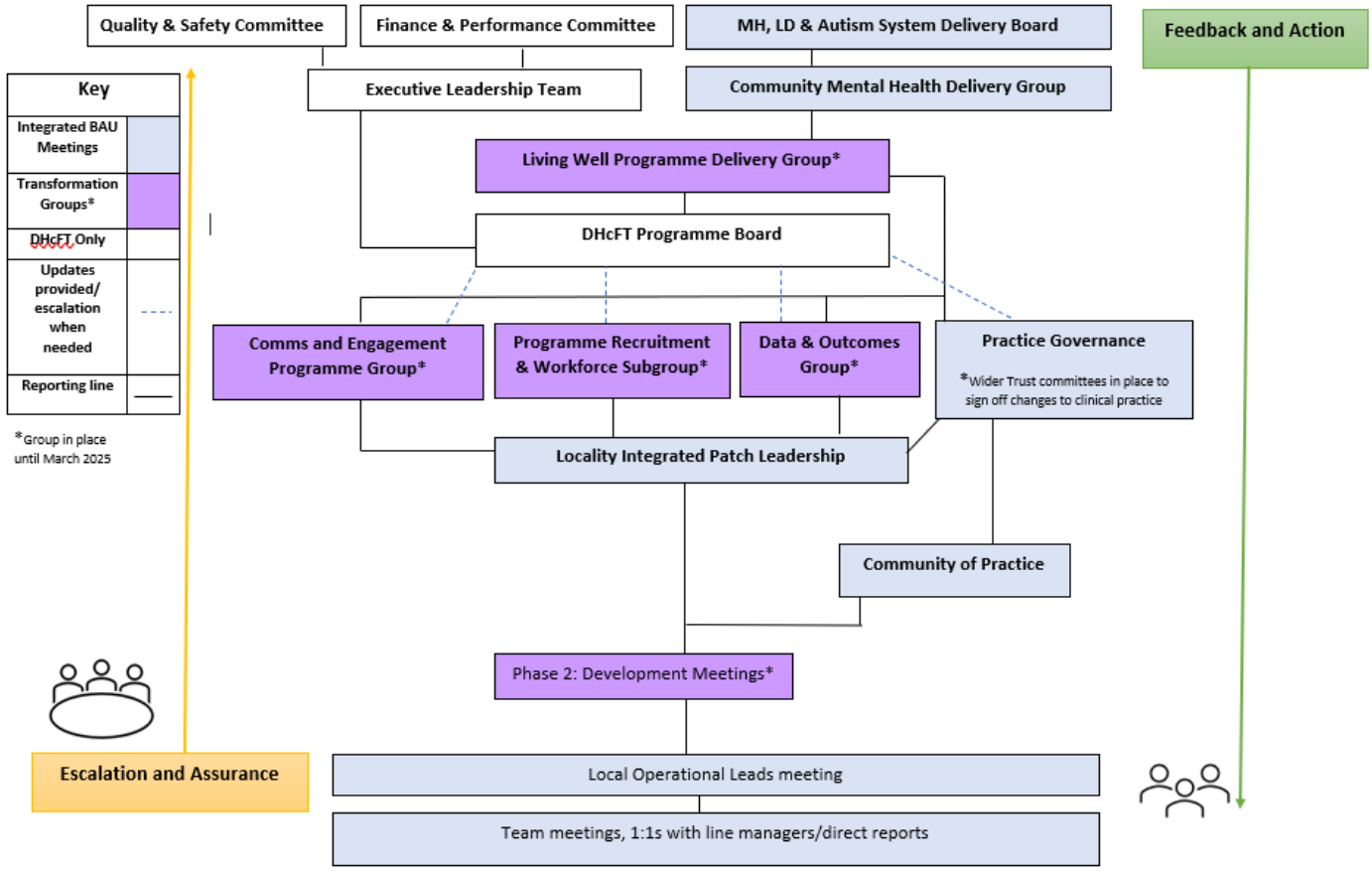
Unit Name	Hospital	Bed Capacity	Operational Date	Staff in Post Target	Additional Staff Needed (wte)
Bluebell Ward	Walton Hospital	12-beds	2 September 2024	22 July 2024	33.58
Derwent Adult Acute Unit	Chesterfield Royal Hospital	54-beds	4 December 2024	6 November 2024	32.11
Carsington Adult Acute Unit	Kingsway Hospital	54-beds	11 December 2024	30 October 2024	27.27
Audrey House Enhanced Care Unit	Kingsway Hospital	8-beds	11 December 2024	16 October 2024	55.16
Kingfisher House PICU	Kingsway Hospital	14-beds	31 March 2025	3 February 2025	71.28
Radbourne Unit Ward 32	Royal Derby Hospital	17-beds	Summer 2025	31 March 2025	13.96
Radbourne Unit Ward 35	Royal Derby Hospital	17-beds	23rd March 2026	9th February 2026	1.17

This staffing will be crucial to ensure that each unit operates effectively and with 'safer staffing' levels to provide the necessary care and support to service users.

The early recruitment of staff for these units is a positive step, as it allows for adequate time for training, orientation, and the establishment of effective teams and ensures that the units can open on schedule with limited disruption to servicer user recovery.

Living Well Programme

Following the publication by NHS England of the Community Mental Health Framework in February 2020, the "Living Well programme" was set up by Derbyshire Healthcare NHS foundation Trust. The overarching aim was to improve mental health care and access to mental health services across the city and country, particularly for people identified with severe mental illness. The programme brought together health workers from the trust and aligned them with the voluntary and social care sector as a means of offering more holistic inclusive support, this is called "Living Well Derbyshire". This incorporated Derbyshire Healthcare NHS Foundation Trust, voluntary sector organisations, local authorities, the CCG and those with a lived experience of mental health illness, and their carers worked collaboratively to create this transformative service model for local communities across the city and the county. A clear governance structure is in place to provide oversight and accountability.



This was developed in stages, covering the city and country with Wave 1, Wave 2 and Wave 3 sites. The eight new Living Well teams roughly aligned with previous Community Mental Health Team (CMHT) areas as follows: Derby City (known as Derby Wellbeing) Amber Valley, Erewash, South Derbyshire, Derbyshire Dales, North East Derbyshire and Bolsover, Chesterfield, High Peak. A Community Mental Health Framework (CMHF) roadmap was developed with the requested deliverables from NHS England covering all aspects of the model development, care provision, workforce planning and recruitment, data and outcomes and alignment with existing specialist services. The teams received training and inductions and worked through the new paperwork and forms (Welcome Call, Initial Conversation, Staying Safe, my Care Plan and Moving Forward). These new forms had comprehensive input from experts by experience and have been generally very positively received. Led by the programme team, the teams mobilised into Living Well teams in stages (Wave 1, Wave 2 and Wave 3) and I'm delighted to say that all teams are now mobilised and live with the last team, South Derbyshire mobilising in March this year. Beyond the teams' mobilising it also incorporated community collaboratives, which were monthly meetings open to all scheduled for each Living Well area and led by a local area co-ordinator. This is a space open to all and has been attended by GPs, Living Well team members, the voluntary sector, carers and members of the public.

Phase 2 (April 2024 to March 2025)

With all teams now mobilised, an updated plan was put in place to cover the period from April 2024 to the end of March 2025 when the programme team secondment ends. The Phase 2 model development works in alignment with the CMHF Roadmap and specifies key deliverables for the year. This includes things such as being open re-referrals, referrals from carers, increased system integration, advancing local equalities, improved data and outcome monitoring, moving beyond CPA and increased access and preparation for self-referrals from April 2025. It also looks at Key enablers, such as ongoing system wide inductions for new starters.

The teams have fortnightly planning meetings in which any issues are raised and which I attend. They have been overwhelmingly positive in terms of how the workforce offers care as an integrated team from the healthcare, social care and voluntary sectors. The Living Well teams have received training from psychology leads around cognitive behavioural therapy (CBT) and Dialectical Behavioural Therapy (DBT) and training around a trauma informed care approach to help develop a 12-week Short Term Offer and a “no wrong door approach” which includes groups such as coping with emotions, dealing with trauma, anxiety management and a range of practical help. Linking in with the voluntary sector is aimed to increase flow through the service and the figures show there has been an increase in demand and a drop in waiting times compared with Community Mental Health Teams waiting lists.

The teams have also incorporated “learning labs” which is usually a fortnightly or monthly meeting designed to work through any issues raised and help provide a service of continuous improvement. They continue to have regular planning meetings led by the programme team. Overall, the increase in demand is being coped with well at present, though there have been challenges in replacing staff who have left with recruitment going through the vacancy control process. Overall though, there’s no doubt in my mind that the Living Well model in Derbyshire is achieving its key deliverables of greater access and a better standard of care."

Recruitment Update

To support and provide assurance for the recruitment for the ongoing programmes there is an ongoing strategy to ensure success of recruitment into all posts.

The Strategic Recruitment Lead appointed last year, continues to review and further develop the recruitment timeline/strategy for the programmes, which includes a detailed plan for each category of role and how we will adapt our approach dependant on each role, as and when funding becomes available, in line with the wider programme timescales.

The focus over last year, and which continues into 2024/25, is on utilising alternative means of recruiting through social media, websites, promotional advertising and branching out into the community to attract a more diverse range of applicants as part of an inclusive recruitment approach, whilst promoting what the programmes and the organisation have to offer.

This includes the following initiatives:

- Recruitment campaigns for Registered Nurses (Band 5) include pro-actively promoting roles to registered Nurses via a range of platforms including Facebook, LinkedIn and Indeed. This will aim to target the passive applicants and highlight the benefits of working for the Trust
- Expressions of Interest offered at all recruitment events and websites to collect data from applicants who have expressed an interest in working for the Trust. All applicants will be sent relevant information about a range of jobs available and signposted to current opportunities. All qualified staff will be signposted directly to vacancies and fast-track interviews offered for registered Nurses
- For specialist and hard to fill roles, such as medical Consultants/Staff Grade Doctors, an applicant pack has been developed and we have used paid job board advertisements to support those specific campaigns, such as British Medical Journal and LinkedIn. Campaigns will be developed, and bespoke strategies will vary depending on the roles recruited to. For specialist hard to fill Consultants, an RRP (Recruitment and Retention Premia) is being offered to make the Trust more competitive

- A review of our recruitment approaches for estates and facilities roles will be carried out with the aim of targeting wider promotions within our communities such as the use of job centres and outreach work. As of July 2024, we are running a employment programme working with people who are out of work in Derbyshire, who will undertake a pre-work programme then be guaranteed interviews on completion of the programme for Domestic roles in the Trust. This could be rolled out to other areas
- Careers events and recruitment fairs have been attended by the Trust and this will continue for the next 12 months. A Trust-wide jobs fair is planned for October 2024 and future events will take place
- By August 2024, seven international Nurses will have joined the Trust as RMNs, alongside two Allied Health Professionals. A review will take place to see if international recruitment can take place across other clinical areas to support hard to fill vacancies. A Practice Facilitator is in place to support new international arrivals to help them prepare for the Objective Structured Clinical Examination (OSCE) and a Pastoral Officer in in place to support their transition to the UK
- Continued engagement with current staff to aid in retention and wellbeing
- Creation of recruitment packs and, video adverts and paid recruitment campaigns have been created for arrange of roles
- Further engagement with the Universities of Derby, Nottingham and Leicester will continue and we have continued with our fast-track student process where newly qualified staff are offered roles across the Trust once qualified.
- Promotion of the wellbeing offer at all staff engagement events.

The Trust has reviewed its staff benefits offering and as part of our attraction package launched a range of new salary sacrifices including gym memberships, travel and leisure, home and electronics and family.

In addition, a health plan will also be offered. The Trust already offers lease car and cycle to work. All other benefits will be promoted Trust-wide, so all staff are aware of the existing benefits and these will be promoted in a Trust-wide benefit pack. Staff benefit drop ins will take place regularly to ensure staff are aware of the full range of benefits and a new benefits page will host all benefits in one place.

Recruitment training has been reviewed and in 2024, a role out of chairs training will take place to ensure recruitment practices are fair and inclusive. Recruitment spotlight sessions will also be run to improve staff awareness around recruitment areas, such as shortlisting and reasonable adjustments.

Recruitment for the Trust and all programmes is a top priority to ensure safe staffing and high-quality service user experience and engagement.

Divisional and Staff Group Workforce Plan updates

	New Roles	Supply	Assurance
Older People's Mental Health	Development of Living Well role.	Living well - supply and development of current workforce. Bluebell ward – supply – supporting staff to move over from Adults of Working Age (AWA) directorate, engagement with higher trainees for medical input, utilising existing older peoples leadership workforce to support mobilisation.	Assurance through Making Room for Dignity (MRfD) and clinical and operational assurance forums.
Acute Assessment Adults of Working Age	Internal and external apprenticeships for Assistant Practitioners, Registered Nurses, Occupational Therapy and Approved Clinician/Responsible Clinician roles. Pilot of Approved Clinician/Responsible Clinician roles in Acute and Crisis Resolution Home Treatment Team settings.	Focussed recruitment events for current and Making Room for Dignity projects across Registered Nurses and Allied Health Professional roles. Skill mix and transformation review to look at Occupational Therapy staffing in/out of numbers. Making Room for Dignity roadshows and external and internal events, advertising and promotion, comms and international recruitment. Use of 'early offer' for psychiatric nursing graduates to support recruitment.	Dedicated Making Room for Dignity recruitment role in place to support enhanced recruitment. Role to feedback and escalate within MRfD forum and project groups. Reports and escalations through Clinical and Operational Assurance Team (COAT) and

	Longer term Approved Clinician/Responsible Clinician strategy needed to embed within services going forward.	Formal transfer offer for Temporary Workforce Healthcare Assistant and Registered Nursing staff into substantive posts within acute wards. Option to free up staff to train whilst in current non-Psychiatric Intensive Care Unit role for establishment of new ward team (including Acute+ and Psychiatric Intensive Care Unit). New Allied Health Professionals Lead roles for Speech and Language Therapy (SLT) to support developments around Neurodevelopment and adaptive working.	Acute Ops as well as dedicated agenda items within Making Room for Dignity (MRfD) Project Board and Future Workforce Planning Group.
Community Mental Health Adults of Working Age	Mental Health Wellbeing Practitioners in recruitment to pilot. Ongoing development of the Nurse Associate role to increase skill mix. Approved Clinician (AC)/Responsible Clinician in recruitment. Ongoing Recruitment of Nurse and Occupational Therapist apprenticeships	Non-Medical Prescribers in recruitment with plan to develop from Band 6 to 7. Mental Health Practitioners currently open to Registered Mental Health Nurses, Occupational Therapists, Learning Disability nurses and Social Workers to increase registered workforce, as difficult to recruit to Registered Mental Health Nurses.	Discussions through Clinical and Operational Assurance Team and divisional operational meetings.
Neurodevelopment	Two AC roles embedded into Neurodevelopment Trainee Advanced Clinical Substantive Head of Practice (HoP) established Transition role (Derbyshire Community Health Services (Host Organisation) No further opportunity to consider new roles past this given the financial position. All future posts will need to be considered alongside the financial envelope, creatively (where possible) but in line with the vacancy controls within the Trust.	Skill mix using redeployed staff from Hillside into FST. Utilising clinical operational leadership across the integrated division to maximise resource and skill.	Clinical and Operational Assurance Team. Operations meeting. Neurodevelopment steering group.
Children's	Specialist Health Visitor in Perinatal and Infant mental health, funded by the family hubs for one year.	Skill mix review with a potential of three wte posts to alternative bands and professions. Call to action local advertising campaign. Retention package. Five student Health Visitor posts and two Student Nursing posts which have been recruited into for September. Four newly qualified Health Visitors to commence September.	Executive Leadership Team, Clinical and Operational Assurance Team and Trust Operational Oversight Leadership Team.

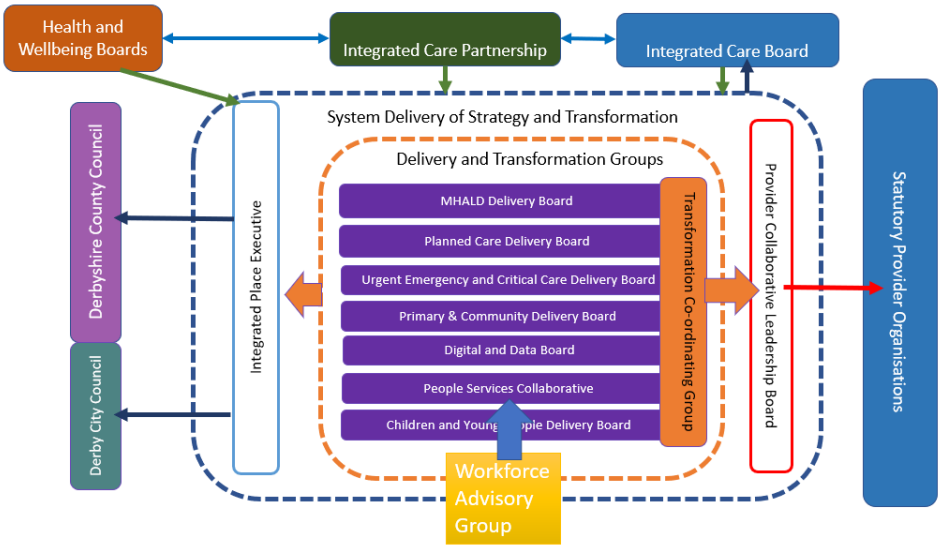
		One newly qualified School Nurse to commence September.	
Forensic and Rehabilitation	Approved Clinician/ Responsible Clinician (AC/RC) clinical governance and guidance in Forensic Community Health Team (FCMHT) is being developed to provide clarity and assurance of role, remit and functions within forensic directorate. Eating Disorders Team still in recruitment through usual channels and considering alternative roles. Gambling Service – continuing to recruit into new roles – successful recruitment into majority of posts outstanding 0.6 Lived Experience role and 0.4 Cognitive Behavioural Therapy (CBT) post - currently in recruitment. Perinatal Services: Development of Community Outreach worker post, following successful pilot. Perinatal Services: Non-medical prescriber within recruitment plan.	Forensic Community Team – vacancies remain in the team including AC/RC posts. MOU completed with Derby City LA for SW in the team. Criminal Justice Liaison and Diversion – under service model review due to increased demand on service and increased role and function within this portfolio. Community Rehabilitation – awaiting final sign off of clinical and staffing model at Executive Leadership Team (ELT). Some staff already in post. Forensic Community Team, Liaison and Diversion - ongoing recruitment and Band 5 to 6 Nurse development process in place. Consider skill mix and alternative professions. Dietetics and Physio - looking at activity, difficult to recruit to mental health Dietetics and Physiotherapy. Commenced growing own in Physiotherapy work underway to do the same in Dietetics. Perinatal Services: Band 6 Registered Nurse of AHP. Perinatal services: Band 6 to 7 development opportunity.	Discussions through Clinical and Operational Assurance team and divisional clinical and operational meetings. Perinatal services: Discussions through Clinical and Operational Assurance team and divisional operational meetings.
Pharmacy	Recruitment to Making Room for Dignity roles. Continued recruitment to new Pharmacist roles associated with Living Well. Development/transformation of Pharmacy Technician roles to directly support Pharmacists and medicines optimisation in Community Mental Health Teams. Development of independent prescribing roles for existing Pharmacists. Rebalance use of Pharmacist resource away from wards and dispensary to better	Pharmacy Support Workers – Apprenticeship posts to continue. Established competency-based Band 2 to Band 3 pathway with good completion rate. Route into Pharmacy Technician training (PTPT). Pharmacy Technicians – recruit and train Pre-registration Trainee Pharmacy Technicians (PTPTs) subject to NHSE funding as requested via METP. Specialist Mental Health Pharmacists - fund post-graduate Mental Health pharmacy qualifications for Pharmacists and support independent prescribing qualifications; subject to NHSE funding as requested via METP. Established Band 6 to Band 7 competence-based pathway continues to support less experienced pharmacists to be able to practice as specialist mental health Pharmacists, joining as Band 6 and progressing after 18-24 months. Pharmacist Undergraduate placements – provided for MPharm students from University	Vacancy for one x Band 8b Deputy Chief Pharmacist will be held until March 2025, while need for the post and best use of budget is assessed by the team. Pressures on pharmacy workforce pipelines addressed via JUCD Pharmacy Faculty and JUCD Academy.

	support services in the community.	of Nottingham in years 2 and 4, to increase exposure to mental health environment and Mental Health pharmacy specialty careers. Pharmacist Foundation Trainees – Through 2024/25 we continue to support two placements from the University of Nottingham integrated MPharm course; these will end after this year due to reform of Pharmacist foundation training. Two Band 5 foundation placements offered through Oriel to commence in July 2025 for 12 months. Training shared with a community pharmacy provider in line/preparation with mandate for cross sector foundation training from July 2026. Retention – adopted non-contracted hybrid working including working from home days for members of the team whose roles are compatible with this. Support relevant staff to attend Trust training, eg, Aspiring to Be Leaders (A2B). Support relevant staff to attend funded external training, eg, NHSE Pharmacy Leadership Training, Mary Seacole. Support attendance at College of Mental Health Pharmacy events. Refresh Pharmacy Strategy once Trust Strategy updated. Link to ongoing work by JUCD Pharmacy Faculty.	
Division of Psychology and Psychological Therapies	New structure with completed skill mix now finalised and in place. CBT (therapists as part of Community Mental Health teams. Use of a range of psychological therapy training across the landscape and profession. Assistant Psychologists delivering group work into the Living Well. Multi-Professional Approved Clinicians (MPAC): six current trainees, four will likely be approved by the spring and the other two by the end of 2024/beginning 2025 (Nurses and Psychologists). One more MPAC training post agreed to come online in the spring. Employing counselling Psychologists in areas where their skills are beneficial.	Divisional vacancies around 7% (lower than nationally and regionally). New 0.4 Consultant Psychologist funded by Universities of Nottingham & Lincoln (Doctorate in Clinical Psychology). Increased number of trainees employed by the Trust: 16 across 3-year groups – aim to recruit straight from training. Hosting more trainees from other areas including the Maudsley. Themes re leavers relate to NHS working, not the Trust/division. Issues with recruiting staff through subcontractors in talking mental health.	Divisional vacancies got as low as 4% in February. This is growing again due to recruitment pause. Themes of leavers: lack of Psychology staff in teams; recruitment pause. Consultant Psych post now active; and new trainee cohort of eight starts in September. Talking Mental Health Derbyshire (TMHD) will be changing the workforce in line with new contract until July 2025 Continue to host a range of trainees in different disciplines (counselling, Psychology and Psychotherapy). Changes to Psychology workforce in Living Well - leaving only one Psychologist in post for the whole of the Living Well Derbyshire-wide. Two vacancies remain.

			Counselling Psychologists now part of the workforce. MPACs – of the six trainees reported on last time – two have now been approved and are awaiting development of a role; three further trainees are due to submit (and hopefully gain approval) in July 2024. One new trainee has joined the cohort so there are two due to qualify in 2025.
Estates and Facilities	Additional Estates & Facilities staff for operation of the new Making Room for Dignity developments (North and South).	Making Room for Dignity roadshows and external and internal events, advertising and promotion, communications and recruitment. Cleaning staff currently employed by Derbyshire Community Health Services being TUPE transferred to Derbyshire Healthcare NHS FT.	Funding agreed via Making Room for Dignity business case. New posts agreed via Executive Leadership Team. Oversight at Making Room for Dignity Project Board.
Allied Health Professionals	Explore opportunity for a dedicated Chief Allied Health Professional role. Creation of Task and Finish group for Advanced Clinical Practitioners in discussion at Allied Health Professional council. Embedded speech and language therapy representation in Adults of Working age.	Plan for Allied Health Professional apprenticeships but challenge regarding backfill costs. International recruitment ongoing but at small scale. Improve retention - face to face stay conversations for new recruits at nine and 14 months. Supporting the operationalisation of exit interview for all staff leaving roles to identify any common themes.	Discussions through clinical quality division and chief nurse as well as Allied Health Professional council. Recruitment initiatives remain challenging due to fiscal constraints.
Medical	Development through CESR (Certificate of Eligibility for Specialist Registration) programme to obtain Consultant competencies. Standard Operating Procedure for new roles in development.	International recruitment – General Medical Council (GMC) sponsorship application in progress with expectation of recruiting international candidates by the end of 2024. A new Trust Medical Bank service has been introduced and work continues to expand this further. Medical Bank to substantive conversion programme.	Medical Workforce Group. Executive Leadership Team.

Workforce Planning and Workforce Transformation Governance

The Derby & Derbyshire Integrated Care System (ICS) Architecture/Governance for workforce planning is described below:



In JUCD, a Mental Health Alliance has been established where a partnership agreement has been co-developed with all Partners. Early priorities identified by the Alliance include a focus on workforce development including the opportunities within the following areas:

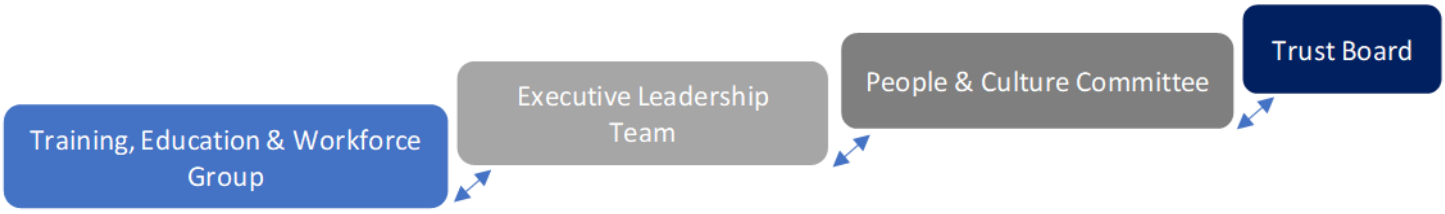
- Standardising pay rates/agreements for employment
- Training offer – standardising courses/gaining economies of scale on delivery
- Workforce needs – looking at roles and responsibilities
- Focus on retention – looking at cross organisational career paths and support options, need to look at culture of working and embedding psychological safety within workplace
- Using cross organisational working/placements to support breaking down of organisational ego and increasing understanding of pressures and demands
- Making the best use of a joint workforce.

Alliance partners agreed that what would be beneficial is the development of a joint workforce strategy which includes:

- Joint recruitment activities
- Joint training needs analysis, plans and offerings
- Joint Career development opportunities.

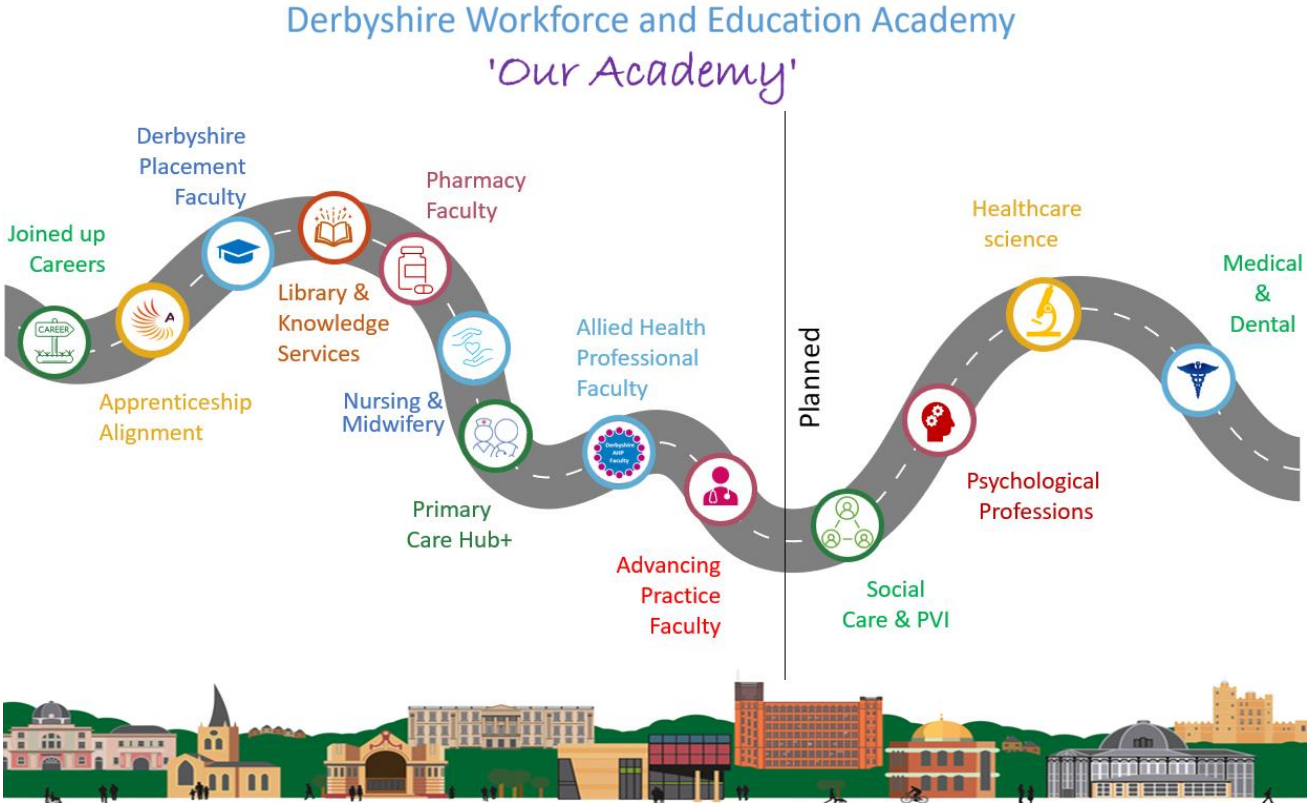
As such it is expected that the Alliance workplan delivery will support all organisations in reducing workforce risks, improving recruitment and retention.

The Trust's Architecture/Governance for workforce planning is described below:

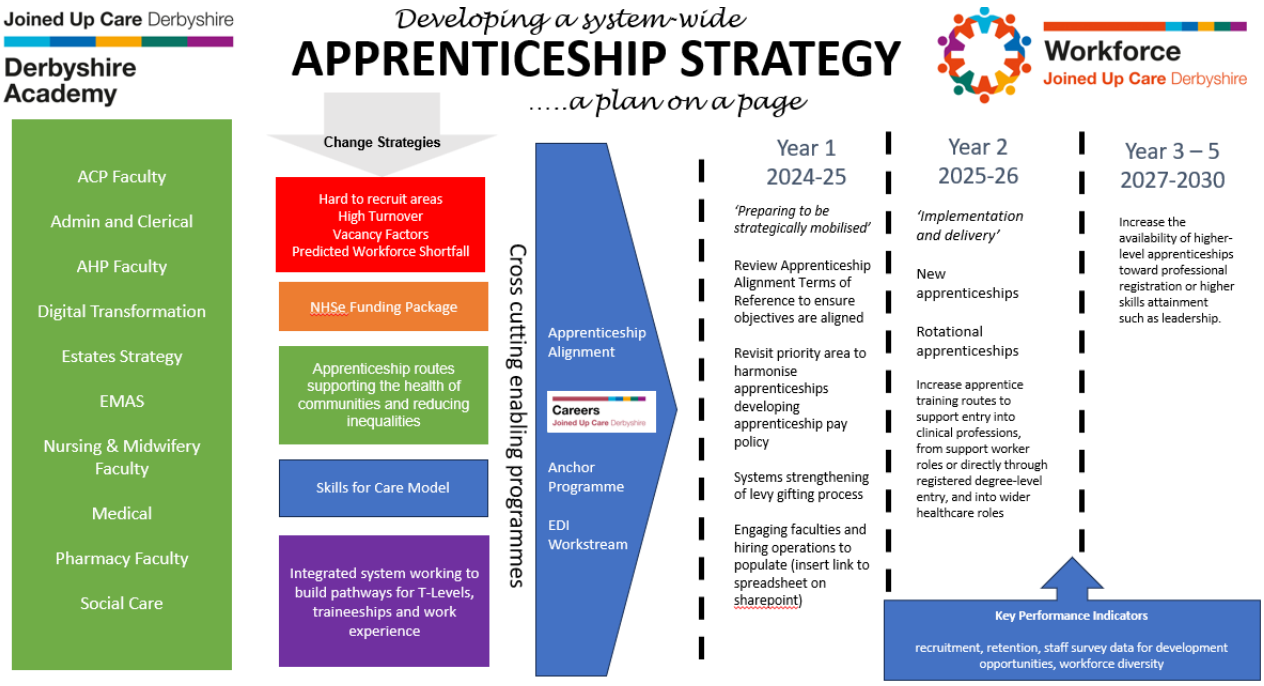


The Training, Education and Workforce Group membership has representatives from all service areas and clinical staff groups.

The Derbyshire Workforce and Education Academy continues to expand following its formal creation last year. The purpose of the Academy is to provide strategic direction and leadership across the Derbyshire Integrated Care System (ICS) working in partnership to bring system-wide health professional groups and existing programmes of work under the umbrella of Joined up Care Derbyshire, to realise efficiencies and impact. Along with the System Funding Oversight Group, the Academy provides governance, oversight, project facilitation, programme management and co-ordination/prioritisation of system funding.

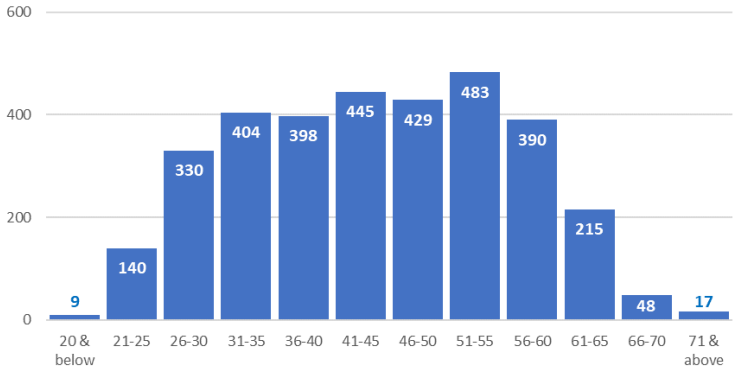


One of the Academy's key programmes is the development of the System Apprenticeship Strategy, with the plan to increase the number of clinical apprenticeships from 7% to 22% by 2031/32.



4.0 Trust Workforce Profile

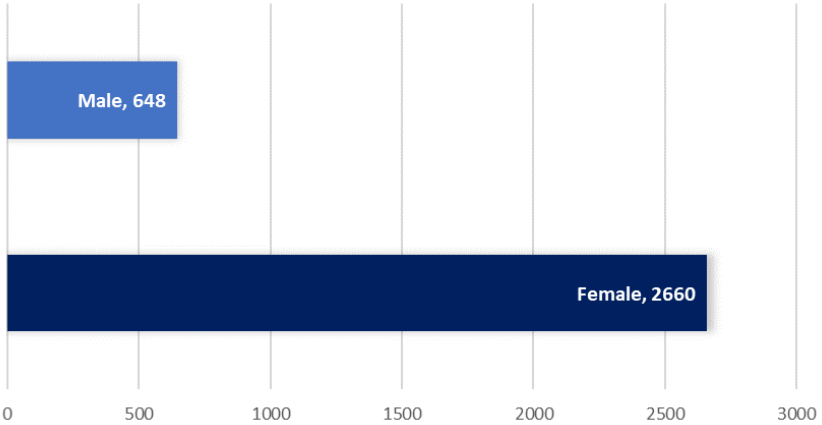
DHcFT Workforce Age Profile



The Trust employs 3,308 people (contracted staff in post) with an average age of 45, which has remained the same for many years. The data shows that 35% of the workforce is aged 51 or above, with only 4.5% of the workforce below the age of 26. The opportunity for retirement at age 55, with special class status for many staff, poses additional risk to workforce supply against demand in clinical roles. Analysis of the nursing workforce highlights that 31.36% of staff are aged 51 and over and 35.29% of medical staff falling within this age range. Allied Health Professional workforce highlights 21.56% of staff are aged 51 and over. Additional Professional Scientific and Therapeutic staff (this includes Psychologists and Social Workers) 19.52% and 32.63% Additional Clinical Services (clinical support staff) are aged 51 and over.

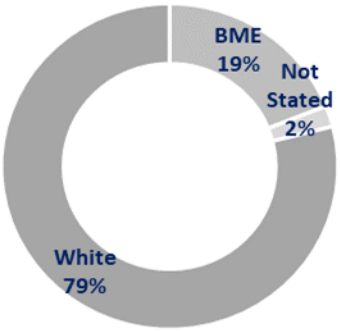
The average retirement age over the past 12 months was 59 years and 2 months. The average retirement age for Nursing staff was 58, for medical staff 61, Allied Health Professionals 61, Additional Professional Scientific and Therapeutic staff 59 and for Clinical Support Staff it was 59. Retention of specialist skills and knowledge within these key staff groups will be a priority moving forwards as well as attracting, developing, and retaining the workforce of the future. Workforce development strategies including role redesign, development of new roles and apprenticeships will be key for workforce supply to meet demand now and in the future.

DHcFT Workforce Gender Profile



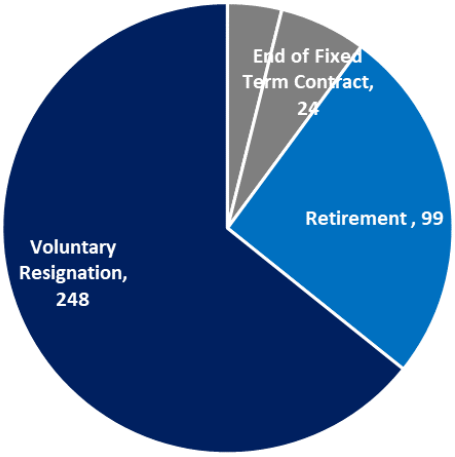
Our workforce gender profile is 20% male and 80% female, compared to the NHS as a whole, currently 26% male and 74% female. The latest Gender Pay Gap (GPG) submission for the Trust reported a GPG of 16.42% based on the average hourly rate, down from 19.01% in 2017 when the GPG reporting was launched nationally. Work continues within the Trust to reduce the gap further through our Equality, Diversity and Inclusion (EDI) team, staff, managers, union and professional body representatives and partners.

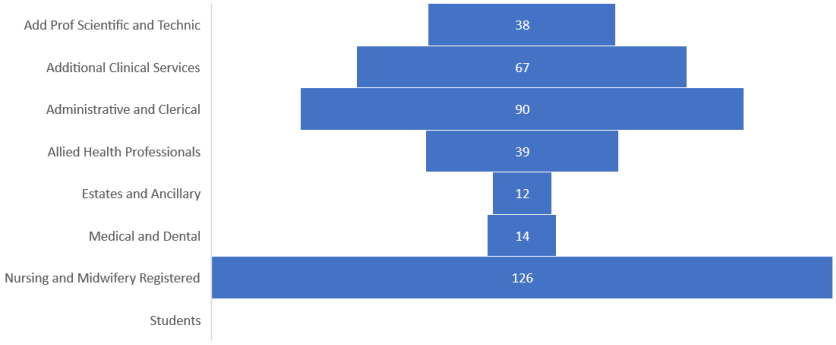
DHcFT Workforce Ethnicity and Disability Profile

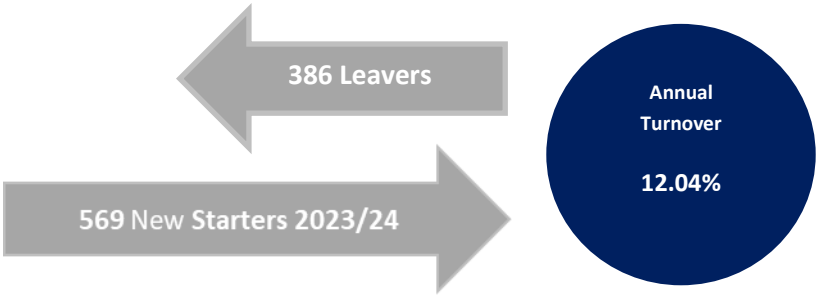


Our workforce ethnicity profile is 79% white, 19% black or minority ethnicity and 2% recorded as not stated. Comparted to 2017, we have seen a 7% increase in our black or minority ethnicity workforce from 12% to 19%. Our workforce declaring a disability is 10%. Compared to 2017, we have seen a 5% increase in staff declaring a disability from 5% to 10%. We continue to work towards reducing the not stated category through improved data quality during the recruitment process and encouraging employees to update their personal information directly via self-service functionality within the Electronic Staff Record (ESR).

DHcFT Workforce Leavers Profile







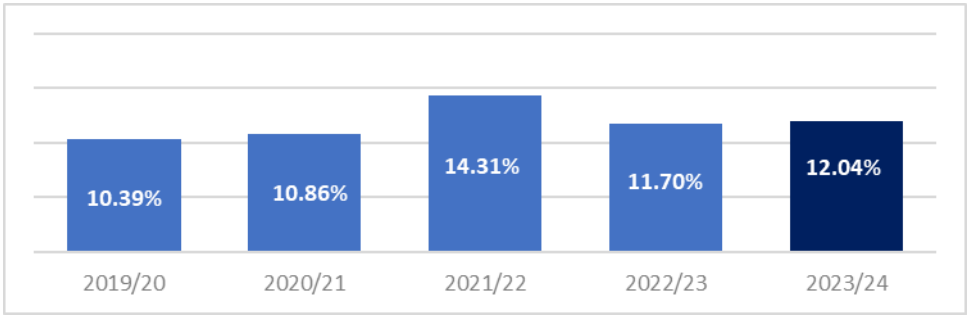
During 2023/24, we welcomed 569 new starters into the Trust through external recruitment and we saw 386 staff leave the Trust, of which 26% retired. Analysis of leaver data shows that 19% of staff leave within their first year of employment with the Trust, 17% between 1 and 2 years, 9% between 2 to 3 years, 9% between 3 to 4 years and 46% with more than 4 years' service.

Reviewing 'Voluntary Resignation' reason for leaving, 'Other/Not known' represented 15% of all leavers, followed by 'Promotion' at 14%, 'Work Life Balance' 12%, 'Relocation' 9% and 5% 'To undertake further education or training'.

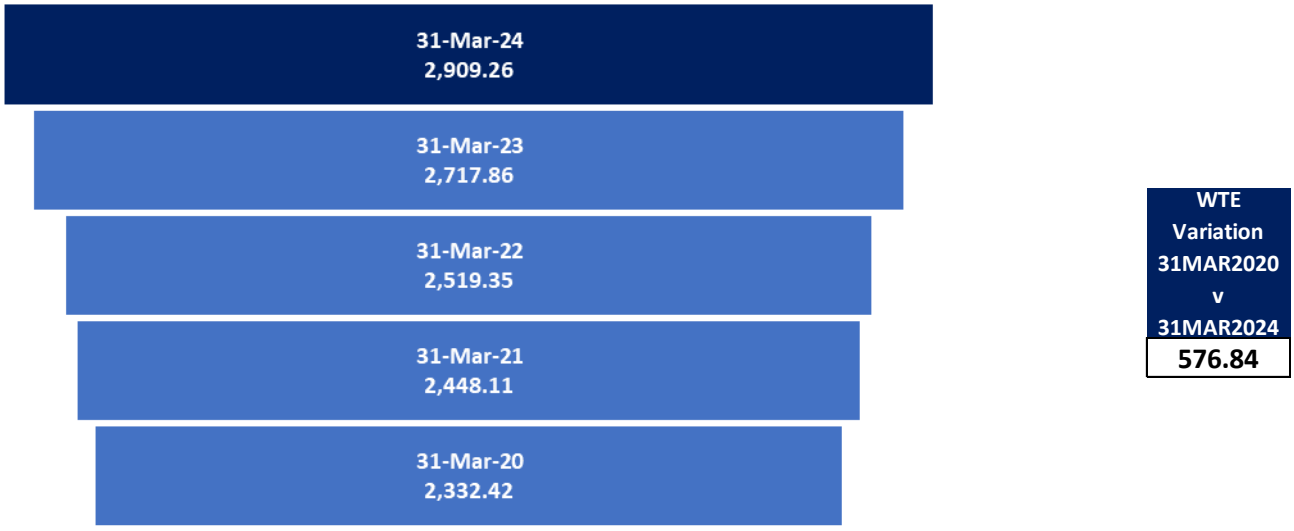
Annual turnover within the Trust is running at 12.04%, which is 0.34% higher than in the previous year. The highest level of turnover is within the Allied Health Professionals staff group running at 16.67%, followed by Additional Professional Scientific and Technical at 14.10% and Administrative & Clerical 14.01%.

The Trust's approach to hybrid and flexible working and initiatives like the new the 'Stay' discussions continue to help reduce those leaving the Trust and improve retention of the workforce.

DHcFT Workforce Supply (Turnover and Growth)



Annual turnover rates for the Trust remain below the National Mental Health (MH) and Learning Disabilities (LD) average of 12.31%. However, for the first time in several years are above the East Midlands MH and LD average of 11.03% for 2023/24. Historical turnover rates pre-2022 ran at around 10% and following a period of delayed natural turnover, in particular delayed retirements during the pandemic, turnover rates increased substantially during 2021/22. For the last two years, we have seen lower turnover rates. However, they remain higher than pre-pandemic levels. By continuing to improve staff retention we hope to help our workforce supply by reducing the number of staff we need to recruit to maintain existing staffing levels.



Contracted staff in post increased by 576.84 whole time equivalents (wte) during the period March 2020 to March 2024, representing workforce growth of 24.73% over and above turnover.

Further work continues over and above traditional recruitment to maximise all workforce supply routes to cover turnover and close the gap on vacancies for 2024/25. This work includes 12 Nurses from oversees recruitment, five Nurses and five Allied Health Professionals on a Return to Practice programme, 15 Apprenticeships (covering Trainee Nurse Associates, Mental Health Top Up programme and Allied Health Professionals) and a further four support role apprenticeships. There are also a further 163 preceptees, 110 in Nursing, 49 in the Allied Health Profession and four Scientific/Therapeutic/Technical Staff on track for completion during 2024/25.

5.0 Challenges and Risks

As a Trust and as a system, we recognise that there are a number of challenges which impact on the workforce, specifically:

- National shortage of key occupations
- Future commissions of key posts insufficient for current and expected demand
- Meeting the financial challenge.

We may not be able to retain, develop and attract enough staff to protect their wellbeing to deliver high quality care, potentially leading to:

- Risk to the delivery of high-quality clinical care including increase waiting times
- Exceeding of budgets allocated for temporary staff
- Loss of income.

In addition, the following areas impact on workforce recruitment and retention:

- Development opportunities for the existing workforce are limited
- Retention of staff in some key areas is difficult
- Sufficient funding to deliver alternative workforce solutions is constrained
- Maintaining a reputation as a great place to work
- Ensuring continued investment and support in apprenticeship programmes.

The main risk that we carry is around workforce supply with competing demand to meet our Cost Improvement commitment to the System which is echoed across the ICS. The existing demand on supply pipelines has increased, staff turnover remains high, in particular an increase in the number of retirements, and an aging workforce. Post-COVID, the Trust experienced higher levels of turnover and sickness absence than pre-COVID. However, we are now seeing a downward trend in both metrics.

There are also risks associated with the workforce for the Making Room for Dignity transformation programmes due to the scale of additional workforce needed, these include:

- Unable to grow the workforce if existing vacancies are not filled before the recruitment of additional staff
- Safe staffing numbers resourced by the ICB through the business cases is not achieved
- Understaffing due to difficulty recruiting qualified staff in specialty areas
- Loss of experienced staff during transition to new hospital
- Lack of experienced staff/mentors to support the high number of newly qualified staff
- Insufficiently skilled/trained workforce due to a lack of staff training pre-opening.

These risks are managed through the programme governance structures with agreed mitigating actions and identified risk owners.

6.0 Strategic Actions

Specific strategic actions that are in place or are considered to be required in order to support the delivery of the Trust's aims and workforce challenges, needs and aspirations are outlined below and grouped under the headings within the People Plan.

Looking After Our People

Throughout 2023/24, we have continued to offer key services and support to staff to maintain, enhance and improve staff health and wellbeing. Using the NHS health and wellbeing framework, we are able to ensure continuous commitment to staff wellbeing across the organisation.

In addition, the framework enables us to identify areas of improvement and new initiatives to support colleagues. Examples of changes we have been able to implement over the course of the last year are detailed below.

In May 2023, we merged our wellbeing champions network with Joined Up Care Derbyshire (JUCD) colleagues to create one, diverse network. We currently have 48 active and engaged champions within Derbyshire Healthcare and members of the JUCD network. The champions provide a key role in ensuring a wellbeing culture in teams and services.

Alongside our JUCD colleagues we launched 'Your Wellbeing Survey', building on work last year to understand the health needs of the workforce, the survey provides valuable data to ensure that we meet those needs and prioritise key areas.

By using valuable data, we have established a rolling training programme consisting of the following:

- Stress workshops
- Stress high impact interval training (HIIT) sessions
- Healthy working workshops
- Introduction to wellbeing
- Wellbeing conversation training.

We were able to secure funding to offer training for a limited number of staff to become grief first aiders, this training was delivered in November 2023 and the group have become wellbeing champions and offer their expertise via the wellbeing team.

The hobbee-hive, a craft and wellbeing drop-in session, funded by charitable funds, launched on the run up to Christmas in December 2023, where staff can try and learn different activities, have a coffee and chat to the team and colleagues. 95% of colleagues who gave us feedback scored the hobbee-hive between 8-10 stars, with 84% intending on continuing to craft in their own time.

Building on a model, implemented by our JUCD colleagues, we have been able to procure the equipment to offer staff Body MOTs to improve their awareness of their own physical health. Three planned sessions at different sites have delivered over 40 body MOTs and we will run a programme of sessions at sites across the county over the next year.

We were also successful in a bid to enable us to launch the 'Peak Challenge' the first of several physical activity challenges which will enable colleagues to make sustainable lifestyle changes, impacting on physical and mental health.

Using the health and wellbeing framework we have identified a number of improvements for 2024/25 which includes:

- Increasing awareness of the wellbeing offer through different communication methods
- Raising the profile of key areas including MSK issues and financial wellbeing through campaigns
- Upskilling and empowering staff to drive their own wellbeing agendas through targeted work with teams and services based on the NHS staff survey feedback, increasing the number of engaged wellbeing champions and producing guidance and materials for leaders
- Source training and establish a network for mental health first aiders
- Procure a database of mental health self-help support guides and deliver mental health awareness training
- Endeavour to understand more about the impact of wellbeing interventions.

Belonging in the NHS

Belonging in the NHS is one of the four pillars of the NHS People Plan. Together with our commitment to create a compassionate and inclusive culture in the NHS People Promise, the Trust is committed to making this a felt reality for everyone in our organisation. Equality, Diversity and Inclusion (EDI) sits at the heart of this approach for the benefit of our patients, local community, colleagues, and the people who we hope will join us for their future career.

Our Staff Survey results, and Workforce Race and Disability Equality Standard (WRES and WDES) reports show areas of positive progress in developing a workforce which is more representative of our local community, and this includes diversity in the most senior leadership level at the Trust. However, like other NHS Trusts, there have been persistent challenges in bullying, harassment, and discrimination, and in equitable opportunities for career progression. Tackling inequality and creating an environment in which all our people can thrive is essential to creating a great place to work and to receive care.

As a public sector organisation, we are committed to the objectives in the Public Sector Equality Duty to:

- Eliminate discrimination, harassment, and victimisation
- Advance equality of opportunity
- Foster good relations between people.

In 2024/25, the Trust is embarking on a wide-ranging review of organisational culture which will highlight areas where unfairness occurs and why and develop targeted actions to address them, as well as areas of good practice to build on. In addition, the Trust will be working towards the six High Impact Actions in the NHS England EDI Improvement Plan. The actions in the WRES and WDES reports this year have been brought together into five domain areas to improve our culture and benefit everyone who works with us:

- Leadership
- Creating and sustaining a culture of inclusion and belonging
- Addressing bullying, harassment, abuse, and discrimination
- Inclusive recruitment
- Career progression and promotion.

This work takes place within the legal framework of the Equality Act 2010 and national NHS guidance and, importantly, with our colleagues' voices and experiences at the heart of the process. Examples of ongoing projects aligned to the five domains above include:

1. A continued roll out of race equity training sessions and beginning work on an anti-racism strategy
2. A new process and extra support for providing reasonable adjustments for colleagues with disabilities and long-term health conditions
3. A reciprocal mentoring programme
4. Specific equality objectives for the Chief Executive and Chair
5. Re-design of mandatory EDI training for all colleagues.

New Ways of Working

New ways of working enable trusts to make the most of the skills within teams, with a key focus on upskilling staff and expanding capabilities. The principle behind this is that this creates a more flexible workforce, boosts morale, supports career progression and attracts new staff to the organisation.

Peer support workers (PSW) in DHcFT and other organisations. These support our Living Well teams. We have funding from Health Education England (HEE) to train PSW and we coordinate this across the system. There is also supervision training and team preparation for teams and supervisors to ensure that PSW are given the support required.
PSW apprenticeships we continue to explore apprenticeships for PSW.
Advanced Clinical Practitioners (ACP) in mental health are being trained to support out workforce in different ways.
Multisystemic Therapy (MST) - the use of technology has enabled staff to work more effectively. Look towards additional digital technologies for the future.
Retain and attract more Volunteers who play a vital support role in the Trust.

Growing for the Future

The Trust's ageing workforce continues to be a risk in terms of retaining specialist skills and knowledge. However, this is in line with the regional trend. Succession planning and talent management approaches, along with attraction strategies to increase representation of staff across all age groups, will be key to addressing this.

The Long-Term Workforce Plan has outlined the utilisation of Apprenticeship routes to provide 22% of all training for clinical staff by 2031/32 – up from an average of 7% today. As an employer of choice, the Wider Workforce team develops our workforce through an Apprenticeship First Approach.

This is for both new and existing employees, offering career pathways to support the growth and development of our current and future workforce.

Apprenticeship Initiatives include:
Internal and External apprenticeship recruitment for:
Clinical: Student Nursing Apprenticeships (SNA), Healthcare Support Workers, Pharmacy Technicians / Nurse degree / AHP – Speech and Language, Occupational Therapy, Physiotherapy & Dietetic.
Non-Clinical Apprenticeships: Leadership/Business Administration/Human Resources/Finance/ Estates and Facilities/Customer Service.
Widening Participation by supporting local Job fairs, recruitment events, offering Information Advice and Guidance on Apprenticeships, work experience opportunities, pre-employment programmes, T-Levels.
Local and System-wide working to align and further develop Apprenticeship pathways and widening participation pipelines in our local communities.

7.0 Recommendations

The board is asked to note this workforce plan and its contents and support the strategic actions outlined above.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2024

Flu and COVID Campaign Plan – Autumn/Winter 2024/25

Purpose of Report

To outline the Flu and COVID campaign for 2024/25 and the work undertaken to deliver the programme.

Executive Summary

- The HPU (Hospital Hub +) will lead on the work with support from peer vaccinators in key sites
- The Trust has purchased Flu vaccination doses based upon lessons learned for the 2023/24 campaign to minimise waste
- Additional Flu doses may be purchased if demand is higher than 2023/24
- COVID vaccine doses are procured throughout the campaign
- The NHSE foundry portal will be the principal reporting platform at ICB level, to allow comparison data against other organisations and COVID-19 programme
- ImmForm data submission is being reviewed by the National team
- Blended working and reduced footfall on key sites are an area of focus for the planning of this campaign
- The underpinning message of the campaign is on informed choice, to support discussion of facts and evidence and to respect personal choice
- The Joint Committee on Vaccination and Immunisation (JCVI) detail has yet to be released and will inform the eligible cohorts for this year
- All staff will be contacted via letter outlining their options and access to vaccination for this year.

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

- Hospital Hub + model enables staff and patient COVID vaccination, we would not otherwise be able to make this offer
- 75% target is ambitious in the context of declining vaccination rates across the NHS
- We will work closely with system partners to deliver a flexible and quality service building on the work we have undertaken over the last few years.

Consultation

- Joined Up Care Derbyshire (JUCD) Flu planning group
- Weekly Vaccine planning meeting (DHcFT)
- DCHS colleagues – Flu planning group
- People and Culture Committee.

Governance or Legal Issues

- Commissioning for Quality and Innovation (CQUIN) reporting requirement
- National Incident Management System (NIMS)/National Immunisation and Vaccination System (NIVS) (national vaccination recording database compliance)
- NHSE Hospital hub site approval process
- JCVI green book compliance and adherence to annual updates regarding eligible cohorts and advisories.

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:

Vaccination programmes have highlighted that uptake is significantly influenced by historic health inequalities and accessibility issues across a range of demographic groups and those with protected characteristics. This is noted amongst staff groups as well as those who access our services. The principle of 'proportionate universalism underpins the work of the team at trust level and across the JUCD system. Our data allows us insights into uptake amongst represented groups.

Recommendations

The Board of Directors is requested to receive the 2023/24 Flu Vaccination Campaign and note a full discussion has taken place in People and Culture Committee.

Report presented by: **Rebecca Oakley**
Director of People Services

Report prepared by: **Richard Morrow**
Assistant Director of Public and Physical Health Care

Flu and COVID Campaign 2024/25

The 2024/25 campaign is set to be run between October 2024 and February 2025, the pause of CQUINs for 2024/25 sees a shift in focus. Providers are expected to ensure that 100% of eligible staff are offered a vaccine to maximise uptake and reduce the risk to patients in our care. Although a target figure has not been announced for 2024/25 both vaccination programmes have had aspirations for 75% + uptake in recent years.

In 2023/24 the uptake rates for Flu (44%) and COVID (33%) were lower than we hoped and below the level that would give confidence our workforce and patients were adequately protected. Despite the challenges related to vaccine scepticism fuelled by misinformation, the vaccination programme remains the most effective way to reduce the risk to patents and increase and increase the resilience of the health workers.

The reporting period will begin in Q3 and run into Q4. There remains ongoing and significant concern about respiratory disorders and illness, everyone who works for the Trust (all staff groups) will be offered access to a vaccine. We have ordered 1,600 vaccines for DHcFT staff and patients. This is to reduce the wastage we saw last year and anticipating that our colleagues will access vaccinations off-site, as around a third of DHcFT staff did during the last campaign. The Trust can provide vaccine to colleagues with egg allergies/intolerance with no upper age limit. The vaccines are expected to be delivered during the last week in September.

Data collection for 2024/25, as in the previous year, is captured within two systems. The first is populated by ImmForm data, submitted by the Trust in accordance with the frontline health worker definition from the Joint Committee on Vaccination and Immunisation (JCVI) Influenza: the green book, chapter 19 - GOV.UK (www.gov.uk). This definition is open to interpretation and ambiguous in the JCVI document and the last definition provided was in 2021, in the Coronavirus » Operational Guidance: Vaccination of Frontline Health & Social Care Workers (england.nhs.uk). To this end, the Trust has offered all employees a vaccination for Flu and COVID since 2021. We have elected to only submit data for those we have vaccinated as Foundry data identifies those who have had the vaccination elsewhere through the National Incident Management System (NIMS) which the Trust is not able to replicate due to GDPR restrictions. As in previous years, the Trust notes that there is inconsistency between the CQUIN definition and the JCVI guidance regarding social care staff and will submit data as outlined in the detail of the letter circulated to trusts in 2021, unless otherwise directed. The JCVI states:

Immunisation should be provided to healthcare and social care workers in direct contact with patients/clients to protect them and to reduce the transmission of influenza within health and social care premises, to contribute to the protection of individuals who may have a suboptimal response to their own immunisations, and to avoid disruption to services that provide their care. This would include:

- *Health and Social care staff directly involved in the care of their patients or clients*
- *Others involved directly in delivering health and social care such that they and vulnerable patients/clients are at increased risk of exposure to influenza (further information is provided in guidance from UK health departments).*

The clarification guidance (Operational Guidance; Vaccination of Frontline Health and Social Care Workers. 2021) details the following as being eligible:

- *Staff working on the vaccination programme.*
- *Staff who have frequent face-to-face contact with patients and who are directly involved in patient care in either secondary or primary care, mental health, urgent and emergency care, and community settings.*
- *Those working in independent, voluntary, and non-standard healthcare settings such as hospices, and community-based mental health or addiction services.*
- *Laboratory, pathology, and mortuary staff*
- *Those working for a sub-contracted provider of facilities services such as portering or*
- *Temporary, locum or 'bank' staff, including those working in the COVID-19 vaccination programme, students, trainees, and volunteers who are working with patients.*
- *Frontline social care workers directly working with vulnerable people who need care and support irrespective of where they work (for example in hospital, people's own homes, day centres, or supported housing); or who they are employed by (for example local government, NHS, independent sector or third sector).*

The second report is taken form the NHSE FOUNDRY system. This includes all ESR staff and reconciles with the NIMS database and the Electronic Staff record (ESR) which reports all staff working for DHcFT. This report also provides uptake data by demographic and profession. Comparable data is also available for COVID vaccination taken from the same data sources, allowing exploration of the impact of work to support both campaigns and any differences identified in uptake.

The ICB confirms that the FOUNDRY data will be the benchmark data for providers in Derbyshire as it is felt to the most consistent, does not leave reporting or results open to individual organisations interpretation and is inclusive of the benefit that all colleagues provide to ensuring services are delivered throughout the Winter period. Since 2021, DHcFT has included an offer for all staff irrespective of their role or profession to have a vaccine supported by the trust campaign. It should be noted though that approximately a third of colleagues access a Flu vaccine form their GP or local pharmacy and these would not be included in our ImmForm submission.

There is regional and national concern about the reduced uptake amongst healthcare workers and the growing scepticism about the efficacy and validity of vaccination campaigns. We will be holding engagement sessions to explore with colleagues any concerns or questions that may help resolve or understand these issues in more detail.

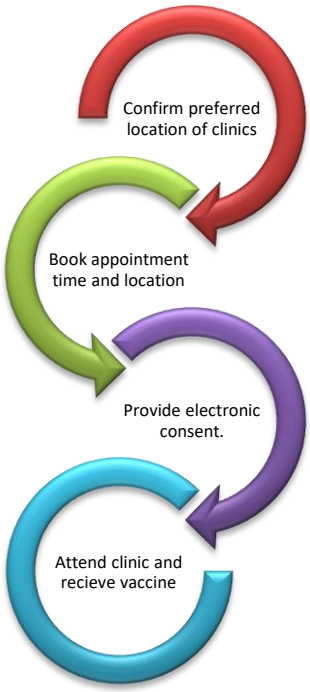
The vaccination campaigns over the last two years have been approached on a 'question asked – question answered', checking back to make sure that any further questions have been addressed. The focus of this year's campaign once again is to help people to **'make an informed choice'**.

We expect that most vaccines will be administered before mid-December 2024.

The method

The experience gained during the pandemic has seen rapid learning to realise Infection Prevention and Control (IPC) compliant and efficient clinic models which:

- Identify likely numbers per location using ESR data and liaison with local managers
- Pre-book appointments to allow clinics to match demand. In development for launch early September (dates and locations identified with Health Protection Unit (HPU) and DCHS colleagues)
- Virtual registration and consent process to streamline process
- Allocated vaccine awaiting staff on attendance. Clinics starting as vaccines arrive.



The clinics continue to utilise a locally evolved system of booking, administration, logistics oversight and internal reporting which are adapted to suit both flu and COVID clinic approaches and allow concomitant administration.

DHcFT continues to work closely with DCHS to develop a collegiate delivery programme for staff across both organisations.

Feedback from last year's campaign and lessons learnt has been previously shared – the below are some of the pertinent issues:

Planning and Engagement

- Wastage has been high as roughly 1/3 of all vaccines administered have been from Community services such as local Pharmacy, GP, etc. We have reduced the order quantity for 2024/25
- Early planning/engagement meetings with operational leads to plan and publicise the programme will commence in August to ensure that opportunities such as team meetings/ away days are utilised
- School holiday periods see very low uptake and bases are much quieter. Blended working models have been a challenge when attending team bases as numbers at site are notably lower than anticipated.

Communication

- Communications team are core to delivery. However, there seems to be less engagement with Trust-wide communications than before
- Focussed communications for staff which reinforce patient safety and informed choice message is important
- Personal testimonies remain a valuable engagement and promotion tool from senior leadership team and trusted colleagues

- Uptake of focus group/bespoke sessions was low during 2023/24 campaign. Informal feedback would suggest that vaccination has been a lower priority against other life/work challenges
- Reinforce that vaccination for colleagues is free and a work perk
- System approach to communications and materials is being explored
- Focus on facts as well as the importance of the programme in terms of protecting patients. Wording of campaigns is important
- HPU will write to all staff outlining where, how and when they can access a vaccine and provide link to booking system
- Increasing the number of roving clinics is helpful but resource heavy. Support from peer vaccinators has been requested to enable more localised vaccination work to take place.

National/System Level Reflections

- Promote Flu and COVID-19 separately to avoid confusion. However, being able to offer coadministration is helpful
- There has been a negative impact of mandatory vaccination programme and language and wording which connect to that campaign are detrimental to uptake
- Enable bulk uploads on NIVS (significant admin burden during this season's campaign)
- Positive meetings at system level provide opportunity to share good practice and enable collaboration between system partners is notable within the JUCD approach
- Publishing staff uptake rates not a helpful tool – can be off-putting as seen as corporate target as opposed to protecting people
- Review ethics of incentives for vaccination, system recommendation remains to avoid this approach
- Measles vaccination learning has identified that a cohort effect, where the children of families concerned about MMR vaccine are now parents themselves and appear to be concerned about vaccine safety for measles and other diseases, are voicing concern about vaccination efficacy
- Vaccination remains a popular topic across social media platforms with a significant amount of disinformation being circulated.

Data/Reporting

- Reconciliation of national systems data is tricky as ESR data figure has been hard to replicate
- Uptake data can be viewed by demographic characteristics, which is helpful to better understand uptake and inequality focus
- National dataset does not allow for individual or team vaccination rates to be explored
- Resolve the requirement for the Vaccination as a Condition of Deployment (VCOD) reporting and the PHE HCW ImmForm submissions
- Review uptake data with staff absence data (does vaccination equate to lower sickness or reduced risk of serious illness/transmission) to inform communications (the two do not appear to correlate locally).

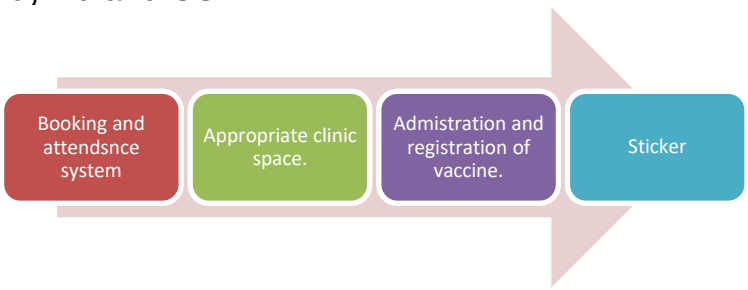
We have already begun to develop a Frequently Asked Questions (FAQ) based upon initial questions and feedback from colleagues and we will evolve this as the programme develops. Colleagues are interested in the relationship between the Flu and COVID-19, the association with future COVID-19 vaccination programme. The vaccine mandate which was intended to come into effect in early 2022 has polarised opinion towards vaccination and we continue the need to be sensitive to the impact/effect this has on uptake and vary our approach and communications accordingly. The focus on informed choice, to support discussion of facts and evidence and to respect personal choice.

Communications

The Trust will utilise its social media platforms (Facebook, Twitter, LinkedIn) and Communications team to ensure staff are aware of how and when to book into clinics. We have already initiated communications alerting staff to the plan to enable access as widely and easily as possible and have been responding to comments from staff raised through social media or direct feedback.

The **communication strategy** for 2024/25 is intentionally simple; the **focus is on informed choice**, to support discussion of **facts and evidence** and to **respect personal choice**. The offer to opt in or out is consciously avoided and we are asserting the expectation that people will want and access a **vaccine as a key patient safety initiative**.

Clinic Settings for Flu, Flu and COVID



Currently, we have several sites across Derbyshire including some of our team bases with clinic space.

- The clinic settings provide a clean room in line with IPC clinical guidance for the administration of vaccines and account for privacy and dignity requirements
- The clinics will have adequate cold storage capacity for the flu vaccines and fridges will be temperature checked and monitored in accordance with the medicines code
- The booking system DHcFT has developed and shared alongside DCHS will be utilised for efficiency and familiarity.

Staff Resource

The approach utilises some peer vaccinators (released from usual duties) and the HPU team. The vaccinators will be released to support the bookable clinics and roving vaccination programme. This is to enable the clinics to be accessible, efficient, IPC compliant and minimise disruption to service delivery.

The option for staff to attend in an ad hoc fashion is also available. In-patient staff will have on-site vaccinators able to facilitate vaccines as well.

The written instruction is being reviewed ahead of the vaccination programme and new and existing vaccinators will be inducted to assure competency and awareness of the systems and processes to allow safe and effective administration. A revised training package has been devised using a blended learning model of e-learning (bespoke package), MSM TEAMS group calls for questions and clarification of expectations and small group sessions for those who need additional information or support.

IT System Support and External Reporting

DHcFT's Information Management, Technology and Reporting (IMT&R) team has been instrumental in delivering the proposed model and enabling an efficient, user friendly and most importantly a minimum touch point system from both an IPC and time efficiency perspective.

The Trust COVID and Flu vaccination group will be weekly and have a reporting/escalation in place to support the organisation to track progress and escalate any local challenges.
DHcFT has worked closely with DCHS and is sharing learning to ensure that we learn from and contribute to system-wide learning. The challenges around written instructions and the legal aspects of the medicines code have been well discussed and we have a model which allows us to operate safely and with good governance within the scope of the medicines code and legislation through a Memorandum of Understanding.

Regarding gaps and challenges in coming weeks for consideration:

- Board Champion – Rebecca Oakley
- Incentive scheme – Local recommendation to avoid – stickers are still a useful and well received recognition of attending for vaccination
- Celebrating success – Oversight of uptake will be through the NHSE platform of Foundry as this provides demographic detail around uptake (no personally identifiable data) and correlates with COVID-19 vaccination programme data. ImmForm data is less reliable as it does not identify colleagues who have been vaccinated elsewhere
- QI approach – this is being applied to all stages and the Flu/COVID-19 programmes have been developed utilising QI methodology over the last five seasons
- The post-mandate effect and growing disquiet on social media about all vaccination programmes are expected to impact upon uptake rates
- Clear and simple message – supporting informed choice.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2024

Workforce Race Equality Standard (WRES) 2023/24 submission and, Workforce Disability Equality Standard (WDES) 2023/24

Purpose of Report

The attached reports are the Workforce Race and Disability Equality Standards (WRES and WDES). Both reports provide narrative to the WRES and WDES data sets submitted to NHS England by 31 August 2024. The data and narrative are accompanied by action plans which were approved by the People and Culture Committee on 24 September 2024.

Executive Summary

The WRES and WDES are nationally mandated data collection frameworks to enable NHS Commissioners and providers to measure race and disability equality in organisations. The indicators in each report are set out in turn with an explanation and show trends over time where possible.

The reports are to be published on the Trust's public website and so the data and explanations are presented in a straightforward manner to enable ease of understanding for the public and all colleagues in the Trust.

Rather than being stand-alone data exercises, the WRES and WDES are intended to form part of the broader equality, diversity, and inclusion landscape. Where appropriate, the actions arising from both reports are aligned with existing and new workstreams in People and Inclusion and with the six High Impact Actions in the NHSE EDI Improvement Plan. Individual actions are brought together into four areas:

1. Bullying, Harassment, Abuse and Discrimination
2. Inclusive Recruitment
3. Progression and Promotion
4. Culture of Inclusion and Belonging

It is proposed that the EDI Steering Group will have quarterly oversight of progress made towards these action areas, in addition to specifics in the six High Impact Actions. This will enable an ongoing dialogue with staff networks and representatives on a regular basis throughout the year.

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

Risks and Assurances

- The WRES and WDES datasets have been submitted to NHS England in time for the deadline of 31 August 2024
- The EDI Steering Group will have quarterly oversight on progress on the above action areas.

Consultation

The action plan will remain a live document and will be updated and co-owned with the BME and DAWN staff networks.

The reports and action plans were approved by the People and Culture Committee on 24 September 2024.

Governance or Legal Issues

Section 149 of the Equality Act sets out the Public Sector Equality Duty (PSED), which offers protection in relation to employment, as well as access to goods and services. The PSED strengthens the duty on employers to eliminate discrimination and advance equality of opportunity for staff with protected characteristics and foster good relations between people.

Public Sector Equality Duty & Equality Impact Risk Analysis

In complying with the WRES and WDES data collection and action plans, reports must identify the equality related impacts on the nine protected characteristics of age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. The REGARDS group of people includes people with Economic disadvantage in addition to others covered by protected characteristics.

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

- The WRES and WDES seek to measure some aspects of race and disability equality at the Trust. They provide useful numerical data which illuminate where the Trust has made progress and where further work is needed. The aggregated data model (BME and White, Disabled and non-Disabled) can risk overlooking disparities within groups, for example, different types of disability, and particular risks to groups based on intersectional identity, for example, additional discrimination experienced by ethnic minority women or those who identify as White from a Roma, Gypsy or Traveller identity
- Some of the disadvantages of the WRES and WDES are outlined in the reports and these can partially be overcome if supplemented with additional qualitative data which offer a richer picture of the lived experience of colleagues.

Recommendations

The Board of Directors is requested to:

1 Ratify the WRES and WDES reports and Action Plans, which were approved by the People and Culture Committee on 24 September 2024
2 Approve for publication on the Trust's public-facing website
3 Note the EDI Steering Group to have quarterly oversight on progress towards action areas with progress updates to the People and Culture Committee.

Report presented by: **Rebecca Oakley**
Director of People, Organisational Development and Inclusion

Report prepared by: **Alex Dougall**
Strategic Recruitment Lead

Lucy Moorcroft
HR and OD Project Lead

NHS
Derbyshire Healthcare
NHS Foundation Trust

Workforce Race Equality Standard (WRES)

Annual Report 2023/24

October 2024

Contents

Introduction

The Workforce Race Equality Standard (WRES) is a data collection framework which measures elements of race equality in NHS organisations. Implementing the WRES is a requirement for NHS Commissioners and NHS healthcare providers including independent organisations through the NHS contract.

The WRES is designed around nine indicators, or measures, which compare Black and Minority Ethnic (BME) colleagues and their White counterparts. We acknowledge and respect that not everyone is comfortable with the term "BME" and prefer other terms instead. However, in following national guidance, this report uses consistent terminology. We also acknowledge that comparing two groups has the disadvantage of masking disparities within each group.

Five indicators of the WRES are populated with workforce data from our Electronic Staff Record (ESR) and show comparative data for BME and White staff. This includes the distribution of staff in each pay band, access to training, likelihood of being appointed following shortlisting, likelihood of entering a formal disciplinary process, and representation in very senior leadership. The remaining four indicators are populated with comparative data from the national Staff Survey and includes: experiences of bullying, harassment, and abuse from colleagues and the public; discrimination, and perceptions of fairness in career progression. The Staff Survey data also shows us the engagement levels of BME and White staff comparatively. Numerical data[1] gleaned from the WRES provides a degree of insight into race equality at the Trust but is best used in conjunction with additional information (such as Freedom to Speak Up, employee relations and recruitment) and the qualitative data from the lived experiences of our colleagues themselves.

Each indicator is set out separately in this report with narrative content and main trends written in italics.

As a public service, our Trust is bound by the Public Sector Equality Duty and, as such, we are committed to:

- Eliminating unlawful discrimination, harassment, and victimisation
- Advancing equality of opportunity between people
- Fostering good relations between people.

In progressing towards these goals, the WRES data is accompanied by an action plan approved by the Trust Board of Directors.

[1] As a relatively small Trust, our numerical data expressed as percentages or ratios can be more prone to fluctuation. For example, where only a small number of staff are counted (fewer than 10), a small number of additional recruits, or leavers, can have a bigger impact on percentage scores than in larger groups of staff. In the report, we have highlighted where this might be the case and shown data trends over time to give the most accurate picture.

Context

The Trust serves the population of Derby City and Derbyshire County, both of which have different profiles in race and ethnicity. In the 2021 census, Derbyshire County was 6.3% BME[2]. In the NHS nationally, 22.4% of staff are from a BME background[3].

A snapshot of data taken on 31 March 2024 shows the total number of staff employed by Derbyshire Healthcare was 3308. Of these, 627 identified as BME and 2612 identified as White. There was no data recorded for 69 members of staff. The proportion of BME staff over time is as follows:

	2018	2019	2020	2021	2022	2023	2024
Total % of BME staff employed within the Trust as of 31 March	12.6	12.9	13.8	15.5	16.7	18.5	18.95%

From 2018 to 2024, the number of BME staff has increased from 314 to 627. This is an increase from 12.6% in 2018 to 18.95% in 2024. Trust diversity has increased year on year since 2018.

Indicator 1

Indicator 1 is a measure of staff distribution across pay bands (Under Band 1 to Very Senior Manager (VSM)). Data are collected in three main occupational groups: non-clinical, clinical (non-medical), and clinical (medical and dental). The figures as of 31 March 2024 and 2023 are shown in the following table. The headcount figure is the total headcount. The percentage figure is the proportion of BME or White staff *within* each pay band for that year. Percentage figures have been rounded up or down to whole numbers.

[2] Ethnic group, language and religion (arcgis.com)
[3] NHS England » NHS Workforce Race Equality Standard (WRES)2022 data analysis report for NHS trusts

Non-Clinical

	2024			2023		
Pay Band	BME # (%)	White # (%)	Unknown # (%)	BME # (%)	White # (%)	Unknown # (%)
Under Band 1	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0%)	0 (0%)	0 (0%)
Band 1	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0%)	0 (0%)	1 (100%)
Band 2	52 (26.3%)	137 (69.2%)	9 (4.5%)	50 (26%)	135 (70%)	7 (4%)
Band 3	22 (10.5%)	186 (89.0%)	1 (0.5%)	20 (10%)	174 (89%)	1 (1%)
Band 4	18 (11%)	142 (87.1%)	3 (1.8%)	18 (11%)	144 (88%)	1 (1%)
Band 5	17 (18.3%)	74 (79.6%)	2 (2.2%)	9 (11%)	71 (87%)	2 (2%)
Band 6	7 (11.7%)	52 (86.7%)	1 (1.7%)	5 (9%)	51 (89%)	1 (2%)
Band 7	2 (5.4%)	34 (91.9%)	1 (2.7%)	5 (15%)	27 (79%)	2 (6%)
Band 8a	0 (0.0%)	21 (100.0%)	0 (0.0%)	0 (0%)	21 (100%)	0 (0%)
Band 8b	0 (0.0%)	17 (100.0%)	0 (0.0%)	0 (0%)	12 (100%)	0 (0%)
Band 8c	1 (9.1%)	10 (90.9%)	0 (0.0%)	1 (9%)	10 (91%)	0 (0%)
Band 8d	0 (0.0%)	4 (100.0%)	0 (0.0%)	0 (0%)	4 (100%)	0 (0%)
Band 9	0 (0.0%)	2 (100.0%)	0 (0.0%)	0 (0%)	5 (100%)	0 (0%)
VSM	1(16.7%)	5 (83.3%)	0 (0.0%)	1 (20%)	4 (75%)	0 (0%)

In 2024, the overall percentage of BME staff in non-clinical roles (14.6%) is slightly lower than the figure across the whole Trust (18.95%). 61.6% of the total number of BME staff are concentrated in Bands 2 and 3 (2023 it was 64.2%). Despite a reduction of BME staff in bands 2 and 3 from 2023, in 2024 47.2% of White staff were in the equivalent bands. 1.7% (2 people) of the total number of BME staff are in roles at Band 8a and above compared to 8.6% of White staff (59). In terms of the total number of staff at 8a and above 3.3% are BME and 96.7% White[4].

[4] Unknowns have been excluded for this narrative paragraph.

Further work needs to be done to understand barriers to BME progress in non-clinical roles at band 8a and above. As there is less roles at higher bands, progression needs to be monitored over a longer period and reviewed alongside staff survey training data and leaving reasons for BME staff.

Clinical (non-medical)

	2024			2023		
Pay Band	BME # (%)	White # (%)	Unknown # (%)	BME # (%)	White # (%)	Unknown # (%)
Under Band 1	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0%)	0 (0%)	0 (0%)
Band 1	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0%)	0 (0%)	0 (0%)
Band 2	1 (7.7%)	12 (92.3%)	0 (0.0%)	1 (25%)	3 (75%)	0 (0%)
Band 3	118 (29.7%)	265 (66.8%)	14 (3.5%)	112 (29%)	259 (29%)	12 (3%)
Band 4	16 (10.5%)	135 (88.8%)	1 (0.7%)	16 (12%)	114 (87%)	1 (1%)
Band 5	115 (28.5%)	280 (69.3%)	9 (2.2%)	84 (25%)	245 (72%)	11 (3%)
Band 6	97 (12.2%)	685 (86.4%)	11 (1.4%)	92 (12%)	649 (86%)	11 (1%)
Band 7	41 (10.6%)	338 (87.8%)	6 (1.6%)	36 (10%)	315 (88%)	7 (2%)
Band 8a	14 (13.6%)	88 (85.4%)	1 (1.0%)	13 (14%)	78 (85%)	1 (1%)
Band 8b	3 (5.5%)	51 (92.7%)	1 (1.8%)	4 (8%)	45 (92%)	0 (0%)
Band 8c	3 (16.7%)	15 (83.3%)	0 (0.0%)	2 (12%)	15 (88%)	0 (0%)
Band 8d	0 (0.0%)	4 (100.0%)	0 (0.0%)	0 (0%)	5 (100%)	0 (0%)
Band 9	1 (50.0%)	1 (50.0%)	0 (0.0%)	1 (100%)	0 (0%)	0 (0%)
VSM	0 (0.0%)	0 (0%)	0 (0.0%)	0 (0%)	0 (0%)	0 (0%)

The overall percentage of BME staff in clinical (non-medical) roles is slightly lower (17.6%) than the Trust average. Further analysis of groups of staff can bring some of the disparities into sharper focus. For example, the majority of registered nurses (amongst others) are employed at Bands 5, 6 and 7 and, to an extent, the band increase represents career progression.

For Bands 8a and above BME staff comprise of 11.7% of the workforce (2023 was 12.2%) and White staff 88.3%. 5.1% of BME staff are in bands 8a and above compared to 8.5% of white staff. Although this has not changed considerably from the previous year, further action is required to understand barriers to BME applying for and/or being appointed to Band 8a and above jobs.

As there are less roles at higher bands, progression needs to be monitored over a longer period and reviewed alongside staff survey training data and leaving reasons for BME staff.

Clinical (medical and dental)

In Clinical (Medical and dental) roles, the disparity is not represented by total numbers in the same way for other groups. For this staff group, disparities can include clinical awards, academic posts, and fitness to practice referrals. This is analysed further in the Medical WRES (MWRES) which will be published in February 2025.

	2024			2023		
	BME # (%)	White # (%)	Unknown # (%)	BME # (%)	White # (%)	Unknown # (%)
Consultants	46 (58.2%)	30 (38.0%)	3 (3.8%)	50 (62%)	29 (36%)	2 (3%)
of which senior medical manager	8 (72.7%)	2 (18.2%)	1 (9.1%)	1 (100%)	0 (0%)	0 (0%)
Non-consultant career grade	25 (62.5%)	14 (35.0%)	1 (2.5%)	22 (58%)	15 (40%)	1 (3%)
Trainee grades	27 (64.3%)	10 (23.8%)	5 (11.9%)	24 (62%)	12 (30%)	3 (7%)
Other				0 (0%)	0 (0%)	0 (0%)

Indicator 2

Relative likelihood of staff being appointed from shortlisting across all posts calculated for the 12 months prior to 31 March in the reporting year. If a candidate is shortlisted, it means they have met the person specification criteria to be interviewed for the post they are applying for.

Indicator 2 is expressed as a “disparity ratio” where complete parity, or equality, is represented by the number 1. A number of 2 would be that a shortlisted candidate is twice as likely to be appointed. In Indicator 2, a number above 1 shows the extent to which a White candidate is more likely to be appointed. The table below shows this trend over the past 5 years.

	2019	2020	2021	2022	2023	2024
Indicator 2	2.86	2.02	1.60	1.78	1.75	2.1

Indicator 2 shows a continuing disparity over time and the ratio increased in 2024 from 1.75 to 2.1. Given the overall large numbers of shortlisted and appointed candidates, there is a possibility that the overall figure masks wider disparities in particular areas and bands.

In 2024 more BME applicants were shortlisted for interview (960) compared to 2023 (834), however in 2024 the number of BME applicants appointed dropped from 102 in 2023 to 97 in 2024. The number of white applicants shortlisted also dropped by 2245 in 2023 to 1827 in 2024 and the number appointed also dropped from 480 in 2023 to 390. In 2024 white applicants were more likely to get the job than BME applicants when shortlisted.

The drop in applications shortlisted could be linked to types of roles being advertised. Further analysis is required to understand the roles where BME applications have been shortlisted and reasons as to why they have not been successful. The numbers of withdrawals for shortlisted candidates will be monitored to see if there is any trends in this data and an understanding of the diversity of applicants by band will help identify specific issues across the Trust.

There is also external factors that can have an impact on applications for certain roles such as government changes to immigration polices so the impact this has on application numbers can be reviewed.

Indicator 3

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. A figure above 1 would indicate BME staff are more likely to enter the formal disciplinary process.

	2018	2019	2020	2021	2022	2023	2024
Indicator 3	3.03	2.45	1.43	10.52	0.0	2.70	2.1
No of cases	Un-available	BME 5 White 13	BME 2 White 11	BME 2 White 1	BME 0 White 4	BME 8 White 5	BME 2 White 4

This indicator shows the likelihood of entering formal discipline compared to the proportion of BME and White staff in the whole organisation. In summary, the disparity ratio in 2021 shows the greatest disparity but this score is unrepresentative of the small number of total discipline cases overall. The potentially more concerning figure is in 2023.

The numerical data here is of some value but needs supplementing with qualitative data to understand the full picture behind the cases. In 2024 there is a reduction in the number cases for BME employees, but the overall pattern remains that BME staff are proportionately more likely to enter formal discipline than are White staff.

Indicator 4

Relative likelihood of staff accessing non-mandatory training and CPD. A figure above 1 would indicate BME staff are less likely to access non-mandatory training and CPD.

	2018	2019	2020	2021	2022	2023	2024
Indicator 4	1.53	0.97	1.13	1.52	0.73	1.31	0.84

This disparity ratio applies to all staff so is more likely to be an accurate representation and the trend over time is of greater parity than some other indicators. When read against indicator 7 (perceptions of fairness in career progression and promotion) we can see that a wide disparity remains. This indicates that BME staff are more likely to access non-mandatory training and CPD.

It may be that there is more equitable access to professional development learning, but this is not translating into progression so further work needs to be done to understand the barriers to progression for BME staff across services.

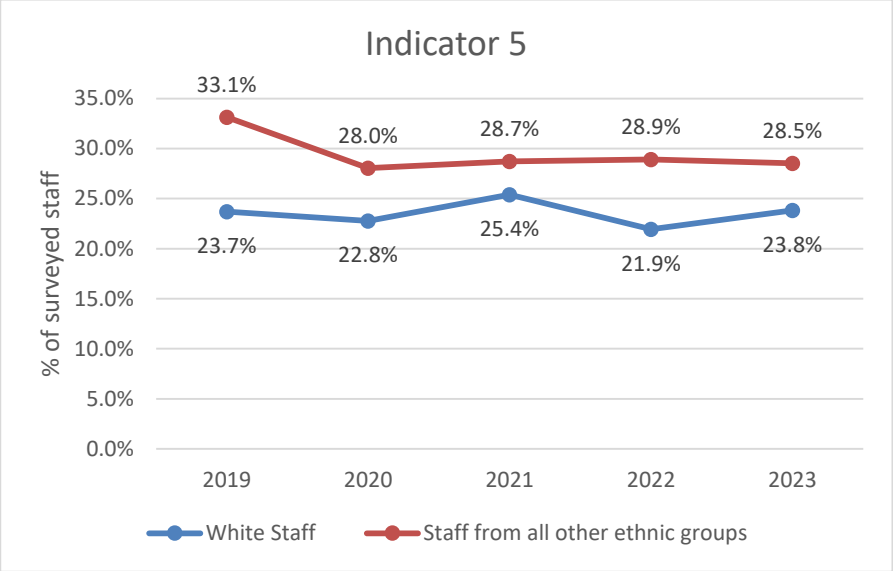
Indicators 5-8

Data for the following Indicators are taken from the staff survey[5] and do not include figures for 2024 as those results will be published in 2025. A benchmarking report compares Derbyshire Healthcare to other Mental Health and Learning Disability Trusts (51 organisations are in the benchmarking group).

[5] The full data set is available here: NHS Staff Survey Benchmark report 2022 (nhsstaffsurveys.com)

Indicator 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or members of the public in the last 12 months.



In 2022, the percentage for BME staff experiencing harassment, bullying or abuse from patients, relatives or members of the public was 28.9% and has reduced slightly in 2023 to 28.5%.

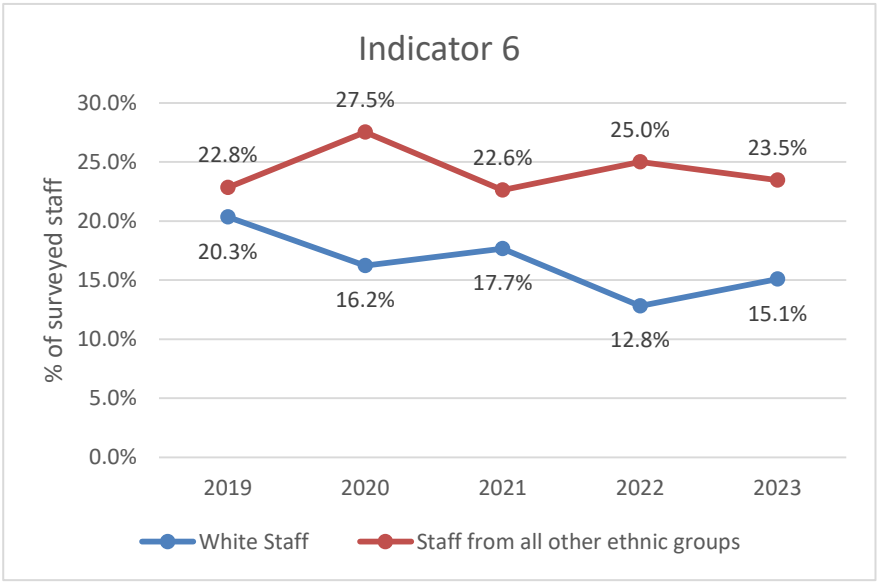
Since 2020 this figures has been increasing until 2023 showing a slight drop.

The 2022 figure for White staff is 21.9% and has increased in 2023 to 23.8%.

Out of the respondents to the staff survey (62% of the total number of staff), 74 BME staff and 324 White staff reported being harassed, bullied, or abused by patients, relatives or members of the public.

Indicator 6

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

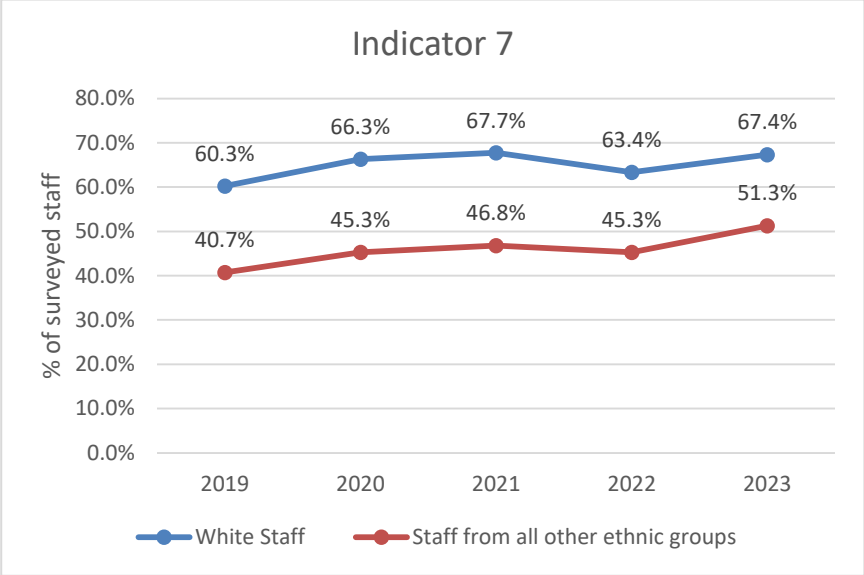


In 2023, the percentage of BME staff experiencing harassment, bullying or abuse from staff was 23.5% compared to 15.1% for White staff. Incidents of harassment, bullying and abuse from other staff has steadily reduced since 2020 for both groups over time but a persistent disparity has remained.

Out of the respondents to the staff survey (62% of the total number of staff), 59 BME staff and 236 White staff reported being harassed, bullied, or abused by their colleagues.

Indicator 7

Percentage believing that the Trust provides equal opportunities for career progression or promotion.



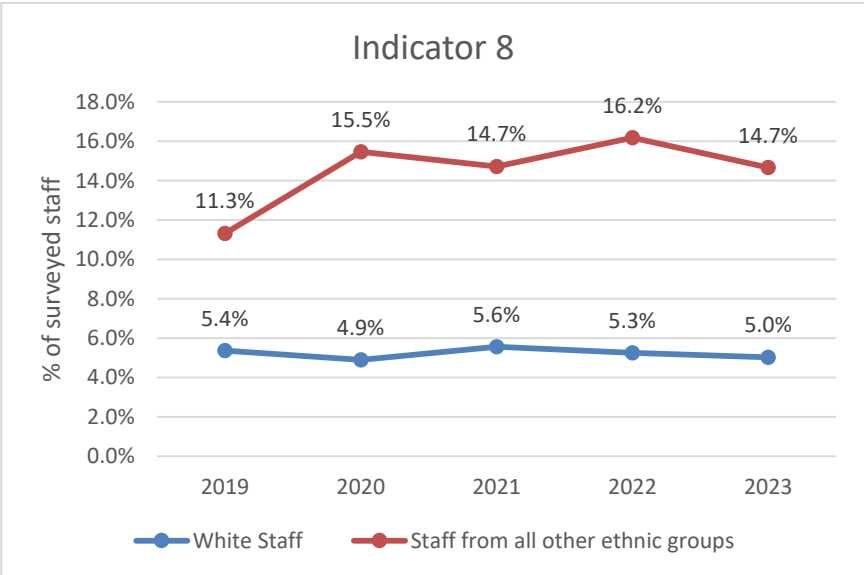
In 2023, the percentage for BME staff believing that the trust provides equal opportunities for career progression was 51.3% compared to 67.4% for White staff. Figures for both groups have steadily improved over time, but a wide and persistent disparity remains.

Out of the respondents to the staff survey, 136 BME staff and 1076 White staff believed the Trust provides equal opportunities for career progression and promotion.

Over time, the picture at the Trust is largely consistent with other trusts in the benchmarking group. Compared to that group, our figure is marginally higher for White staff at the trust and lower for BME staff.

Indicator 8

Percentage of staff who have personally experienced discrimination at work from their manager/team leader or other colleagues in the last 12 months.



In 2023, the percentage of BME staff who have personally experienced discrimination at work from their manager/team leader or other colleagues was 14.7% compared to 5% for White staff. Apart from the outlier figure for BME staff in 2019, the data has remained consistent for both groups over time and a persistent disparity remains.

Out of the respondents to the staff survey (62% of the total number of staff), 39 BME staff and 79 White staff experienced discrimination from their manager, team leader or other colleagues.

The data mirrors the national trend against the benchmarking groups.

Indicator 9

Percentage difference between the organisation's Board voting membership and the overall workforce. This Indicator shows the representation of BME staff by comparing two figures: the percentage of BME staff in the organisation, the percentage of BME voting membership at the Board, and then working out the difference.

The percentage below is the difference between the two figures. In 2024, the percentage figure for BME staff across the whole workforce is 18.95% and the percentage for BME voting Board members is: 38.5%. The difference is therefore 19.55%. The previous year difference was 14.8%.

Conclusions

The WRES provides NHS trusts with a series of quantitative measures which demonstrate race disparity. WRES data has been collected since 2018 from which we can assess trends over time. We can also draw some conclusions about what is and isn't working to improve race equality at the Trust.

Positive progress has been made year-on-year to maximise opportunities at the Trust for minority communities and this has resulted in a more representative total staff group. Over the past two years we have also increased ethnically diverse leadership at Board level. This gives the Trust a firm basis in making progress towards equality.

However, as demonstrated above, there are issues with bullying, harassment and discrimination from colleagues, managers, and members of the public. Although these have reduced since 2022 these are still higher than white colleagues are experiencing.

There is also large disparities between BME and White employees who believe that the Trust provides equal opportunities for career progression or promotion.

We also know that the figures show BME staff in many occupational groups are overly represented in lower pay bands for both clinical and non-clinical roles (excluding medical roles) and there is a continuing disparity in many mid-level to senior leadership posts. More must be done to understand the reasons why BME staff are not progressing and/or appointed to roles at 8a and above.

Analysing numerical WRES data tells us the "what", and we are committed to further investigation into the "why". To maximise the effectiveness of the WRES, the indicator measures and accompanying actions will be an integral part of wider culture transformation at the Trust.

Action Plan

Quarterly oversight of the WRES actions sits with the Equality, Diversity & Inclusion (EDI) Steering Group which is chaired by the Director of People, Organisational Development and Inclusion and the Director of Nursing, AHPs, Quality and Patient Experience. The group brings together colleagues in key corporate roles, with staff networks and staff representatives. In June 2023, NHS England published its EDI Improvement Plan[6] with six high impact actions, some of which are aligned to the WRES objectives below.

Action Area	Activities	Who The EDI Steering Committee will be sighted on all actions and review progress at quarterly meetings	When	Status
Bullying, Harassment, Abuse & Discrimination	Candidates put forward for the Active Bystander Train-the-Trainer programme as well as visual displays to support the active bystander initiative	EDI Team and others (in progress)	2024/25	In progress
	Deliver facilitated sessions on "Understanding & Talking About Race"	EDI Team	2024/25	Ongoing
Inclusive Recruitment	Deliver Chair of panel inclusive recruitment and selection training	Strategic Recruitment Lead	January 2025	Ongoing
	Review and monitor outcomes of BME applicants shortlisted to try to identify trends and themes in outcomes	Strategic Recruitment Lead	January 2025	Ongoing
	Review withdrawal data of applicants to understand if this disproportionally disadvantages particular groups	Strategic Recruitment Lead	2024/25	To be commenced
	Run EDI spotlight events throughout the year to raise awareness of EDI issues	Head of EDI / Head of Resourcing	2024/25	To be commenced
Progression and Promotion	Review of Recruitment Inclusion Guardians	Head of EDI / Strategic Recruitment Lead	2024/25	To be commenced
	Develop specific actions related to JUCD career aspirations and barriers questionnaire for BME colleagues	Deputy Director of People & Inclusion	March 2025	Ongoing

[6] NHS equality, diversity, and inclusion improvement plan (england.nhs.uk)

	Understand Barriers for progression of BME staff in both clinical and non-clinical roles	OD Lead, Head of EDI	January 2025	To be commenced
	Audit outcomes of interviews for BME staff for band 8A and above jobs	Strategic Recruitment Lead	January 2025	To be commenced
Culture of Inclusion and Belonging	Anti Racism strategy development and implementation	Head of EDI	March 2025	Ongoing
	Utilising exit interviews to understand reasons for BME staff leaving the Trust	Head of EDI	October 2024	Ongoing
	Implement divisional actions plans based on staff survey data and results	Head of EDI / EDI team	March 2025	To be commenced

Derbyshire Healthcare
NHS Foundation Trust

Workforce Disability Equality Standard (WDES)

Annual Report 2023/24

October 2024

Contents

Introduction

The Workforce Disability Equality Standard (WDES) is a data collection framework which measures elements of disability equality in NHS organisations. Implementing the WDES is a requirement for NHS Commissioners and NHS healthcare providers including independent organisations through the NHS contract.

The WDES is designed around ten indicators, or measures, which compare disabled colleagues and their non-disabled counterparts. We acknowledge and respect that some people with disabilities do not refer to themselves as Disabled, denoting this part of their identity. However, in following national guidance, this report uses consistent terminology and refers to "disabled staff" or staff with a 'Long lasting condition or illnesses. We also acknowledge that comparing two groups has the disadvantage of masking disparities within each group.

Four indicators of the WDES are populated with workforce data from our Electronic Staff Record (ESR) and show comparative data for disabled and non-disabled staff. This includes the distribution of staff in each pay band, likelihood of being appointed following shortlisting, likelihood of entering a formal capability process, and representation in very senior leadership. A further five indicators are populated with comparative data from the national Staff Survey and includes: experiences of bullying, harassment, and abuse; discrimination, feeling pressure to come into work while unwell, engagement and perceptions of fairness in career progression. The remaining metric refers to whether the voices of disabled staff are heard within the organisation.

Numerical data[1] from the WDES provides a degree of insight into race equality at the Trust but is best used in conjunction with additional information (such as Freedom to Speak Up, employee relations and recruitment) and the qualitative data from the lived experiences of our colleagues themselves. The data on ESR relating to our disabled staff is incomplete although this has increased in accuracy following a concerted effort to improve. This is explored below in more detail.

Each indicator is set out separately in this report with narrative content and main trends written in italics.

As a public service, our Trust is bound by the Public Sector Equality Duty and, as such, we are committed to:

- Eliminating unlawful discrimination, harassment, and victimisation
- Advancing equality of opportunity between people
- Fostering good relations between people.

[1] As a relatively small Trust, our numerical data expressed as percentages or ratios can be more prone to fluctuation. For example, where only a small number of staff are counted (fewer than 10), a small number of additional recruits, or leavers, can have a bigger impact on percentage scores than in larger groups of staff. In the report, we have highlighted where this might be the case and shown data trends over time to give the most accurate picture.

In progressing towards these goals, the WDES data is accompanied by an action plan approved by the Trust Board of Directors.

Context

The Trust serves the population of Derby City and Derbyshire County, both of which have different profiles in terms of disability. In the 2021 census, data shows the percentage of people indicating that their day-to-day activities were limited by a long-lasting condition or illness. In Derbyshire the figure was 20.1%. This definition is unlikely to cover various conditions which might be defined as a disability. Similarly, the NHS Staff Survey asks whether staff have a disability or long-term condition, and this is recorded differently on ESR as solely a disability. This slightly hinders getting accurate data, however, the WDES does indicate clear trends and disparities between disabled and non-disabled staff.

Figures from the Department for Work and Pensions in 2021/22 indicate that 24% of the total population have a disability[2]. The Trust in 2024 had 10.25% who disclosed a disability which is below the Derbyshire County average.

A snapshot of data taken on 31 March 2024 shows the total number of staff employed by Derbyshire Healthcare was 3308. Of these, 339 identified as disabled, 2475 identified as non-disabled. There was no data recorded for 494 members of staff. The recorded proportion of disabled staff over time is as follows:

	2018	2019	2020	2021	2022	2023	2024
Total % of disabled staff employed within the Trust as of 31 March	Un-available	4.5% (115)	4.4% (117)	5.3% (149)	6.7% (194)	8.9% (273)	10.25% (339)

Indicator 1

Indicator 1 is a measure of staff distribution across pay bands (Under Band 1 to Very Senior Manager (VSM). Data are collected in three main occupational groups: non-clinical, clinical (non-medical), and clinical (medical and dental). The figures as of 31 March 2024 and 2023 are shown in the following table. The headcount figure is the total headcount. The percentage figure is the proportion of disabled or non-disabled staff *within* each pay band for that year. Percentage figures have been rounded up or down to whole numbers.

[2] UK disability statistics: Prevalence and life experiences - House of Commons Library (parliament.uk)

Non-Clinical

	2024			2023		
Pay Band	Disabled # (%)	Non-disabled # (%)	Unknown # (%)	Disabled # (%)	Non-disabled # (%)	Unknown # (%)
Cluster 1 Bands <1 to 4	50 (8.8%)	431 (75.6%)	89 (15.6%)	45 (8%)	402 (73%)	104 (19%)
Cluster 2 Bands 5 to 7	18 (9.5%)	149 (78.4%)	23 (12.1%)	19 (11%)	132 (76%)	22 (13%)
Cluster 3 Bands 8a to 8b	8 (21.1%)	23 (60.5%)	7 (18.4%)	6 (18%)	19 (58%)	8 (24%)
Cluster 4 Bands 8c to 9 and VSM[3]	0 (0.0%)	18 (78.3%)	5 (21.7%)	1 (4%)	21 (84%)	3 (12%)

Clinical

	2024			2023		
Pay Band	Disabled # (%)	Non-disabled # (%)	Unknown # (%)	Disabled # (%)	Non-disabled # (%)	Unknown # (%)
Cluster 1 Bands <1 to 4	51 (9.1%)	413 (73.5%)	98 (17.4%)	41 (8%)	372 (72%)	105 (20%)
Cluster 2 Bands 5 to 7	188 (11.9%)	1185 (74.9%)	209 (13.2%)	140 (10%)	1091 (75%)	219 (15%)
Cluster 3 Bands 8a to 8b	15 (9.5%)	129 (81.6%)	14 (8.9%)	13 (9%)	112 (79%)	16 (11%)
Cluster 4 Bands 8c to 9 and VSM	2 (8.3%)	19 (79.2%)	3 (12.5%)	1 (4%)	20 (87%)	2 (9%)
Cluster 5 Medical and Dental Staff-Consultants	4 (5.1%)	53 (67.1%)	22 (27.8%)	5 (6%)	52 (64%)	24 (30%)
Cluster 6 Medical and Dental Non-consultant career grade	1 (2.5%)	27 (67.5%)	12 (30.0%)	1 (3%)	22 (58%)	15 (39%)
Cluster 7 Medical & Dental Trainees	2 (4.8%)	28 (66.7%)	12 (28.6%)	1 (3%)	27 (69%)	11 (28%)

[3] Very Senior Manager

The number of unknowns has reduced, and the overall percentage of recorded disabled staff has steadily increased. This gives us more confidence in the data derived from ESR.

Indicator 2

Relative likelihood of staff being appointed from shortlisting across all posts calculated for the 12 months prior to March 31 in the reporting year. If a candidate is shortlisted, it means they have met the criteria to be interviewed for the post they are applying for.

Indicator 2 is expressed as a "disparity ratio" where complete parity, or equality, is represented by the number 1. A number of 2 would be that a candidate is twice as likely to be appointed. In Indicator 2, a below above 1 shows the extent to which a non-disabled candidate is more likely to be appointed. The table below shows this trend over time.

	2018	2019	2020	2021	2022	2023	2024
Indicator 2	2.88	1.40	1.05	1.05	1.04	1.17	0.76

The data indicates that candidates who have a disability are more likely to be appointed than those who do not. Although there is no direct evidence of this, training to managers on awareness of disabilities and putting reasonable adjustments in place at the candidate's request may increase the chance of disabled applicants being successful at selection events. Further guidance and awareness is required to ensure applicants feel they can request reasonable adjustments and managers have the knowledge to implement these effectively. Further work needs to be undertaken to encourage staff to have the confidence to disclose disabilities.

The clear trend over time shows that there is a reduced disparity in shortlisting. However, caution should be exercised given the large numbers of shortlisted and appointed candidates. The more disability data that is submitted will allow for better data to be reviewed for future returns. There is a possibility that the overall figure masks some disparities in particular areas. Further data analysis is required to look at shortlisting in relation to different types of disability and progression.

Indicator 3

Relative likelihood of staff entering the formal capability process, as measured by entry into a formal capability process. This is calculated for the 12 months prior to 31 March in the reporting year. From 2022 this is calculated over a 2-year period and the figure divided by two, hence the appearance of halves in the headcount figure. A figure above 1 would indicate disabled staff are more likely to enter the formal capability process.

	2018	2019	2020	2021	2022	2023	2024
Indicator 3	Un-available	0.0	0.0	0.0	0.0	0.0	0.0
Average Headcount Disabled Non-disabled	Un-available	0 0	0 0	0 0	0 0.5	0.5 1.5	0.5 1.5

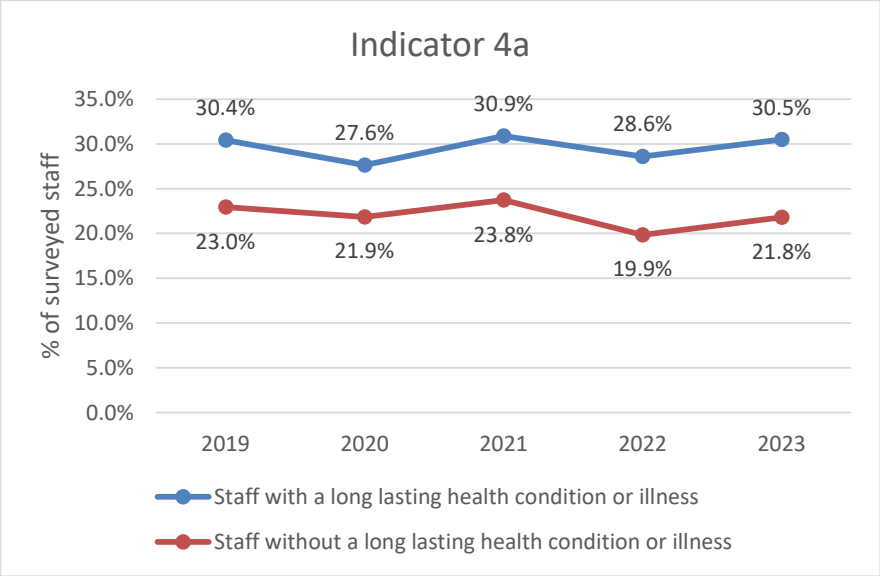
Given the very low number of formal capability cases overall, this Indicator offers limited insight into the comparative experiences of disabled and non-disabled staff when there are performance concerns. This will need to be monitored over a longer period.

Indicators 4a to 9b

Data for the following Indicators are taken from the staff survey[4] and do not include figures for 2024 as those results will be published in 2025. The data from the staff survey refers to staff who indicate they have a "long lasting health condition or illness" rather than a disability. This is due to the staff survey and ESR collecting information in a different way. A benchmarking report compares Derbyshire Healthcare to other Mental Health and Learning Disability Trusts (51 organisations are in the benchmarking group).

Indicator 4a

Percentage of staff experiencing harassment, bullying or abuse from patients, service users or members of the public in the last 12 months.



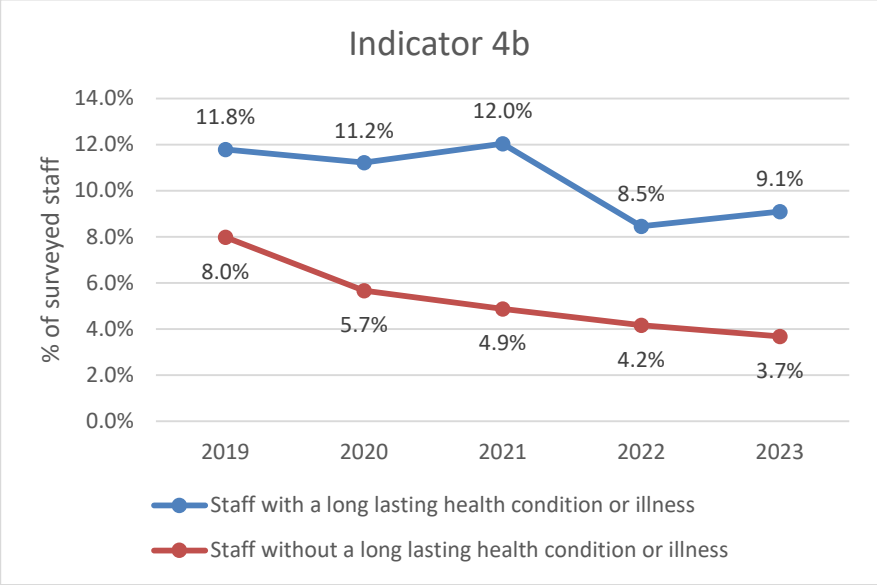
In 2023, the percentage of staff with a long-lasting health condition that experienced harassment, bullying or abuse from patients, service users or members of the public was 30.5% compared to 21.8% of staff without a long-lasting condition. The figure for both groups has slightly increased this year.

The Trust figures are lower than those in the benchmarking group.

[4] The full data set is available here: NHS Staff Survey Benchmark report 2022 (nhsstaffsurveys.com)

Indicator 4b

Percentage of staff experiencing harassment, bullying or abuse from their managers in the last 12 months.

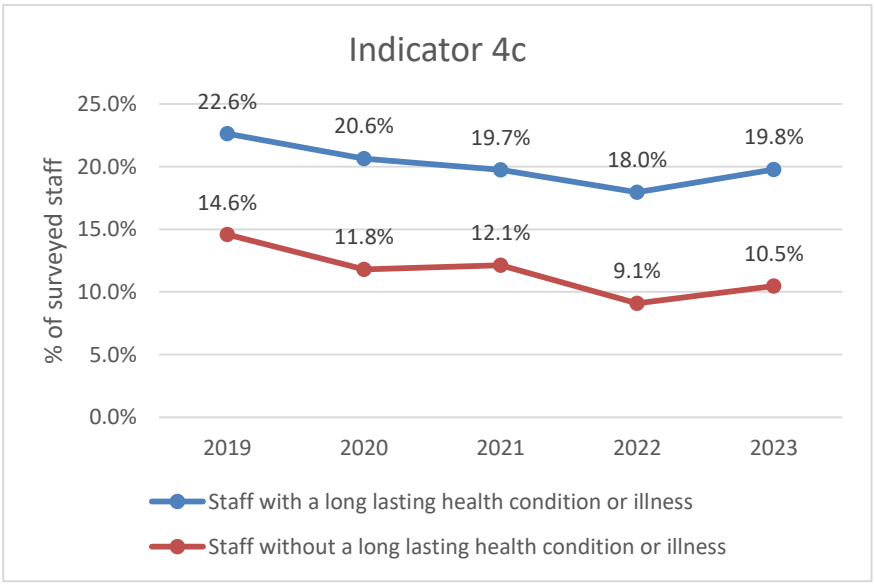


In 2023, the percentage of staff with a long-lasting health condition that experienced harassment, bullying or abuse from their manager was 9.1% compared to 3.7% of staff without an LTC. The figure for both groups has fallen steadily and show a downward trend with a slight spike this year for those with long lasting conditions.

The Trust figures are lower than those in the benchmarking group.

Indicator 4c

Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.

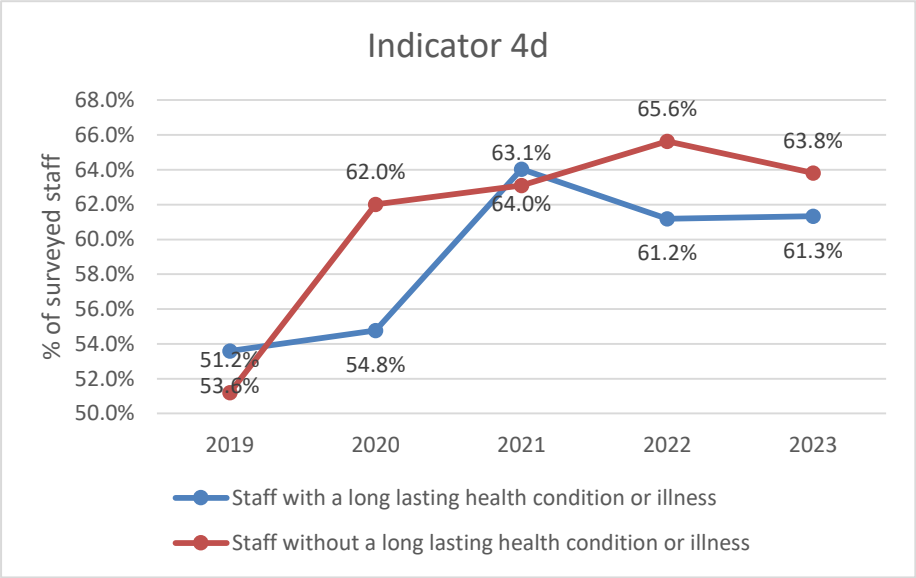


In 2023, the percentage of staff with a long-lasting health condition that experienced harassment, bullying or abuse from colleagues was 19.8% compared to 10.5% of staff without a long-lasting condition. The figure for both groups has been decreasing over time until this year.

The Trust figures are lower than those in the benchmarking group.

Indicator 4d

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

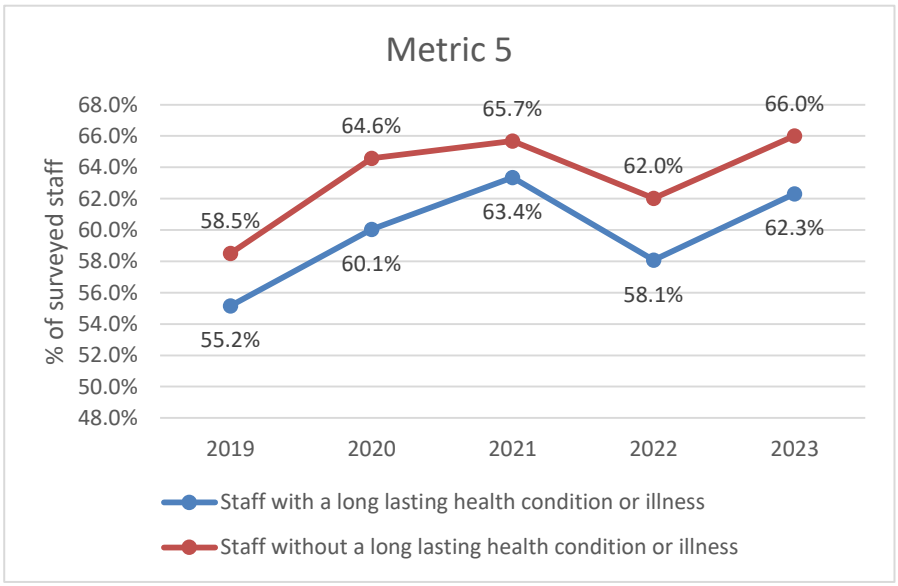


In 2023, the percentage of staff who stated that they reported harassment and bullying at work with a long-lasting condition was 61.3% compared to 63.8% of staff without. The figure for both has shown an upward trend with a slight decrease this year for those without a long-lasting condition.

The Trust figures are similar to those in the benchmarking group.

Metric 5

Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.

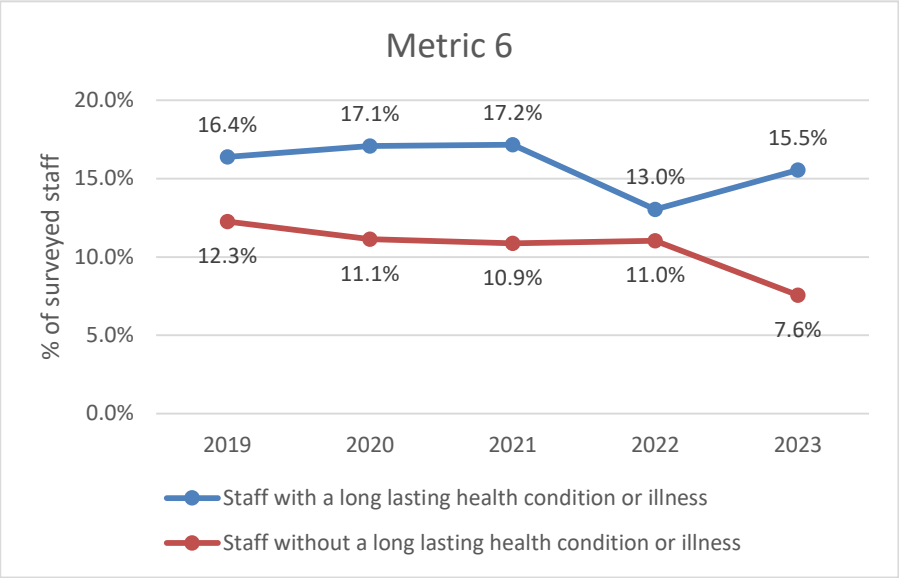


In 2023, the percentage of staff who believed that the organisation provides equal opportunities with a long-lasting condition was 62.3% compared to 66% of staff without a condition. The figure for both groups has risen steadily and show an upward trend.

The Trust figures are similar to those in the benchmarking group.

Metric 6

Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

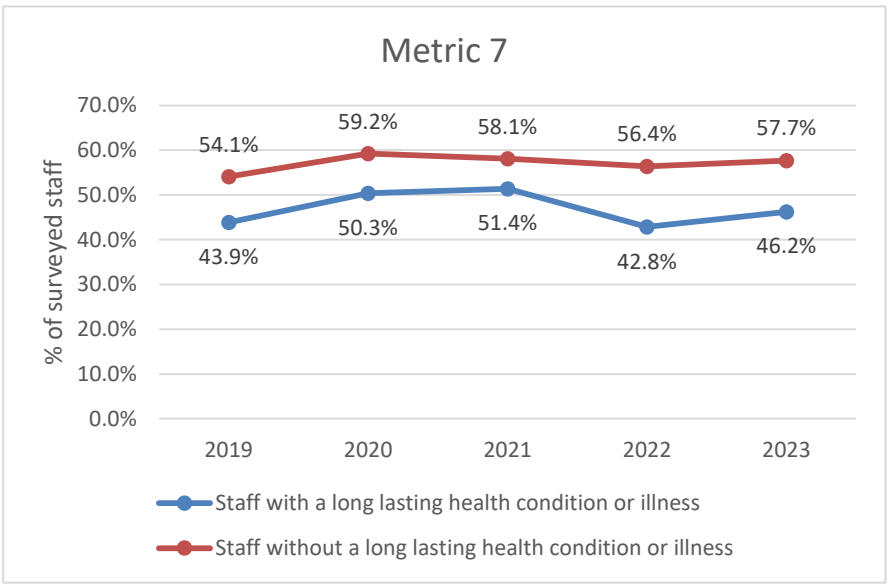


In 2023, the percentage of staff with long lasting condition that felt pressure to come to work despite not feeling well enough was 15.5% compared to 7.6% of staff without a condition. The figure for those will conditions has increased this year with the score for those without a condition being the lowest score recorded.

Compared to the benchmarking group, our Trust figures are significantly lower for staff with a condition and slightly lower for staff without a condition.

Metric 7

Percentage of staff saying they are satisfied with the extent to which the organisation values their work.



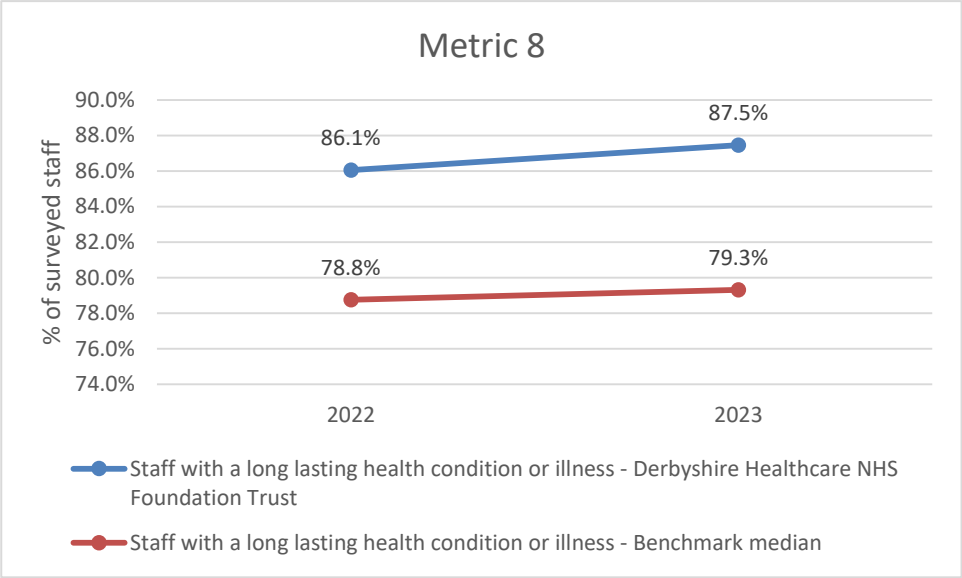
In 2023, the percentage of staff that have a long-lasting condition that reported they are satisfied with the extent the organisation values their work was 46.2% compared to 57.7% of staff without a long-lasting condition. The figure for both groups had risen steadily in an upward trend.

The Trust figures are similar overall to those in the benchmarking group.

Metric 8

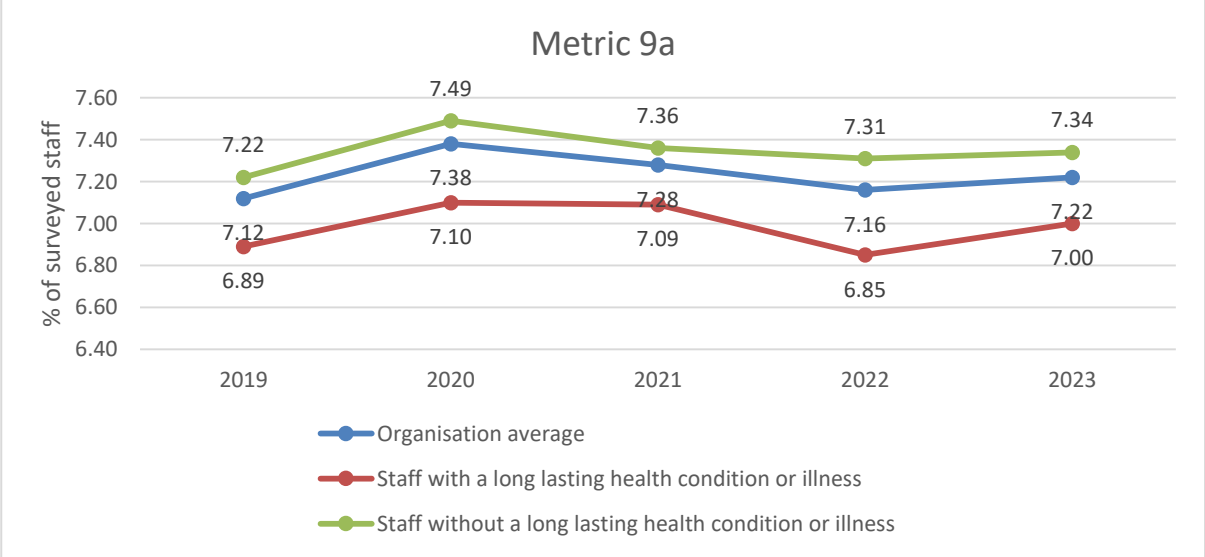
Percentage of staff with a long-lasting health condition or illness saying their employer has made reasonable adjustments to enable them to carry out their work.

Figures in the staff survey state that 87.5% of staff with a long-lasting condition or illness felt that reasonable adjustments had been made. This compared to a benchmarked figure of 79.3%.



Indicator 9a

Staff engagement score for disabled staff, compared to non-disabled staff. The data shows an increase in staff engagement in 2023 for all groups.



Indicator 9b

Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard (Yes/No).

Yes. We have an active staff network DAWN (Disability and Well-being Network) who are supported with resources from the Trust who provide support for their members and are members of the EDI Steering Group.

Indicator 10

Percentage difference between the organisation's Board voting membership and the overall workforce.

This Indicator shows the representation of disabled staff by comparing two figures: the percentage of disabled staff in the organisation, and the percentage of voting membership at the Board, and then working out the difference. In 2024, the percentage difference between the organisation's Board voting membership and its organisation's overall workforce is 5 %.

Conclusions

The WDES provides NHS trusts with a series of quantitative measures which demonstrate disability disparity. WDES data has been collected since 2019 from which we can assess trends over time. We can also draw some conclusions about what is and isn't working to improve disability equality at the Trust.

In common with trusts across NHS England, there is a continuing issue with unrecorded data on the Electronic Staff Record. However, the Trust has made real progress on this in recent years, reducing the number of unknowns across the Trust. The DAWN staff network has been instrumental in this achievement.

While ESR records "disability", the staff survey records staff who have a long-term conditions or illness so there are some difficulties in directly comparing the two groups. However, we can see clearly where the disparities lie in the Trust. On most measures of bullying, harassment and discrimination, staff with a long-term condition or illness are significantly more likely to have negative work experiences than their counterparts and this increased from 2022 to 2023. Further work will need to be done to understand this.

The results from staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties increased for staff with a long-lasting condition where it has reached its lowest ever metric for those without a condition. This needs to be reviewed further. There is also evidence of disparity which needs to be monitored across a range of indicators.

On a positive note, some of the indicators are showing improvements over time including 87.5% of staff with a long-lasting condition felt reasonable adjustments were made.

Analysing numerical WDES data tells us the "what", and we are committed to further investigation into the "why". To maximise the effectiveness of the WDES, the indicator measures and accompanying actions will be an integral part of wider culture transformation at the Trust.

Action Plan

Quarterly oversight of the WDES actions sits with the Equality, Diversity & Inclusion (EDI) Steering Group which is chaired by the Director of People, Organisational Development and Inclusion and the Director of Nursing, AHPs, Quality and Patient Experience. The group brings together colleagues in key corporate roles, with staff networks and representatives. In June 2023, NHS England published its EDI Improvement Plan[5] with six high impact actions, some of which are aligned to the WDES objectives below.

Action Area	Activities	Who The EDI Steering Committee will be sighted on all actions and review progress at quarterly meetings	When	Status
Bullying, Harassment, Abuse & Discrimination	Review and redesign EDI Essentials Training to clearly state what behaviour consists of, how to prevent it, and manage it when it occurs	EDI team	January 2025	To be commenced
	Candidates put forward for the Active Bystander Train-the-Trainer programme as well as visual displays to support the active bystander initiative	EDI team and others (in progress)	January 2025	To be commenced
Inclusive Recruitment	Deliver Chair of panel inclusive recruitment and selection training	Strategic Recruitment Lead	Ongoing and to continue in 2025	Ongoing
	Develop action plans to become disability confident leader	Chair of DAWN / Head of EDI / Strategic Recruitment Lead	January 2025	To be commenced
	Reasonable adjustment recruitment masterclass	Chair of DAWN / Strategic Recruitment Lead	Spring 2025	To be commenced
	Develop partnerships with DWP on initiatives to support disabled applicants with work opportunities	Strategic Recruitment Lead	January 2025	To be commenced.
	Develop guidance for applicants on what reasonable adjustments look like to and why we ask for this information	Strategic Recruitment Lead / Recruitment team	January 2025	To be commenced
Progression and Promotion	Review of Recruitment Inclusion Guardians	Head of EDI	March 2025	To be commenced
	Review barriers to progress for those with a disability	Head of EDI	Spring 2025	To be commenced

[5] NHS equality, diversity, and inclusion improvement plan (england.nhs.uk)

Culture of Inclusion and Belonging	Try and encourage staff who have not completed disability diversity data to disclose	DAWN / Head of Workforce / Head of EDI	Spring 2025	To be commenced
	Utilising exit interviews to understand reasons for disabled staff leaving the Trust	Head of EDI	October 2024	Ongoing
	Implement divisional actions plans based on staff survey data and results	Head of EDI	March 2025	To be commenced

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2024

Safer Staffing Annual Review

Purpose of Report

To provide a statement to the Board on the required skill mix and provide assurance to the Committee on the work being undertaken to monitor and develop the skill mix of staff across Derbyshire Healthcare NHS Foundation Trust (DHcFT) to ensure safe services.

Executive Summary

This report considers issues in relation to the skill mix and staffing levels in the Trust since the previous annual report.

It compares the performance of DHcFT against national data outcomes as well as providing dashboard data and updated Skill Mix figures linked to the Care Hours Per Patient Day (CHPPD) benchmark.

It describes the Trust's process for identifying safe staffing requirements within the Trust and comments on steps being taken by the Trust to attract and develop new staff to achieve quality of care, standards, and safety.

DHcFT was below average overall with 10.15 CHPPD hours achieved, when benchmarked against other Mental Health trusts in the country (11.5 hours). When compared with the safer staffing data reported in September 2023, there has been an overall increase of 25% in services achieving safe staffing levels for Registered Nurses. In the previous report 71% of teams achieved their safer staffing numbers during both the day and the night for registered staff and 100% of the time for unregistered care staff.

In comparison, in September 2023, safer staffing numbers were reached 43% of the time for Registered Nurses both during the day and during the night and in non-registered care staff, safer staffing numbers were achieved 100% of the time.

All areas of deficit in qualified workforce have a level of mitigation through the over-achieving of unqualified care staff levels. To meet the safer staffing need, actions are identified in the main report to ensure that staffing levels are in line with national safer staffing standards and as anticipated, safer staffing numbers in relation to Registered Nurses have improved since the last report.

A new establishment review process is currently being rolled out, which includes the implementation of the evidence-based Mental Health Optimal Staffing Tool (MHOST) as an adjunct to the electronic rostering system and a multi-disciplinary review process. This will use both the safe staffing multipliers relevant to our ward types from the MHOST and structured professional judgement to determine the appropriate levels of staffing per ward.

This process is expected to reduce the use of temporary staffing and agency within Trust inpatient services and to improve compliance with safer staffing requirements. Having agreed this process, work is underway to establish the process for reviewing community staffing requirements following a similar methodology.

DHcFT is below the average in relation to the numbers of qualified Nurses and Allied Health Professionals (AHP) when compared nationally with similar services. However, according to available data, DHcFT has a lower-than-average vacancy rate for Registered Nurses of 4.78%, against a national vacancy rate of 8.4%.

DHcFT has a lower-than-average proportion of Registered Nurses and Medical Staff leaving the Trust when compared with regional peers. Analysis is ongoing around the reasons for staff leaving and actions are being used to improve recruitment and retention in all areas. The number of Allied Health Professionals and Health Visitors leaving the Trust is higher than average, over a rolling 12-month period. However, it is acknowledged that retention and recruitment of Health Visitors is a particular challenge at present, due to the low number of professionals going into this career. Efforts are being made to recruit into this service and retain staff, despite other NHS and private providers providing monetary incentives to join them.

According to the most recent benchmark data, the Trust is spending less than our local and national peers on temporary staff and agency. However, it is recognised that the use of temporary staffing has increased since the introduction of zonal observations in some areas. The use of temporary workforce and agency staffing is monitored via a monthly meeting and a monthly performance report is provided to the Trust senior leadership team.

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

Risks and Assurances

- The report provides evidence of progress and assurance that we are working towards our aspiration to ensure that we have the right staff in the right place at the right time
- The Trust sits above national benchmarking figures linked to staffing levels and shows a lower percentage of vacancies and turnover of staff compared to national and regional benchmarks
- In any redesign of services, and ward size reductions, changes in environments a full review of skill mix would be undertaken to re-evaluate the clinical risks and required standards.

Consultation

- Head of Nursing team
- Director of Nursing
- Lead AHPs
- Deputy Director of Nursing
- Managing Director Acute Services
- Quality and Safeguarding Committee.

Governance or Legal Issues

- 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)
- National Quality Board guidance on Safe Staffing (2016)
- Safe, sustainable, and productive staffing in mental health services
- Improvement resource to help standardise safe, sustainable, and productive staffing decisions in mental health services. Edition 1 (January 2018).

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.

Recommendations

The Board of Directors is requested to note the contents of the report and its scrutiny and assurance received at the Quality and Safeguarding Committee.

Report presented by: **Tumi Banda**
Director of Nursing, AHPs, Quality and Patient Experience

Report prepared by: **Joseph Thompson**
Assistant Director for Clinical and Professional Practice

Safer Staffing Annual Review

Introduction

The Trust approach to safe staffing continues to focus on the ability of the organisation to provide a person-centred, trauma-informed care, patient pathway that has the right staff with the right skills and for those staff to be in the right place at the right time.

In 2019, after several concerns were identified, the Care Quality Commission (CQC) published the report, “Identifying and responding to Closed Cultures”. Within this, it is identified that all clinical providers must take the responsibility to ensure they are working to:

- The right staff – Ensuring staff are relevant and specific training and there are appropriate numbers of trained and skilled staff
- The right culture – Ensuring that managers create a culture of respect for human rights, person-centred care, and least restrictive practice
- The right model of care – Ensuring people are receiving care in an appropriate place and time.

The main contributing factors to an organisational decline in patient safety, care and experience are highlighted by The CQC in the Closed Cultures report as:

- Large numbers of staff vacancies
- Inexperienced staff and lack of training
- Poor supervision and leadership, lack of training and poor or weak leadership and management.

This is further supported by the National Quality Board that highlights the below as an essential criterion for staffing skill mix:

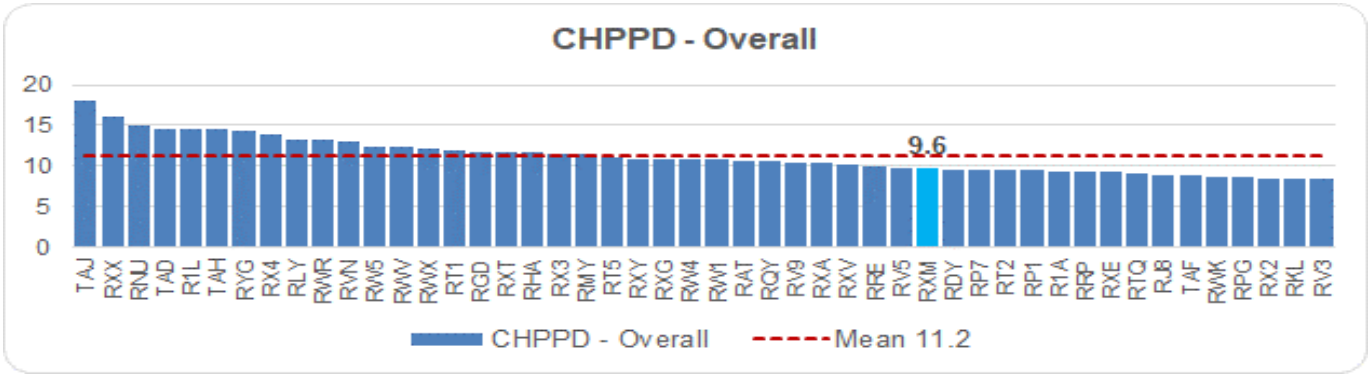
Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

This report will focus on the Trusts approach to staffing including:

- Care Hours per Patient Day and safer staffing
- Current vacancy position and impact
- Recruitment and retention.

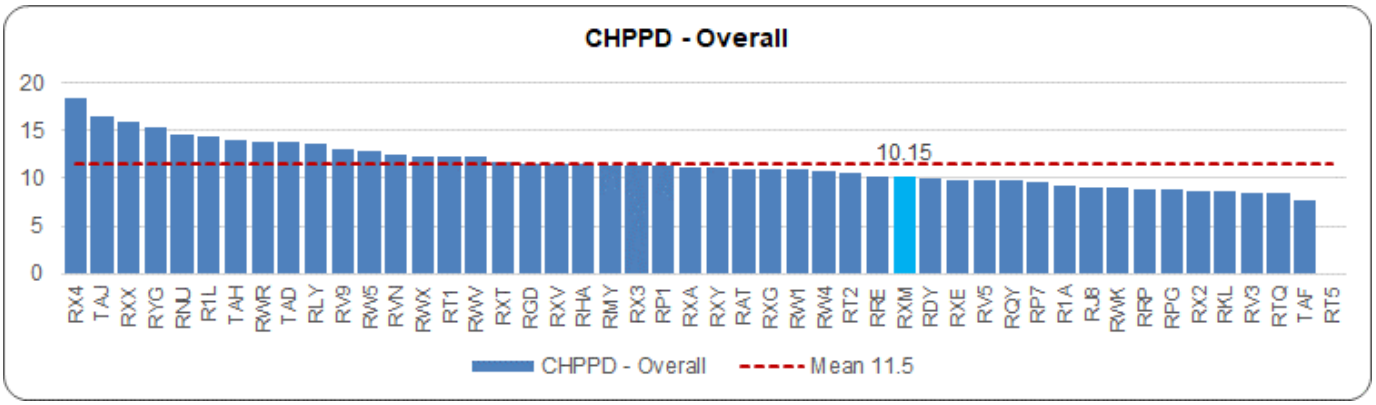
Skill Mix and Safer Staffing

Care Hours Per Patient Day (CHPPD)

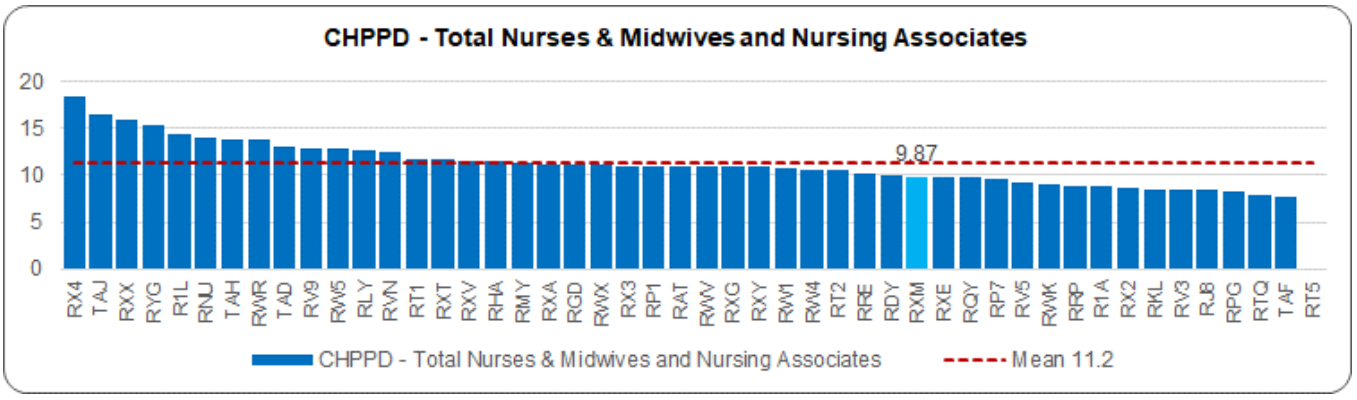


CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered Nurses and Midwives and by Healthcare Assistants are added together. Each day, the number of patients occupying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

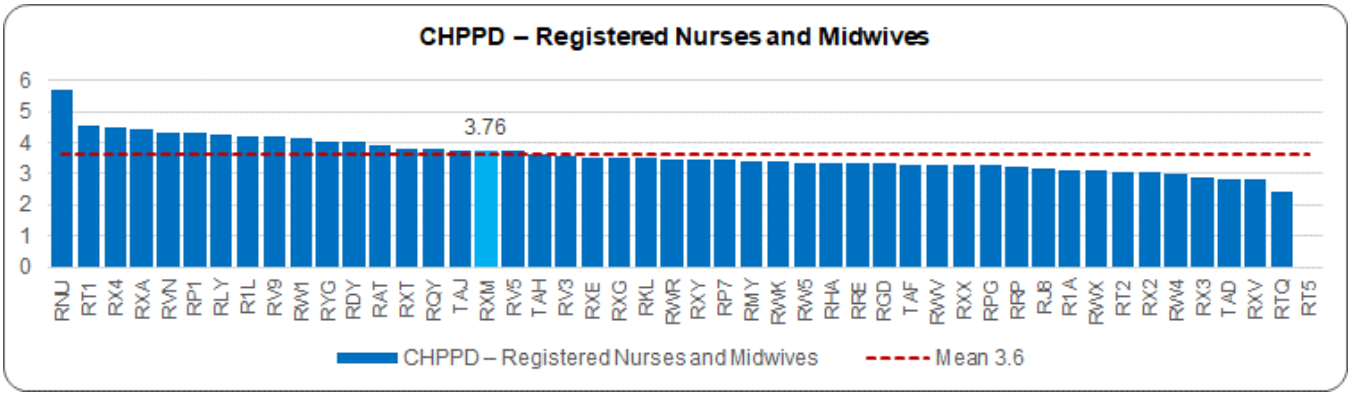
The chart below indicates DHcFT overall achieved 10.15 hours, which was below the national average of 11.5, when benchmarked against other mental health trusts in the country. However, this is an improvement of 0.55 when compared with the report in November 2023.



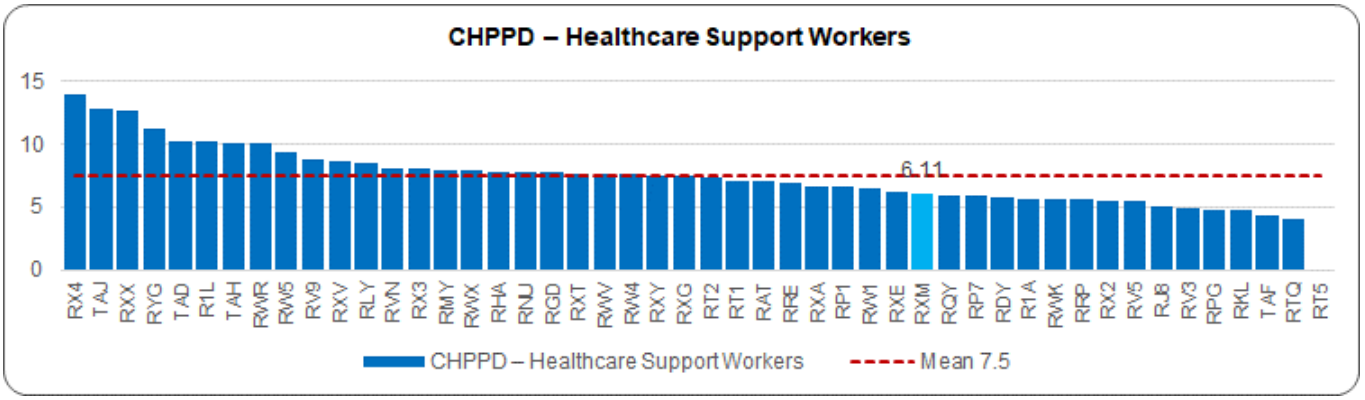
For registered Nurses and Nursing Associates, the Trust achieved 9.87 hours against the national average of 11.2 hours:



For registered Nurses the Trust achieved 3.76 hours above the national average of 3.6 hours:



For Healthcare Support Workers the Trust achieved 6.11 hours against the national average of 7.5 hours:



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

Safer Staffing and Skill Mix

The DHcFT safer staffing levels table below shows the current Trust safer staffing levels related to the care hours per patient day. This data is used to input and set up e-Roster structures for inpatient area teams and is also publicly displayed and available for the Integrated Care Board (ICB) and CQC visibility. The staffing levels below are based on a staffing ratio of one qualified staff member per six to eight patients (depending on ward size and patient acuity). The Royal College of Psychiatry accreditation process (AIMs) identifies that an inpatient setting is required to follow minimum ratio of one qualified staff member per 10 patients. The increased ratio adopted by DHcFT allows and takes into account, the current bed design, dormitories, large wards (over 18 beds) and a consideration for absence from work (eg, sickness) to reduce the possibility of shifts where the required ratio is not met. In addition, a newly qualified professional workforce has been considered when agreeing the current establishment.

It is important to acknowledge that these figures do not take into consideration staff that do not sit within shift numbers, eg Advanced Clinical Practitioners, Recreational Workers, Physiotherapy, Hub staff and Occupational Therapists, who also add to the quality-of-care experience in the safer staffing of the units.

A new process around establishment review has been agreed, which utilises the safecare function of the e-Roster in conjunction with the mental health optimum staffing tool (MHOST) with the final establishment agreed using a professional judgement framework to sense check the recommendations from MHOST. The process is fully outlined in the next section of the report.

A project being monitored via the "Life Qi" Platform, is to diversify the skill mix in three pilot wards to identify a professional role that would improve patient and staff experience and in turn, improve retention and recruitment into inpatient areas, has been put on hold due to increased recruitment of registered Nursing staff undergoing preceptorship.

Staff under preceptorship require the support of an experienced registered Nurse and cannot be left in charge of a ward without supervision. Therefore, it would not be safe at present to introduce another registered professional that could not take charge of a ward or carry out the statutory duties of the Mental Health Act, such as enacting a Section 5(4). Preceptees take around one year to complete their preceptorship and become an experienced member of staff. Therefore, due to the number of preceptees that have been recruited and are due to start over the next six months, this project will be reviewed again in around 18 months. However, it should be noted that a Clinical Educator recruited to support this project, will now focus on improving the clinical skills of staff currently in practice, so preceptees have strong role models and will develop sustainable resources that will improve clinical practise of existing staff and support the development of preceptees.

Safe Staffing Establishment Review

The Trust has introduced an evidence-based staffing tool (MHOST), alongside clinical judgement, to enable the Trust to review trends for each service in respect of clinical dependency observations, use of additional temporary staffing, rostering practice and management, incidents, complaints , training and supervision and to reach a conclusion as to whether the levels of staffing allocated in budgets is appropriate to the level of clinical activity, having first determined that observations and other clinical activities, which drive staffing needs, are appropriately prescribed and stepped down, and that rosters are well managed. A cohort of Trust staff has completed the MHOST inter-rater reliability assessment training, which allows them to train other staff.

Each ward has to undertake a minimum of 20 days' scoring and this data would need to be put into the MHOST data table, which would provide a recommendation around an establishment allied to acuity and dependency, based on the measurements provided. The e-Roster team will calculate and analyse the data and provide each ward with a score and suggested establishment for consideration, alongside clinician's professional judgement before an establishment is finalised.

To do this accurately, a professional judgement framework is applied to provide confidence in the results, or flag circumstances where judgement might be used to recommend a variation from the calculated MHOST figures. This will involve completion of a standardised template giving information around staff vacancies, turnover, sickness/absence, use of temporary staff, accurate use of the e-Roster, environmental factors, differences between workload in the day/night, use of enhanced observations, skill mix of ward, experience of ward team and the shift patterns in use.

Following the data collection and analysis process, an Establishment Review Panel, chaired by the Head of Nursing is set up to review the MHOST's recommendation and to apply the Professional Judgement Framework. Following analysis of The MHOST and the Professional Judgement Framework, the panel will make a final recommendation on the establishment for that ward provided to the Director of Nursing who will scrutinise.

As a result, a recommendation on the safe staffing level will be made to the General Manager of a service, where an increase is recommended will be required to submit a case for investment. Key stakeholders, such as Finance and People and Culture colleagues, will be included in the establishment review process.

DHcFT Safer Staffing Levels

	Morning Reg'd	Morning Unreg'd	Morning Total	Afternoon Reg'd	Afternoon Unreg'd	Afternoon Total	Night Reg'd	Night Unreg'd	Night Total
Cubley Court Male	3	4	7	3	4	7	2	3	5
Cubley Court Female	3	4	7	3	4	7	2	3	5
Tissington Ward	3	3	6	3	3	6	2	2	4
The Beeches	2	2	4	2	2	4	1	1	2
Cherry Tree Close	2	3	5	2	3	5	2	1	3
Kedleston Unit	4	4	8	4	4	8	2	4	6
Ward 33	3	2	5	3	2	5	2	1	3
Ward 34	3	2	5	3	2	5	2	1	3
Ward 35	3	2	5	3	2	5	2	1	3
Ward 36	3	2	5	3	2	5	2	1	3
Pleasley Ward	3	2	5	3	2	5	2	1	3
Tansley Ward	3	2	5	3	2	5	2	1	3
Morton Ward	3	2	5	3	2	5	2	1	3

The safer staffing data table below shows how the safer staffing ratio is reviewed and if it is met. Although the table shows red when numbers are under establishment, it also shows red when the staffing ratio is over establishment.

For a more in-depth picture of current skill mix and assurance, Appendix 1 demonstrates the data that is followed to identify that staffing levels are safe.

Safer Staffing Data, January 2024

Selected Month - January 2024	Day		Night	
	Registered Midwives / Nurses	Care Staff	Registered Midwives / Nurses	Care Staff
Ward Name	%	%	%	%
CHILD BEARING INPATIENT	116.9%	140.1%	124.7%	200.6%
CTC RESIDENTIAL REHABILITATION	104.7%	113.8%	97.8%	251.6%
HARTINGTON UNIT - MORTON WARD ADULT	106.0%	211.2%	94.4%	271.8%
HARTINGTON UNIT - PLEASLEY WARD ADULT	79.2%	114.3%	101.5%	144.6%
HARTINGTON UNIT - TANSLEY WARD ADULT	70.7%	160.6%	107.3%	226.3%
KEDLESTON LOW SECURE UNIT	101.7%	108.6%	100.0%	104.1%
KINGSWAY CUBLEY COURT - FEMALE	100.3%	148.4%	106.7%	134.8%
KINGSWAY CUBLEY COURT - MALE	156.7%	135.9%	110.8%	200.3%
KINGSWAY TISSINGTON UNIT - OLDER PEOPLE	102.3%	112.8%	100.4%	126.6%
RADBOURNE UNIT - WARD 33 ADULT ACUTE INPATIENT	92.9%	215.3%	72.7%	471.0%
RADBOURNE UNIT - WARD 34 ADULT ACUTE INPATIENT	113.6%	155.5%	88.7%	301.3%
RADBOURNE UNIT - WARD 35 ADULT ACUTE INPATIENT	96.8%	158.0%	88.9%	290.3%
RADBOURNE UNIT - WARD 36 ADULT ACUTE INPATIENT	132.3%	94.7%	85.5%	296.8%

When compared with the safer staffing data reported in September 2023, there has been an overall increase of 25% in services achieving safe staffing levels for Registered Nurses. As of January 2024, 71% of teams achieved their safer staffing numbers during both the day and the night for registered staff and 100% of the time for unregistered care staff.

In comparison, in September 2023, safer staffing numbers were reached 43% of the time for Registered Nurses both during the day and during the night and in non-registered care staff, safer staffing numbers were achieved 100% of the time.

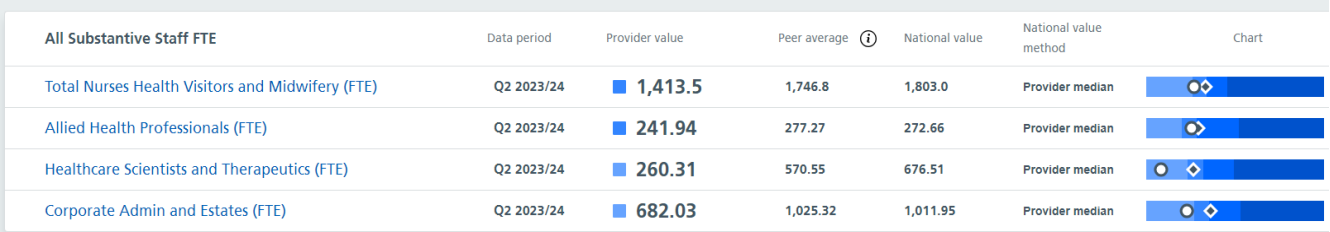
Short- and long-term sickness rates continue to impact on safer staffing numbers and staff have been asked to work excess hours to ensure safe staffing is achieved. This does however increase the risk of staff fatigue and burnout.

All areas of deficit in Qualified workforce have a level of mitigation through the over-achieving of unqualified care staff levels. In some cases, the over resourcing of care staff is considerable (200% plus where there have also been higher levels of engagement observation required). The data would suggest that the improved recruitment is having a positive effect on meeting safer staffing levels on the wards and to better meet this need, the following actions are being taken:

- Recruitment of registered and non-registered staff into all ward areas continues
- Board agreement to over recruit two registered and two non-registered staff per ward is being actioned. However, there is an acknowledgement that over recruiting registered staff is unlikely to be achieved. Therefore, this offer includes the resource related to a training programme of recruiting two Nurse Associate Apprentices per ward
- Fast track recruitment is offered to all final year Nursing Students at Derby University
- All General Managers to work with local teams to ensure suitable mitigations are in place to address shortfalls in workforce
- The new establishment review process is underway.

Skill Mix

Skill Mix Full-Time Equivalent (FTE) Ratio Table



All Substantive Staff FTE	Data period	Provider value	Peer average	National value	National value method	Chart
Total Nurses Health Visitors and Midwifery (FTE)	Q2 2023/24	1,413.5	1,746.8	1,803.0	Provider median	
Allied Health Professionals (FTE)	Q2 2023/24	241.94	277.27	272.66	Provider median	
Healthcare Scientists and Therapeutics (FTE)	Q2 2023/24	260.31	570.55	676.51	Provider median	
Corporate Admin and Estates (FTE)	Q2 2023/24	682.03	1,025.32	1,011.95	Provider median	

With regards to overall skill mix, as per the Skill mix FTE ratio table above, when comparing skill mix with National Mental Health Services, DHcFT is below average in relation to the number of qualified Nurses and Allied Health Professionals (AHP) when compared nationally and to peers.

Current Vacancy Position and Impact

Data from NHS England shows a vacancy rate of 8.4% as of 31 December 2023, within the registered Nursing staff group (34,709 vacancies). This is a decrease from the same period the previous year when the vacancy rate was 10.7% (43,251 vacancies). The Trust has a lower-than-average vacancy rate for this staff group of 4.78, and as per the table below, the Band 5 fill rate has increased by 15% when compared to the previous report. Band 6 vacancies and Healthcare Assistant posts continue to be over recruited.

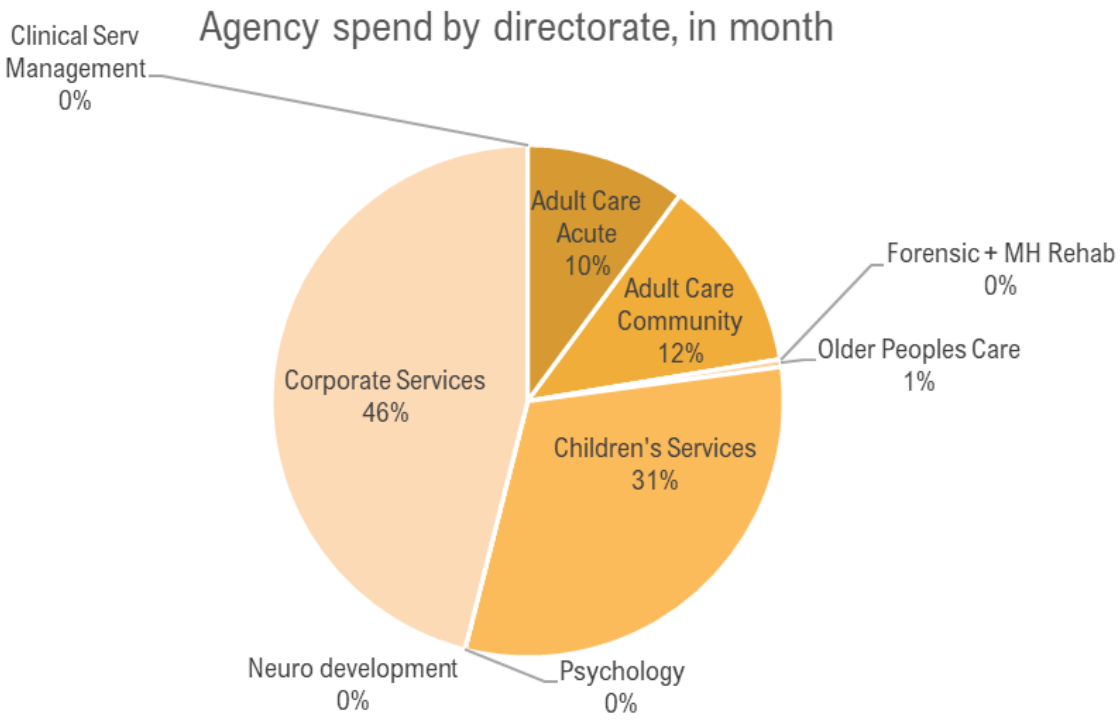
Staff funded/In Post as of January 2024

Ward	Band 5 Nurse Funded	Band 5 Nurse in Post	Band 3 HCA Funded	Band 3 HCA In Post
Ward 33	15.4	10.8	9.4	10.8
Ward 34	15.4	12.8	9.4	18.32
Ward 35	15.4	10.4	9.4	10.4
Ward 36	15.4	13.2	9.4	11.76
Morton Ward	14.2	8.6	15.2	15.9
Tansley Ward	14.08	11.6	14.4	15.4
Pleasley Ward	14.6	9.6	11.55	12.49
Cubley Court Female	10.33	10.8	23.92	24.63
Cubley Court Male	11.8	12.6	22.22	22.04
Tissington	12.55	13.4	13.12	16.1
Kedleston	16	17.77	19.39	16.61
Cherry Tree	10.61	10.44	13.2	12.77
Beeches *	9.47	7.4	11.3	12.96
Total	**189.5**	**149.41**	**197.10**	**200.18**

* combined Band 3 and Band 4

Agency Use

As per the chart below, the main agency spend by directorate is as of January 2024 is the Corporate services, Children's services and Adult Acute services. Analysis suggests that this is due to high levels of clinical activity requiring extra staffing and medical and nursing vacancies.



Activity related to agency and temporary staffing use is monitored in a monthly temporary workforce strategy group and is reported upon and monitored at the Trust Operational Oversight Leadership Meeting. Current actions from this include:

- General Managers to ensure robust process in place to authorise expenditure on agency staffing
- General Managers to ensure processes to reduce unregistered agency workforce are fully implemented.

Recruitment and Retention

As per the table below, on average, DHcFT have a lower-than-average proportion of registered Nurses, and Medics leaving the Trust when compared both nationally and with our regional peers. However, the Trust is over-average in relation to allied health professionals and Health Visitors leaving the Trust, with Health Visitors in the worst performing quartile based on data from the model hospital.

Leaver Rates over the past 12 months

Profession	DHcFT levers rate	Regional Peer Leavers' Rate
Registered Nurses	5.5%	6.6%
Medical and Dental	5.4%	8.3%
Allied Health Professionals	7.2%	5.9%
Health Visitors	13.6%	4.9%

Analysis of the data from the model hospital over a rolling 12-month period, suggests that the main reason for staff leaving the Trust is retirement, relocation, work life balance and pay. For Health Visiting, due to an ageing workforce, a number of staff retired but have subsequently returned. A number of staff also left to get jobs nearer to home as they would train in Derbyshire and then get a job nearer to where they live.

Retention and recruitment of Health Visitors is a particular challenge at present due to the low number of professionals going into this career. Efforts are being made to recruit into this service and retain staff, despite other NHS and private providers providing monetary incentives to join them. The Health Visiting service has updated their advert with a video of staff citing positive experiences of working at the Trust and the service also routinely attends recruitment fairs and visit universities to encourage staff to join and highlights benefits such as agile working. The service has also converted some of their Band 6 posts to Band 5 training posts, to develop registered clinicians into Health Visitors and these Band 5 staff are also supported through their preceptorship.

Additionally, staff wanting to join the Health Visiting service are offered a relocation package and this has shown some success with one individual relocating from Hull.

A lower-than-average number of staff leaving a service is a good indication of their satisfaction at work and would suggest retention strategies such as the "Band 5 to 6 program" are having a positive impact and that staff feel supported in the workplace.

Actions

To improve recruitment and retention to the Trust several initiatives are currently live such as:

- Recruitment of 2 HCAs per ward.
- Each ward to aim to have 2 Nursing Associates in post who will be a cost pressure whilst in training. There are current 14 Nurse Associates in training with a plan to recruit an additional 8 apprentices on the March cohort.
- DHcFT have agreed to facilitate 6 Health Support Workers apprentices. As these will be a cost pressure, these are being allocated to wards currently indicated with highest spend on agency HCA workforce in the hope of offsetting the expenditure.
- A "Fast Track" recruitment programme supporting newly qualified nurses into posts within DHcFT is now underway. The next cohort will qualify in September 2023 and the Trust are expecting to appoint approximately 25 newly qualified nurses through this programme.
- DHCFT have recruited 3 international MH.
- Fast Track recruitment is offered to all final year Nursing Students at Derby University

Conclusion

The Trust continues to benchmark favourably in terms of our ability to recruit and retain registered Nursing staff, which is critically important as we progress to the commissioning of the Making Room for Dignity Programme.

However, there are some professional groups which present a more significant challenge in retaining and attracting, such as some AHP groups and Health Visitors particularly.

It also worth noting that our baseline staffing is typically lower than comparators, which will be considered as part of the wider roll out of the Trust's new safe staffing review process.

Appendix 1

Wards	Emergency Staffing	Safer Staffing
All inpatient wards	The minimum numbers expected.	• DHcFT Standard - 1-6/8 ratio – 1q per six patients • National standard/benchmarking is one to 10 or two RNs to 18 beds. In line with AIMs.

Named Wards/Area	Emergency staffing	Safer Staffing – what is on e-roster
Ward 33 – 20 beds normally – Female only		
E	RN 1, NA 3 = 4	RN 3, NA 2
L	RN 1, NA 3 = 4	RN 3, NA 2
N	RN 1, NA 2 = 3	RN 2, NA 1
Ward 34 – 20 beds normally – Male only		
E	RN 1, NA 3 = 4	RN 3, NA 2
L	RN 1, NA 3 = 4	RN 3, NA 2
N	RN 1, NA 2 = 3	RN 2, NA 1
Ward 35 – 20 beds normally – Female only		
E	RN 1, NA 3= 4	RN 3, NA 2
L	RN 1, NA 3= 4	RN 3, NA 2
N	RN 1, NA 2 = 3	RN 2, NA 1
E	RN 1, NA 3= 4	RN 3, NA 2
L	RN 1, NA 3= 4	RN 3, NA 2
N	RN 1, NA 2 = 3	RN 2, NA 1
Morton – 21 patients – Female only		
E	RN 1, NA 3= 4	RN 3, NA 2 = 5
L	RN 1, NA 3= 4	RN 3, NA 2 = 5
N	RN 1, NA 2 = 3	RN 2, NA 1 = 3
E	RN 1, NA 3= 4	RN 3, NA 2 = 5
L	RN 1, NA 3= 4	RN 3, NA 2 = 5
N	RN 1, NA 2 = 3	RN 2, NA 1 = 3
E	RN 2, NA 2= 4	RN 3, NA 2 = 5
L	RN 2, NA 2= 4	RN 3, NA 2 = 5
N	RN 1, NA 2 = 3	RN 2, NA 1 = 3
The Beeches		
E	RN 1, NN 1 (Nursery Nurse) NA 2 = 4	RN 1, NN 1, NA 2 = 4
L	RN 1, NN 1, NA 2 = 4	RN 1, NN 1, NA 2 = 4
N	RN 1, NN 1 = 2	RN 1, NN 1 = 2
Tissington		
E	RN 2, NA 3 = 5	RN 3, NA 3 = 6
L	RN 2, NA 3 = 5	RN 3, NA 3 = 6
N	RN 2, NA 2 = 4	RN 2, NA 2 = 4

Cubleys – Male and Female **18-bedded unit comprised of two separate pods.**		
E	RN 2, NA 4 = 6	RN 3, NA 4 = 7
L	RN 2, NA 4 = 6	RN 3, NA 4 = 7
N	RN 2, NA 2 = 4	RN 2, NA 3 = 5
Kedleston Unit		
Curzon – 8 patients – male – LSU		
E	RN 2, NA 2 = 4	RN 2, NA 2 = 4
L	RN 2, NA 2 = 4	RN 2, NA 2 = 4
N	RN 1, NA 2 = 3	RN 2, NA 1 = 3
Scarsdale - 12 patients – LSU – Male		
E	RN 1, NA 2 = 3	RN 2, NA 1 = 3
L	RN 1, NA 2 = 3	RN 2, NA 1 = 3
N	RN 1, NA 2 = 3	RN 2, NA 1 = 3
Cherry Tree Close – 24 total over 5 bungalows		
E	RN 2, NA 3 = 5	RN 2, NA 3 = 5
L	RN 2, NA 3 = 5	RN 2, NA 3 = 5
N	RN 1, NA 3 = 3	RN 2, NA 1 = 3

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2024

Emergency Powers of the Chief Executive and the Chair

Purpose of Report

To inform the Board of the use of emergency powers by the Chief Executive and the Chair.

Executive Summary

The Board has a mechanism for making timely decisions outside its scheduled meetings under its emergency powers, facilitating service continuity and mitigating potential, resulting risks due to delayed decision making.

The emergency powers have been used twice recently as follows:

On 8 August 2024, the Chair and Chief Executive, having consulted with two Non-Executive Directors (Tony Edwards and Geoff Lewins) approved the decision of the Executive Leadership Team not to participate in the tender process for 2025-2028 Talking Therapy Service Contract (formerly Improving Access to Psychological Therapies (IAPT). An urgent decision was required due to the pre-submission process.

On 9 August, the Chair and Deputy Chief Executive (during CEO cover), having consulted with two Non-Executive Directors (Geoff Lewins and Deborah Good) approved version 2.3 of the Board Assurance Framework. An urgent decision was needed before the rescheduled Board meeting, to meet the deadlines under the review schedule.

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

For the decision taken on 8 August, information on contractual, financial and service implications were provided in background reports. For the decision taken on 9 August, that version of the BAF had been reviewed at the lead Committees and the Audit and Risk Committee.

Consultation

Both issues previous been considered at the appropriate Board Committees and the Executive Leadership Team.

Governance or Legal Issues

The powers which the Board has reserved to itself within its Standing Orders may in an emergency be exercised by the Chief Executive and the Chair, after having consulted at least two Non-Executive Directors (SO 6.2). The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for noting.

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 impact on those with protected characteristics arising from the use of the emergency powers for the decision taken on 8 August will be considered as part of the operational response.

Recommendations

The Board of Directors is requested to note the exercise of emergency powers by the Chief Executive and the Chair as set out in the summary above.

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 1 October 2024

Report from the Council of Governors meeting

The Council of Governors has met once since the last report, on 3 September 2024. The meeting was conducted as a hybrid meeting.

Presentation of the Annual Report and Accounts 2023/24 and report from the external auditors

The Annual Report and Accounts 2023/24 were presented to the Council of Governors. It was confirmed that they will also be presented, consistent with financial reporting, at the Annual Members Meeting on 26 September 2024.

The representative from the Trust's external auditors, Forvis Mazars (formerly Mazars) provided a summary of the positive annual report letter and outlined their responsibilities as follows:

- Give an opinion on the Trust's financial statements
- Assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion).

The representative from Forvis Mazars confirmed that the audit was completed by the deadline and that they had not identified any significant weaknesses which would require further work or wider reporting.

Non-Executive Directors Report

Geoff Lewins, Non-Executive Director (NED) presented an overview of his role and activities at the Trust. This included the annual report of the Audit and Risk Committee.

Escalation item to the Council of Governors from the Governance Committee

Tony Edwards, Chair. provided Governors with an overview of the Making Room for Dignity Programme which included progress on construction of the new facilities and recruitment.

Brief update on performance

A summary of performance was provided by the NEDs. It was noted that as the Public Board meeting had been rescheduled from 3 September to 1 October, the Integrated Performance Report will be circulated to Governors via the Public Board papers for the meeting in October.

Living Well Programme update

An update on the Living Well Programme was presented and included priorities for this financial year, and the impact and performance of the service.

Report from Governors' Nominations and Remuneration Committee – 24 July 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 included:

- An outline of the process for the NED recruitment
- A proposal for the re-appointment of Deborah Good, NED
- Review of the Chair and NED expenses policy
- Confirmation that the summary of the Trust Chair's appraisal had been submitted to NHS England

The Council of Governors approved the:

- Re-appointment of Deborah Good, as Non-Executive Director and Chair of the Audit and Risk Committee, for a further three years from 1 March 2025
- The Chair and NED Expenses policy which mirrors staff mileage and allowances as previously agreed.

Governance Committee Report

The Co-Chair of the Governance Committee presented a report of the meeting held on 12 June 2024. The Council of Governors approved the Governance Committee's recommendation to ratify the Committee's terms of reference for a further year.

Any other business

The Committee welcomed Debra Dudley as the newly Appointed Governor representing Derbyshire Mental Health Forum.

RECOMMENDATION

The Trust Board is asked to note the summary report from the Council of Governors meeting held on 3 September 2024.

FORWARD PLAN - BOARD - 2024/25		07-May-2024	02-Jul-2024	01-Oct-2024	05-Nov-2024	14-Jan-2024	04-Mar-2025
	Deadline for Approved Papers	**25-Apr-2024**	**21-Jun-2024**	**18-Sep-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 (on approval, launch Nov-2024)	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	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
FTSUG	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
DoF	Standing Financial Instructions (following assurance at ARC)			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)			Deferred to Nov-2024	X		
DCEO/CDO	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)			Deferred to Nov-2024			
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) - Quality Account (Jul)				X		
DCEO/CDO	Continuous Quality Improvement: A Stocktake						X
DON	Infection Prevention and Control Annual Report and IPC 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 Oct-2024	X			

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
AC/RC	Approved Clinician/Responsible Clinician
ADHD	Attention Deficit Hyperactivity Disorder
ADI-R	Autism Diagnostic Interview-Revised
ADOS	Autism Diagnostic Observation Schedule (assessment)
AfC	Agenda for Change
AHP	Allied Health Professional
AI	Artificial Intelligence
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
BCP	Business Continuity Plan
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
CBRN	Chemical, Biological, Radiological and Nuclear
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
CESR	Certificate of Eligibility for Specialist Registration
CGA	Comprehensive Geriatric Assessment
CHPPD	Care Hours Per Patient Day
CIN	Children in Need
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CP	Child Protection
CPA	Care Programme Approach
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
CSDS	Community Services Data Set
CSF	Commissioner Sustainability Fund
CSPR	Child Safeguarding Practice Review
CTO	Community Treatment Order
CTR	Care and Treatment Review
CYP	Children and Young People
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
DISCO	Diagnostic Interview for Social and Communication Disorders (assessment)
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
DoLS	Deprivation of Liberty Safeguards
DON	Director of Nursing
DPA	Data Protection Act
DPI	Director of People and Inclusion
DPR	Divisional Performance Review
DPS	Date Protection and Security
DQMR	Data Quality Maturity Index
DRR	Drug Rehabilitation Requirement
DRRT	Dementia Rapid Response Team
DSAB	Derby and Derbyshire Safeguarding Adult Board
DSP	Data Security and Protection
DSCB	Derby and Derbyshire Safeguarding children Board
DSPT	Director of Strategy, Partnerships and Transformation
DTOC	Delayed Transfer of Care
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
G	
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GMP	Guaranteed Maximum Price
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
HCP	Healthy Child Programme
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HFMA	Healthcare Financial Management Association
HoNOS	Health of the Nation Outcome Scores
HoP	Head of Practice
HOPE(s)	The HOPE(s) model is an ambitious human rights-based approach to working with individuals in segregation, developed from research and clinical practice
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HV	Health Visitor
HWB	Health and Wellbeing Board
I	
IAPT	Improving Access to Psychological Therapies
Icare	Increase Confidence, Attract, Retain, Educate
ICB	Integrated Care Board
iCIMS	Internet Collaborative Information Management System
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
INQUEST	
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	
JCVI	Joint Committee on Vaccination and Immunisation
JDF	Junior Doctor Forum
JLNC	Joint Local Negotiating Committee

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
LHP	Local Health Plan
LHRP	Local Health Resilience Partnership
LHWB	Local Health and Wellbeing Board
LNC	Local Negotiating Committee
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LTP	Long Term Plan
LTS	Long Term Segregation
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
MST	Multisystemic Therapy
MSU	Medium Secure Unit
N	
NCRS	National Cancer Registration Service
ND	Neuro-development
NED	Non-Executive Director
NETS	National Educational Training Survey
NHS	National Health Service
NHSCFA	NHS Counter Fraud Authority
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIMS	National Incident Management System
NIVS	National Immunisation and Vaccination System
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
PFF	Probation Feedback Form
PHC	Public Health Commissioners
PHCIC	Physical Healthcare and Infection Control Committee
PHE	Public Health England
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	Persons in a Position 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
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	
s132	Section 132 of the Mental Health Act: As soon as a patient is detained under the Act the patient must be given their rights orally and in writing unless it is not practicable at that time. If this is the case, it must be documented in the patient's electronic care record
s136	Section 136 of the Mental Health Act: Police can use emergency powers if they think you have a mental disorder, you're in a public place and need immediate help. They can take you or keep you in a place of safety, where your mental health will be assessed.
SAAF	Safeguarding Adults Assurance Framework
SAR	Safeguarding Adult Review

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
SAS Doctor	Specialist, Associate Specialist and Specialty Doctor
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SCPHN	Specialist Community Public Health Nurse
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
SLaM	South London and Maudsley NHS Trust
SLR	Service Line Reporting
SMI	Severe Mental Illness
SNOMED CT	Systemised Nomenclature of Medicine – Clinical Terms
SOC	Strategic Options Case
SOF	Single Operating Framework
SOP	Standard Operating Procedure
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
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	
UHDB	University Hospitals of Derby and Burton
UEC	Urgent and Emergency Care
V	
VARM	Vulnerable Adult Risk Management

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
VCOD	Vaccination as a Condition of Deployment
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

September 2024